

The Ten Essential Shared Capabilities: reflecting on the pilot of a learning and development initiative with a group of Adaptation Nurses

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REFLECTIVE ACCOUNT

Ten Essential Shared Capabilities (Hope 2004: 4-5)

'The aim of the ESC is to set out the shared capabilities that all staff working in mental health services should achieve as best practice... ...the ESC should form part of the basic building blocks for all staff who work in mental health whether they are professionally qualified or not and whether they work in the NHS, the social care field or the private and voluntary sectors.'

'...The development of the ESC is a joint NIMHE and SCMH Project. It builds on the work of the SCMH CPF (Capable Practitioner Framework)...'

It is important that the ESC are adopted as a framework not only for the development of education curricula but also as a framework for Personal Development Planning (PDP), Training Needs Analysis...

Introduction

Bedfordshire & Luton Partnership Trust (BLPT) was selected to participate in a national learning and development pilot of the ten essential shared capabilities, in collaboration with the National Institute for Mental Health in England. Nominated as the Trust representative to participate in the Train the Trainer programme for this initiative, I found the learning material very useful. Considering my years of mental health nursing and training, this was the first time that I had experienced the unique situation of attending a residential course where I was sharing, exchanging and communicating information. Furthermore, ideas from a very mixed group of participants, which included service-users, health and social care professionals, proved very stimulating and thought provoking. Receiving training from a service-user on a day to day basis refreshed my thoughts, views and vision. The experience energised me to question and review my beliefs, values and practices in mental health and cascade them amongst other health and social care professionals: prioritising service-users and carers in every aspect of mental health practice was and is my first and foremost positive intention.

The aim of providing and undertaking training in the 'Ten Essential Shared Capabilities' was not only to train the trainer but to enable the trainer to be able to enthuse his future audience with the values and practices learned and experienced and to encourage them to train service-users and other health and social care professionals within the mental health field.

From the first three days of my residential training I had a better understanding of what was expected of me and discussed this with my Assistant Director. His aim was that all health and social care professionals and service-users become involved in this training initiative and he felt that, as a Clinical Trainer, I had the experience, energy and enthusiasm to work and co-ordinate this initiative with colleagues and service-users. There was a commitment from the Trust to enable and enhance people who would become future trainers.

Developing the local Pilot Initiative

The aims and objectives of the training initiative were circulated via personal e-mails to the BLPT address list and the learning & development department assisted by sending a flyer to all Trust departments.

I clearly communicated to all management teams the need to give a commitment to this initiative.

Pilot Phase: my short term plan was to:

- target a specific training group
- provide an intensive 16-hour training programme over 2½ days
- offer the programme to a group

of adaptation nurses (mental health), who were already following a programme of supervised practice and assessment designed for nurses trained outside of the UK and the European Union who want to become registered on the Nursing and Midwifery Council (NMC) professional register – my intention was to enhance their programme with the ten essential shared capabilities, as knowledge that would underpin and assist them to gain the requisite experience to help them become established within the local mental health care service

- provide individual assistance and support
- make available assistance and support for the initiative through telephone and e-mail contact at all times

My long term plan was to:

- provide training for identified service-users, carers and mental health professionals
- provide training packs, access to CD-ROM resources and enable access to internet-based resources which support the training initiative
- provide Trust intranet-based training materials for those without access to training packs
- make available assistance and support for the initiative through telephone and e-mail contact at all times

Rationale and Action Plan for the Training Initiative

The second residential training session

enabled me to have close and further discussions within the classroom setting, through group work and individual presentations. Informally, discussions continued during social periods with mental health colleagues, service-users and carers, which proved stimulating and enriching.

I considered my target audience for the training initiative, which I felt needed to be a wide circle of health and social care professionals, at all levels, and service users and carers, with representatives from the NHS, independent and voluntary sectors. As it was agreed that the target audience needed to be mixed, I invited a cross section of people from the above sectors to take part in the pilot. I also planned to include those whom I thought would cascade the training to others, although it transpired that this was not possible within the time-scale of the pilot and this therefore remains as part of the long-term plan.

Training packs were issued to prospective participants, with individual support, and there was a commitment from the service managers involved to enable their staff to participate.

I felt that in the short term it would be more productive to train individuals with enthusiasm for the purpose of this train the trainer course, who would enable the project to move forward and reach a wider audience. In the long term, and for the purpose of the pilot, the plan is to introduce e-learning, one to one support, group workshops and team presentations.

For the purpose of the Train the trainer programme, I had an agreement with the Human Resources Manager to carry out the seven modules of the Ten Essential Shared Capabilities over

sixteen hours as 2½ days over three consecutive weeks, with participants spending the final half day on a different programme with another trainer, as a way of maximising the use of scheduled training time. The Human Resources Manager attended the final training session to assess my presentation and the individual participants' presentations. This feedback was both very positive and valuable, and it was highly recommended that the training be accessed by all mental health workers and newly qualified staff. This training pack and programme is now being considered for accreditation by the Nursing & Midwifery Council and by Universities in the UK.

For the purpose of this pilot initiative, I focused on the short term plan and prepared to offer the course over 2½ days. Progress evaluation was conducted via telephone and e-mail contact and through the completion of Trust training evaluation questionnaires, which were analysed by the Learning & Development Department.

Providing the Training Initiative

As outlined above, the programme was divided into three days, with a fourth reflective module component (focused on feedback) to be completed independently and returned within a one week period, which would allow participants to reflect by making reference to the seven modules in their pack. The module for each facilitated day followed a specific plan, which involved:

- ice-breaker
- introducing the pack
- emphasising application
- practical exercises (through individual & group work)

- reading
- accessing additional resources for more advanced study (CD ROM / Internet-based)
- relevance to personal development requirements
- focus on national priorities for mental health
- reflections and evaluations

Over the three facilitated training days, the modules of the Ten Essential Shared Capabilities, as supported by specific teaching materials (Faulkner & Basset 2002, Basset 2000) were covered as follows:

Day 1: Module 1 (Getting Started) & Module 2 (Ten Essential Shared Capabilities):

I particularly emphasised the personal development aspects of the programme, highlighting the need for and value of reflecting on learning, self evaluation, self assessment and achieving learning goals using the Ten Capabilities. I encouraged participants to prepare personal action plans using this programme and worked through the activity sheets in the package.

Day 2: Module 3 (Involving Service-Users and Carers), Module 4 (Values-based Practice) & Module 5 (Race Equality & Cultural Capability)

Day 3: Module 6 (Developing Socially-Inclusive Practice) & Module 7 (Personal Action-Planning & Learning Review)

Day 3 was completed with individual participant presentations on the Ten Capabilities and socially inclusive practices.

Evaluation

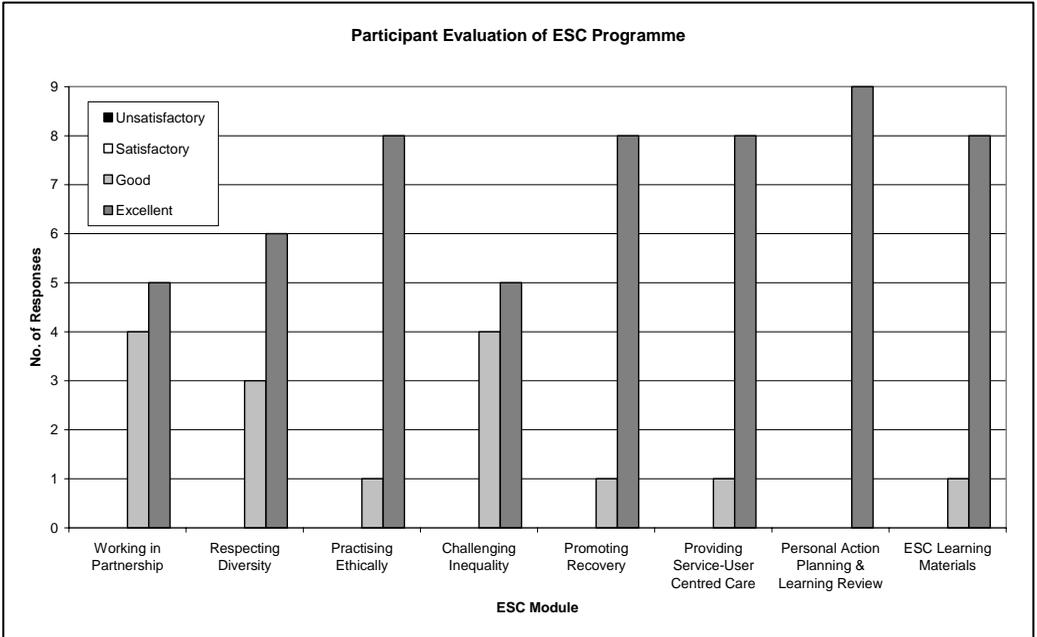
On a sessional basis, in accordance with the teaching plan (as outlined above), an opportunity to reflect upon and evaluate the teaching was offered, with an evaluation form being completed and returned to the Learning and Development Department.

Self assessment forms and goal scoring records were distributed during Day 3 (Module 7), for completion on an individual basis. A review of achievement, with reference to the self assessment forms and goal scoring records, was undertaken.

In addition, an evaluation of the individual's understanding of each module was conducted upon their completion of the module, which involved the following ratings: 1 = Unsatisfactory; 2 = Satisfactory; 3 = Good; 4 = Excellent. Participant ratings for the various modules are shown in Chart 1.

The average evaluation rating was 3.79 over the 7 modules, leading me to believe that the participants were very satisfied with the training received. This is reflected by the recommendation of the Human Resource Manager to continue and expand further applications of this training in other areas. Working closely with the participants was based upon the values and beliefs of the Ten Essential Shared Capabilities. Throughout most of the discussions where experiential learning was demonstrated and acknowledged by the participants, the inclusion of service-users and carers, and their wishes, was acknowledged and discussed.

Chart 1: Evaluation



Self Evaluation and Reflection

In discussing my plans for this training initiative with both the Assistant Director and the Human Resource Manager, I explained the values of the Ten Essential Shared Capabilities and their relevance to the adaptation nurses, who are from different cultures and nationalities and are just at the point of entry to the profession within the UK. The views expressed by the adaptation nurses led me to believe that there was a gap in their approach to the treatment and care of service-users who experience mental health problems. Their knowledge base of the available forms of treatment and care was, in some instances, antiquated, highlighting the importance of introducing the Ten Essential Shared Capabilities upon entry to nursing in the UK. Their enthusiasm for learning and development was

obvious and I felt justified in my choice of participants as an initial training group. Some participants were astonished with our modern approach to mental health care and treatment. The Ten Essential Shared Capabilities promote the beliefs and values of service-users, carers and mental health professionals and also the benefits that can be derived for these groups.

It is expected that the introduction of this programme will enable individuals who enter and engage in employment in the future, given the constraints of professional responsibility and accountability, to understand the beliefs and values of service-users, carers and other mental health professionals. It is also expected that the benefits to service users, carers and participants will be reflected in the findings of clinical / practice audit.

It is worth noting that participants became quite excited about the project as they progressed through the contents of the training pack, leading them to understand the underpinning knowledge and related skills required for the treatment and care of service-users and carers. The participants and trainer shared experiences, competencies and challenged the inequality of practices. I encouraged participants to pass on the knowledge gained and to consider becoming trainers, themselves, for their clinical areas. The participants formed a very cohesive and creative group.

One of the most important messages to emerge from this training programme was the enjoyment of sharing the ten capabilities, as they very much reflect the needs of the service-users, carers and mental health professionals. The seven modules explored each individual's views, expectations and professional practices. The residential training days proved to be very informative, exploring learning theories, teaching and learning methods. As a clinical trainer, the experience of being trained by a service-user was quite unique and the reflections of the trainer's experience proved highly valuable. Sensitive issues and feedback discussed by the trainer were both very helpful and enlightening. I gained very positive responses from sharing my experiences with the participants.

Conclusion

I explored the skills of working in partnership and its merits through the self-assessment of modules. Questions for clarification were asked by participants about whether the beliefs and values expressed through the ten capabilities were currently practised by

mental health workers. I was unable to alleviate their concerns in respect of other mental health workers. However, this led me to feel positive that the project could ultimately cascade to all mental health workers over the coming years.

I have learned that it is important to respect individuals, respect diversity and to practice ethically. Respect for autonomy acknowledges the rights of individuals to make informed choices in relation to health care, mental health promotion and protection. Non-maleficence asserts an obligation not to inflict damage, either physical or psychological, and has often been associated with the maxim, 'to do no harm'. Beneficence, which is closely related to non-maleficence, refers to the obligation to benefit individuals and yet it may not be beneficial for everyone. Traditionally, priorities seem to be set solely on the basis of clinical need and are based on the premise that the 'doctor knows best'. However, this principle does not take account of other issues, nor provides any solution to problems relating to health care systems as a whole (NICE 2005).

A participative style of learning and development is vital for mental health professionals, particularly if involving service-users and carers and enabling an understanding of the wider issues of service users and carers. Promoting recovery, challenging equality, identifying people's needs and strengths, and providing service-user centred care in practice is more likely to be improved or achieved if all concerned in mental health understand the thinking and needs of service-users and carers. Promoting safety and risk taking offers opportunities to achieve autonomy, build trust and confidence with service-users

and the carers of those who are recovering. This approach will therefore promote ethical practice.

This innovative and creative type of training which involves service-users, carers and mental health professionals will make a difference to the modern way of delivering mental health services. I have learnt how to adjust myself to adapt according to the needs of all trainees and to be able to offer support sensitively. It is clearly important to establish ground rules that account for the varying needs of the trainees, whether service users, carers or mental health workers.

Clearly, I needed to be flexible about my training plan, which needed to be modified in light of discussions with my managers: focusing more upon achieving my short-term plan. This proved more realistic for the specified time limitations of the pilot initiative. The intervals between the three training days were very useful in allowing participants the time to confer and explore further the capabilities with service-users and colleagues. This also allowed me the opportunity for adjusting my style of presentation, for developing and strengthening good relationships with the participants, for sharing my experiences, their experiences and for reflecting serious issues related to mental health service-users and carers. It enabled me to consider my own practice, to challenge my own / others' views, to learn from others' experiences and elevated my confidence to withstand the pressures of being a trainer. Generally, I felt that the programme was successful, such that I will endeavour to involve a service-user / carer in my future training programmes. This will help me to demonstrate the importance of participation, involvement,

collaboration, an awareness of issues important to service-users / carers, and appreciate the obstacles and barriers encountered by service-users, carers and professionals, whilst achieving a balance of sensitivity for all concerned.

The knowledge gained from participating in this pilot initiative has given me the courage and confidence to look at training special audiences and to be able to stand-alone and co-facilitate training across the mental health field. The transference of skills, knowledge, experiences and their application in ways that are relevant to the needs of the trainees will hopefully reflect in their individual practices.

Empowering and valuing service-users and carers to look forward in promoting moral, ethical and humane values and beliefs will be a theme for future training programmes in mental health.

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