National Workforce Programme

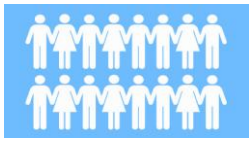
Capable Teams for Children & Young People (CTCYP): Team Profile and Workforce Plan

Example 1
Tier 3 CAMHS
June 09 – November 09

STEP 1 – PREPARATION & OWNERSHIP

STEP 2 – TEAM FUNCTION

STEP 3 – CHILDREN, YOUNG PEOPLE, FAMILIES & CARERS



STEP 4 – CREATING A NEEDS LED WORKFORCE

STEP 5 – IMPLEMENTATION & REVIEW

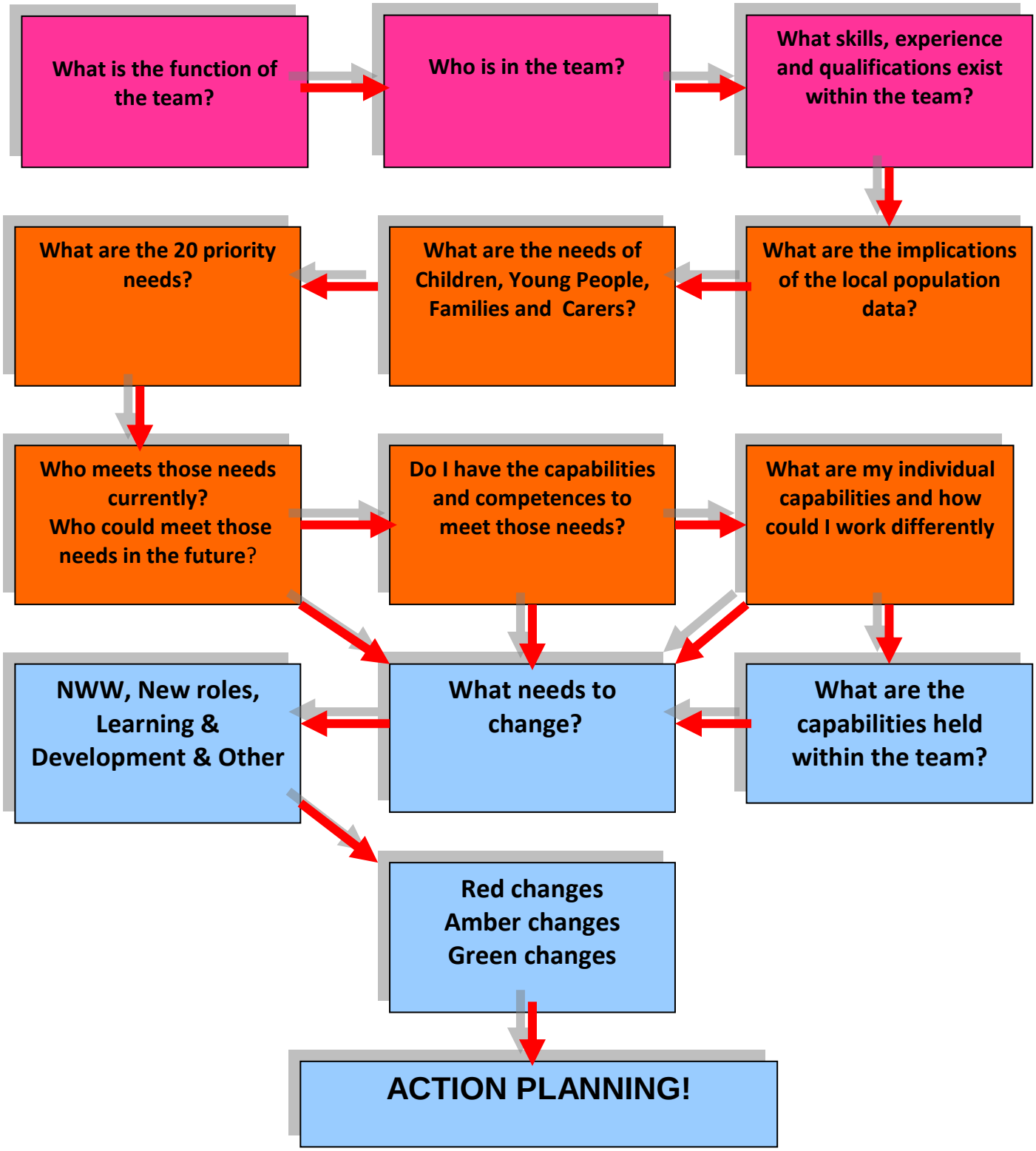
Please note this is an original TPWP developed by a tier 3 team as part of the CTCYP National Development and Implementation Programme

CAPABLE TEAMS FOR CHILDREN & YOUNG PEOPLE (CTCYP)

TEAM PROFILE AND WORKFORCE PLAN

Team	TIER 3 CAMHS	
Base		
Team Leader	**Name**	**Contact Details**
Senior Sponsor	**Director of Workforce**	
Facilitators	**Nicki Hollingsworth**	
Date commenced CTCYP	**19th June 2009**	
Date completed CTCYP	**19th August 2010**	

Workshop pathway



STEP 1: PREPARATION AND OWNERSHIP

Name and one non- work related skill

Alan – engineer
Janice – golfer
Service Manager – 7th backgammon 1997 championship
Ray – gadgets
Glen – bus and coach enthusiast
M..... – painting comp.
Lloyd – basketball
Melrose – Church Choir
Mike – Tennis
Michael – keep chickens
Jane – tenor/French horn
Sabina – black belt
Michelle – photography
Y..... – gardening J..... – writing
Rebecca – lead singer in band
Denise – tap dancing
Team leader– makes good coffee
Helen – taught bird to talk
Rohesia – part time model Sophie – yoga
Lauren – enjoy walking dogs
E..... – sing professional as backing singer
Amanda – scuba diving
Jane – imaginary animals with hands
Andy – sociable/good mixer
L..... – classic trained dancer
O..... - Travelling
Lisa – flat pack furniture builder
Sarah – good swimmer
L..... – Facebooker
K..... – Pool player with both hands
Angela – rum wedding cake maker

What does NWW mean to you and why do you think NWW are needed?

Disseminating skills and knowledge (MH & LD)
Efficiency
Consultancy
Spreading skills across different tiers
Creating equity of access to services
Outcomes
Looking at what is already being done and thinking of ways to improve.
Taking in account teams skills/strengths/weaknesses and putting all together to form a holistic team.
Flexibility of team members.
Effective communication internal and with outside agencies.
Sharing responsibilities and ideas.
Training and supporting professionals working in Tier 1.
Improve services.
Make sure we meet demands of customers.
Providing a psychological minded service.
Partnership between staff and patients.
Looking at a person as a whole person.
Holistic approach (person centred)
Learn about old ways of working
Joint working
Dual roles
Flexibility
Sharing skills
Including everybody

Effective working with less or some resources
Generic working
Clarity of roles and responsibilities
Are meetings necessary? Can they be streamlined?
Prioritising
Training lower tier staff
Audit and outcome measures
Practice – ritual or necessary?

Barriers and solutions to service user and carer involvement

Barriers
Re-imbursement of service users
Service users have other commitments
9-5 service
Stigma
Lack of knowledge - BME Community
Access – empowering individuals
Willingness to participate
Could feel intimidated
People may view it as therapy
People may not be mentally 'well' enough
People may currently be service users

Solutions
Discuss with Gail
Flexible hours
Weekend service
May have to change name
Promote wellbeing
Liaise with BME Community
Develop user groups
Travelling expenses / lunch
Creating user friendly spaces
Explanation of benefits
Create a friendly atmosphere
Create regular meetings with service users
User friendly language
Respect / Diversity
Honesty / Transparency
Clear ground rules/purpose
Boundaries / PALS

Anxieties and fears about the CTCYP

Increased workload not enough staff
Time / How long will it take?
Impact on workload
Doing things on the cheap
Smarter not harder
Time frames
Commissioner's expectations of CAPPA
Loss of skills
Who will monitor independent/safe practice?
Won't be followed through
Sustainability – training
Have our commissioners signed up for this?
Well oiled workforce
Transparent

Hopes and dreams about the CTCYP

United as a team
Efficient workforce
Focus groups
Person centred
More transparency
Valued/supported
Recognised
User groups
Support training needs
More effective, improved communication both internal and external
More capable
Joint working
Identifying people's skills
Redefining relationships
Opportunity for redesign
Develop new skills
Develop greater awareness of other specialities to improve practices

Give us permission to implement new ways of working
Hidden agenda
Cut down on expenses
Undervaluing profession
De-skilling experts

Alienating ourselves from other agencies
Clashing with other agencies
Cost improvement plan
Clarity of services on offer

STEP 2: TEAM FUNCTION

NATIONAL AND LOCAL CONTEXT

Skills I bring to the team

Consultation
Comprehensive psychiatric assessment and management skills
Great footballer
Specialist OT for work on ASD
Communication tolerance
Consultation to other agencies
Good talker, leadership
Radio production skills and been CR radio
Medical expertise
Empathy and understanding

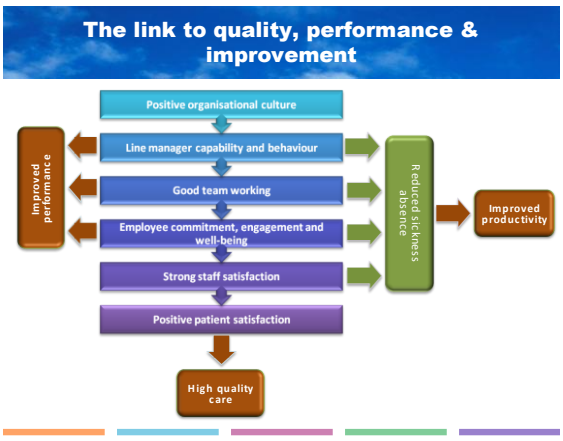
Clinical support and advice is a proactive team member
Consultation
Good communication skills to make sure the right people access the right service
Effective time management
Bring service users to team meetings
Intolerance
Organisational skills in managing paperwork
Team player
Sense of optimism/determination.

Skills I would like to develop

CBT
Engagement skills
Solution focussed therapy
Sensory integration work
Excel
Sleep intervention service for children with SLD
Concise report writing,
Time management

Speak Spanish better
EMDR,
Ethnic's community
Systemic family therapy skills
Leadership skills, group work,
Learn how to drive, to drive at 50mph

How does the CTCYP fit with the organisations strategic direction?



What's happening locally in relation to NWW and New Roles?

IAPT Low intensity & High intensity Workers
Graduate mental health workers
Working across agencies
Providing training
Multi-tiered clinics (integrated teams)
Increase in training, consultancy and supervision
Nurse prescribers
Consultation service (LAC)
Joint assessment/working (for complex cases)
Extension of skills
Supporting Tier 1 and 2
Care bundles
Multi Agency Looked after Children (MALAC)
Choose and book system
Service user input
Referral/team meetings
Star workers
Continuing health care workers
Activity workers – Early Intervention
Housing and accommodation officer
Nurse prescribers
Gateway workers
Primary mental health worker
Looked After Children nurses
Transitional workers
Consultation
CAPA
Tier 3.5 > future
Agenda for change

What could happen locally in relation to NWW and New Roles?

Support worker (3-4) SLD, work outside of 'normal' hours
CPN's – Primary Health Workers
ASD worker (3-4)
Care pathways – prevent crisis/ relapse prevention
Post diagnosis care – implications, advice
Sharing good practice (Across all services)
Groups to address specialist areas, e.g. Behavioural strategies (mirror SLD work)
Allocate responsible person for role.
Having a 'holding' role
Create one stop shop (get rid of Tiers)
Effecting case management
Duty worker
Parent M/H workers
Separate skills/role assessment role > intervention role
Transitional workers
Change of name re: ..... CAMHS
CAMHS crisis team
CAMHS spreads the word training
Flexible hours
Continual continuous dev. Professional Training
Identified Link workers to outside agencies/organisations
Out of hours clinic and admin support
Outreach – increase capacity to see young people in their own homes/schools/etc – transport
Ethical committee
Increase partnership working – Audit of BME via SEN Dep
Redesign service - full stop! TOP HEAVY 80/20
PMHC Team
Service user forum for consultation

24/7 cover – on call
Out of hours – flexible working (admin support via other services)
MAA – for ADHD
Community working – resources V skilling up training > expectations
Consultation – locally based services
Screening – inviting school health nurses/partnership agencies
STAR workers
CAPPA

AREAS OF IMPROVEMENT IN RELATION TO 10 ESC'S
Respecting Diversity – Increase awareness of demographics
On screening form – reminder question and integrated into the assessment
Practising Ethically – Team forum to discuss complex cases/ethical dilemmas
Challenging Trust policies – doing the 'right' thing
Consent for treatment/intervention form
Providing Service User Centred Care – Open days to promote service and get feedback
Evaluate service user's experiences
Flexible working times (e.g. late evening clinics)
Making A Difference – CPDG Development – EBP (clinical)
Signposting (CAB, Housing)
Drop-in's at CAMHS (CAB)
Using CAMHS office base for other agencies to hold sessions/drop in's
What do well – Work with children, their families and key others (Holistic approach) e.g. schools
Confidentiality/trustworthy
Ground rules – but when something needs sharing – do share skill mix
'Nothing to Improve'
Flexibility
Want to improve
Genuine
Give/show respect
Always make people feel valued/listened to
Working in partnership
What we need to do better – involve existing CAMHS service
More services outside 9-5 – perhaps something available at weekend (not everyone sure about this)
More accessible service e.g., Drop in or more community working – our in peoples own areas, etc (plus involve Primary services more raising awareness)
Working more in partnership with school nurses/school health visitors, etc.
Raise awareness and skills increase capacity at Tier 1.
Nothing else/No money
PMHCW – not enough
Involving service users in service planning
Is it (CAMHS) big enough?
Increasing access to psychological therapies to BME population
Commissioning V's service re-design
Commissioning – influence of/multiple funding streams
Flexible working hours (staff and service users)
Ethnics – professional – Trust (Foundation)
- moral – personal
Outcome measures

No more Red Tape
Protocol for partnership working – outreach
Pathways – choice x options
Self and team nearly equal scores with Organisation scoring less
Lowest scores (self & team) – challenging in equality/ user centred care/ making a difference//respecting diversity
Lowest scores (organisation) – all of above and personal development
Action plan – address above

The team		
Name (A)	**Role (B)**	**Number of Years' Experience**
	CPN	19
	OFFICE MANAGER	10
	Y.P. ADVISOR	2
	MANAGER CPN	22
	PSYCHIATRIST	19
	CPN	21
	PARENT	7
	SPECIALIST OCCUPATIONAL THERAPIST	5
	ADVISOR	5
	CLINICAL PSYCHOLOGIST	23
	CLDN (RNLD)	15.5
	PMHW	23
	PSYCHIATRIST	20
	CLINICAL PSYCHOLOGIST	10
	CPN	26
	SP. SOCIAL WORKER	5
	FAMILY THERAPIST	25
	STAFF GRADE	5
	PSYCHIATRIST	17
	CPN (TRANSITIONAL 14-16)	6
	Family Therapist	30
	CPN/LD	30
	OT	3
	OT	12
	CPN/LAC	7
	Admin/secretary	4

	Medical Secretary	6
		1
		24
	Total Number of Years	**400.5**

Existing skills, knowledge and experience within the team

Specialist Training
Play Therapy
Counselling
Family Therapy
Working In Inpatients/Outpatients
Part of Making a Difference Group
Psychology Knowledge, Diversity,
Father
Culture Background
Multi Agency
Different Theoretical Models
Working with LAC Children
Working with Team
Residential Social Worker
Probation
Abroad Refuge in Far East
Court
Prison
Hostel
Do Not Panic At Clinical Work
Specialist
Generic
Sense of Humour
Passion
Challenging
Resourceful
Social Work Legislations Relating To the Law Pertaining To Children
Child Protection
Looking At Families In Terms Of Parenting
Social Model of Care
Disadvantages and How It Impacts On the Child
Offering Psychological Therapies
CBT
One Part Interpersonal Psychodynamic Therapy
Training In Leadership Work, Adult Psychiatry,
Paediatrics, Working With Learning Disability
Inpatients Assessment and Diagnosis
Dedicated/Committed To CAMHS
Good Communication
Empathy
Medical
Worked With Children and Adults with Wide Range
L&D from Moderate to Severe In a Wide Range of Settings
Inpatients/Forensic and Community,
Assessment Skill/Behaviour Management,
High Level Communication Skills
Systemic Working, Humour and Patience
Thoughtfulness and Sensitivity
Worked With Elderly and Adults Who Experience Psychosis
Implemented CBT in Adult
Flexible
Developed and Delivered Training
Set Up Assertive Outreach Services
Mother
Experience of Service
Determination
Optimism
Medical Knowledge
Adult Services and Other Core Speciality
Supervisor and Trainer
Child Protection Lead
CAMHS
Adult Mental Health
Old Age Psychiatry
Computer Skills
Typing, Minute Taking
User Experience,
Family Tradition of Working in Health Care Profession
Interests in Disabilities and Equal Opportunities
CBT
Family Therapy
Speak Hindi and Kannada
Engaging In Practical Issues

Sports as a Medium
Engaging Men in Service
Deliberate Self Harm
Polish Perspective
Human Being, Worked Within Adult Services
Trainer
Adult Psychiatry
Mother and Baby Unit

Recovery Team Services and Funding Mental Health
Daily Services Acute Wards
Group Work
Assessments
Interventions
Administering Drugs
Consultation Work
Training Skills

Existing qualifications

Degree in Mental Health,
Diploma in Nursing
MBC in Family Therapy
Train the Trainer
First Degree in Behavioural Science
Clinical Psychology
Management Course
MA Social Work
CQSW
Qualified/Supervisor Family Therapist
Doctorate
Research
B Science in Mental Health Studies
Social Worker Qualifications, Medical Qualifications
MBBS
Diploma in Child Health
Diploma in Psychological Medicine
Member of RCP
Degree as Doctor
Forensic CAMHS
Adult Inpatient/Rehab/Recovery
Surgery
RNLD
First Line Management Diploma
BSC Honours L&D, ……. Approach
RMN
Diploma Counselling
Diploma Community Health Studies
Masters Health Science

Clinical Nursing Practice
Advanced Practice – ADHD, Training the Trainer
Making a Difference
Level 3 Motor Vehicle
City Of Guild in Engineering
Drive a Forklift
Medical Degree and Higher Training
MRC Psycl, RMN and Psychotherapy
NVQ Business Admin Level 1 And 2
NVQ Business Studies
NVQ Health and Social Care
Infant Observation Psychotherapy
Diploma in Mental Health
Degree in Family Therapy
Diploma in Medical Ethics and Law
RMN 7307 Basic Teaching Qualification
FT Level 1
Doctorate in Clinical Psychology
Post Graduate Diploma in Supervision
Management Course on Managing Health and Social Care
NNEB Nursing Nurse
RMN
BSC in Mental Health Studies
Specialist Practitioner in Children and Adults
..... Approach
BFT
Training for Family Therapy
SFT

The team staffing
What is the teams agreed establishment? • Service Manager x 1 Band 8a • Team Leader CPN x 1 Band 7 • Clinical Nurse Specialist Band 7 x 4 (includes 1 vacancy) • CPN Band 6 x 3.4 • CLDT Band 6 x 1.44 • Social Worker x 1 • Advanced Practitioner OT Band 7 x 0.43 • OT Band 6 x 1 • OT Band 5 x 0.6 • Consultant Psychologist Band 8d x 1 • Consultant Psychologist Band 8c x 2.4 (includes 0.8 vacancy) • Clinical Psychologist Band 8b x 3.9 • Clinical Psychologist Band 8a x 1.4 • Clinical Psychologist Band 7 x 1.32 • Assistant Psychologist Band 5 x 1 • Systemic Family Therapist Band 8d x 1 • Systemic Family Therapist Band 8b x 1 • Consultant Psychiatrist x 3 • Associate Specialist x 1 • Specialist Registrar x 0.6 • Office Manager Band 4 x 1 • Administrator Band 3 x 2 • Administrator Band 2 x 1 (includes vacancy of 0.4) • Medical Secretary Band 4 x 2 • Medical Secretary Band 3 x 1
What is the team's current establishment? – see above
What number of vacancies currently exists within the team? • 1 x Clinical Nurse Specialist Band 7 • 0.8 x Consultant Psychologist Band 8c • 0.4 x Administrator Band 2

WHAT ARE IMPLICATIONS OF TEAM CHRISTMAS TREE?

Issues

- Gaps in Lower band 3-4 workers
- Lack of Primary Mental Health workers
- No psychotherapy service within the trust as a whole workers
- Not enough Social Workers (Early Intervention)
- Staff overload
- Lack of clear/joined up purpose
- Fragmented service delivery

Suggestions

- Improve skill mix/balance/Potential for new roles:
  - PMHC
  - STR Workers (or similar workers would increase the capacity of the team overall.
  - Lower grade staff
  - Administration
  - PMHW (Team) – Gateway
  - Parental MH Worker
  - Post diagnosis/assessment workers e.g. ASD/ADHD
  - Primary Mental Health Workers
  - Transition worker – developing new roles from existing one – i.e. current vacancies
  - High end trauma practitioners
  - Generic CPN's
  - Alternative therapist – music, drama, art
- Four WTE vacancies possibility of lower bands, but roles are usually prescribed by commissioners
- redesign current workforce
- persuade commissioners to expand specialist CAMHS – comprehensive
- CAPA – could answer some questions from commissioners
- Improved links with other services including education would improve continuity helping to identify systemic issues
- Speech and language specialist
- Partnership working > liaison/marketing/clarity/get commissioners into service
- Sessional/group work
- look for money
- More integrated services
- Extra resources to quickly implement new ways of working – CAPA
- Psychotherapy
- 16-18 funding/resource
- Effective services/timely interventions are 'cost effective' – BUT HOW MEASURE? IT'S MORE THAN A FINANCE ISSUE.

The Trust Vision and values

Thanks to the active participation of over 100 service users, carers and staff, the Trust Board has developed the vision, values and goals that will shape our services for the next five years. Underpinning the vision are three values clearly identifying the way we should all operate within the Trust and three goals that describe how we will achieve our aim of banishing stigma and enabling recovery.

Our Vision

"*Banishing stigma enabling recovery*" - We are dedicated to banishing stigma and enabling the recovery of people with mental health issues and learning disabilities. We will do this by working in partnership to proactively provide the right services in the right places at the right times.

Our Values

"*Diversity*" - We recognise the individual, celebrate the similarities and embrace the difference.

"*Learning from each other*" - We believe that through listening and understanding people will take responsibility, feel valued and have pride in what they do.

"*Openness*" - We will be truthful, transparent and trustworthy.

Our Goals

"*Proactive and dynamic*" - We want to have a reputation for having innovative ideas and quickly turning them into visible service improvements.

"*Right service, right place, right time*" - We want to be an organisation that is so responsive that it will deliver integrated services in the best place and at the best time for people who use our services.

"*Realising potential through real partnerships*" - We want to ensure that service users, carers, staff and other partners are actively involved and educating each other at all levels of activity. This involves everything from the daily involvement of individuals in their own care right through to involvement in the shaping and planning of our services.

The team statement
The Child and Adolescent Mental Health Service (CAMHS) is based at……l Road where mainly Tier 2/3 service is provided for children and young people aged between 0 and 16 and young people up to the age of 18 if they are in full time education.

The team's primary aim
To delivery a quality service delivered with kindness, care and integrity to improve your quality of life

The teams core values

- Openness & Transparency
- Integrity & Respect
- Empowerment
- Kindness & Caring
- Quality & Excellence
- Positive & Proactive

STEP 3: CHILDREN, YOUNG PEOPLE, FAMILIES AND CARERS NEEDS

THE LOCAL POPULATION

The Six Towns of Example – Map deleted for confidentiality purposes

The ..... Population (2001 Census):

Population	Example #
Total Number Of People	282,904

Gender	Example #	Example
Males	136,497	48.2
Females	146,407	51.8

Age	Example #	Example %
Aged 0 To 4	18,163	6.4
Aged 5 To 15	43,396	15.3
Aged 16 To 24	29,807	10.5
Aged 25 To 29	19,263	6.8
Aged 30 To 44	62,596	22.1
Aged 45 To 59	48,866	17.3
Aged 60 To 74	39,113	13.8
Aged 75 And Over	21,711	7.7

Ethnicity	Example #	Example # %
White	225,479	79.7
Mixed	5,999	2.1
Asian Indian	25,855	9.1
Asian Pakistani	8,342	2.9
Asian Bangladeshi	3,432	1.2
Asian Other	1,964	0.7
Black Caribbean	9,403	3.3
Black African	580	0.2
Black Other	835	0.3
Chinese	484	0.2
Other Ethnic	542	0.2

Qualifications	Example #	Example #l %
Qualifications At Degree Level Or Higher	19,353	9.7
No Qualifications	90,934	45.6

What do we know about the Children of .....? (Taken from Example PCT):

There are an estimated 75,500 children and young people aged 0-19 years in Example.

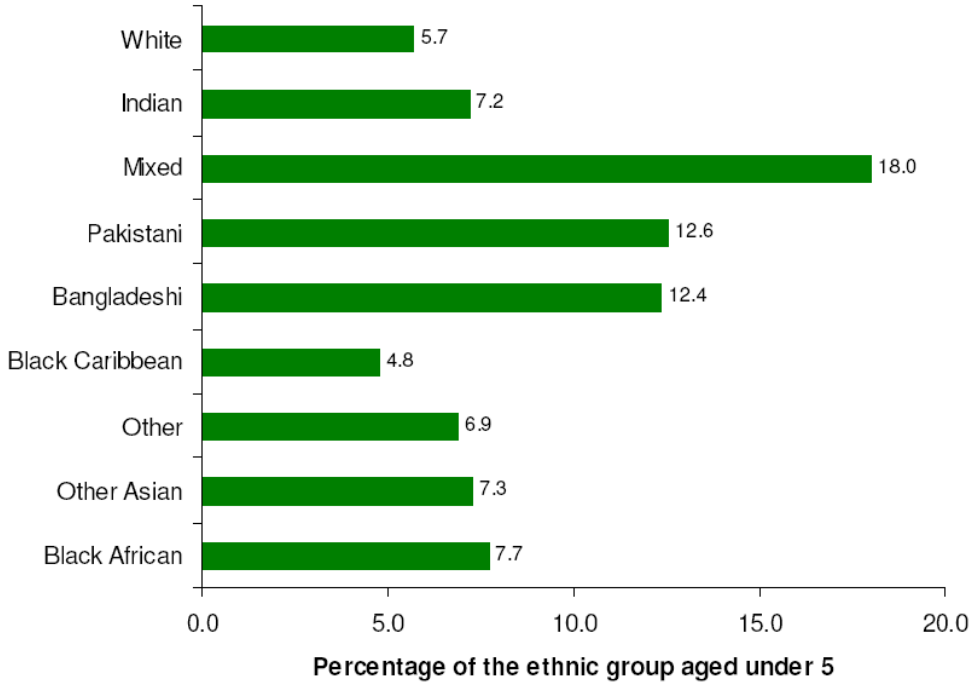
	All Ages (0-19)	0	1-4	5-9	10-14	15-19
Persons	75500	4200	15600	17500	18400	19800
Males	38400	2100	8000	8900	9200	10200
Females	37100	2.1	7600	8500	9200	9700

Table 1 ONS: Mid 2007 estimate (2008)[i]

The Birth Rate and General Fertility Rates are growing. The population of ..... is forecast to grow over the next twenty years. However, growth is not expected in the 0-19 year age group, except for the 5-10 year olds.

The population of Example is ethnically diverse. This is most notable in the younger age groups with levels of ethnicity amongst the 0-19 year olds at 29%.

Example has a 20.3% ethnic minority, however for under 5's this raises to 30.5%. When we look at the age profile of each ethnic group we see that 18% of the mixed population are under 5, compared to only 5.7% of the white population. This relative breakdown is important in considering the future ethnic profile of our population and their needs.



Source: ONS population estimates

Of all households within the Borough 37.4% have dependent children. There are a high proportion of lone parent households within Example, with 8.03% of households consisting of a lone parent with one or more child. This compares to 6.4% across England

Income Deprivation Affecting Children (IDAC) is a subset of the Income Deprivation Domain and comprises the proportion of an SOA's children aged under16 living in income-deprived households. In Example 84 SOAs fall within the 20% most deprived SOAs nationally (an

improvement from 100 in IMD 2004), of which 36 (improvement from 44 in IMD 2004) are within the 10% most deprived.

Overall, deprivation within Example appears to be widespread, with the areas experiencing least deprivation tending to be on the fringes, particularly around …….. and …… in the southern part of the Borough, and around the …….. area in the north. The most severe deprivation largely follows the main industrial belt, running from …… and including some pockets further north, such as …… and …….. and two areas in the southwest around ……. and ,……. & ……..., ……. are the most deprived wards.

One in four households with dependent children in Example is lone parent families. Only one in five (20.5%) of the lone parents are working full-time with a similar percentage in part time employment (19.9%). …….. has the highest proportion of lone parent families, with nearly one in three (30.0%) of households with dependent children being a lone parent.

Since the 2004/05 academic year, eligibility for Free School Meals (FSM) has fallen in Example by 6.4%. …….has had the largest decrease at 29%; in 2004/05, the FSM
Eligibility was 18.5% compared to 13.1% in 2006/07. …….and …… has consistently shown 44% eligibility amongst its resident pupils, largest decrease at 29%; in 2004/05, the FSM this being the highest recorded figure in the borough, and is significantly higher than the borough average which has remained fairly static for the last three years (23.6/22.8/22.1). Why does this matter? In 2007 the achievement gap between..... pupils receiving Free School Meals and their peers at Key Stage 2 were 22.4% and the Key Stage 4 gap was 16%.

The Mental Health of Children & Young People in Example:

Based on the Mental health of children and young people in Great Britain (2004), approximately 10% of all children age 5-16 suffer from a mental health disorder[ii]. Boys in both age categories; 5-10 and 11-16 are more likely to have mental disorder than their female counterparts. Of interest younger boys are twice more likely to suffer from a mental disorder than girls (10.16% boys/ 5.12 girls aged 5-10 year) however, this gap closes by adolescence (12.63% boys/ 10.34% aged 11-16 years). In addition mental disorder increases with age; 7.7% in 5-10 years old and 11.5% in 11-16 years old.

One of the problems of estimating and comparing the current prevalence of mental health data is that different organisations/ agencies use different measures such as age categories, definitions of mental disorders. These differences make it very difficult to come up with a firm estimation of the prevalence of mental illness / disorders in young people.

Local prevalence data, table 4.17 (Children Workforce Development Group: ..... a 2008i) indicates that around 10% of children under 5 require professional help, 15 % of pre-school children have a mental health problem, and 7% of them have severe mental health problems. Amongst the older age group 6% of male versus 16% of females have some form of mental health problem. This indicates that as children grow older the pattern of mental health morbidity increases in female more so than in males. This highlights different priorities for the service provision, as both male and female needs have to be taken into account.

Age Group	n	%
Children require Professional Help	7000	10
Pre school children with mental health problem	2890	15
Pre school children with Severe Mental Health problems	1350	7
16-19 years old males with some form of mental health problem	450	6
16-19 old females with some form of mental health problem	1160	16

Source: Children Workforce Development Group: Example (2008)

Children & Young People with Mild to Moderate Learning Difficulties in Example:

It is estimated that there are 1532 with Mild – Moderate Learning Difficulties in Example, 1179 in Primary School and 353 in Secondary School Education. This does not however include those children who fail to attend school, are placed out of borough or attend one of the 4 Academy Schools.

According to national research it is likely that 40% of these children will also experience mental health problems. This equates to a minimum 613 students in Example alone.

Key implications for the team

Population

- increase in numbers = increase in demand
- implication for CAMHS – more resources
- Increase in under 5 referrals
  - ADHD
  - SLD
  - Expectations?
  - Change in provision?
  - Awareness?
-

Gender Mix

- <13 – higher prevalence of males = more demand for CAMHS Services
- ASD/ADHD higher prevalence of males = more demand for CAMHS Services
- Team Mix – more women – Reduced patient choice of staff gender
- No of Women DSH follows national trend - ? The mix in the team

Ethnicity Profile

- 30% approximately are ethnic minorities

- Under represented in service (cultural differences community support, not seeking service? Not meeting needs?)
- Self harm – higher prevalence in young South Asian females – compared to other geographical areas.
- Gap in knowledge & services
- Links with SAFSS (ethnic groups)
- Referrals from BME to CAMHS
    - Can we meet the need
    - Can we cope e.g. religious SLD

Geography

- Compare & benchmark against areas similar to.....
- There are 'pockets' of extreme poverty – impacts on the efficiency of services
- Location Centralising – barriers for some but also capacity

Education

- No MLD school's (primary, very few secondary)
- MLD children have a higher prevalence of MH, mainstream schools are managing without specialist knowledge
- Tier 2 money currently with inclusion support – provision for Educational Psychologist under resourced
- Many referrals have learning difficulties
    - ? when it gets picked up
    - provision at younger age sparse
-

Local Intelligence/Trends

- Commissioners have no idea about CAMHS needs
- 3 different commissioners in 3 years

Service delivery

Looked after children

- How well do we meet the needs of children in residential care?
- emotional/attachment/mental health needs/behavioural difficulties

PTSD

- Refugees
- Asylum seekers
- Rise in referrals
- Training
- Interventions through interpreters

Prevention/education

- PCWs
- Awareness raised
- Education raised
- Lack of provision
- Parents education/ capacity – meeting this need

Provisions beyond Ax of ASD/ADHD

- deficit of support

Strengths

- Transport
- Voluntary Organisations
- Diversity in food/culture
- Education

Weaknesses

- Education – academy schools more mental health awareness
- We should be providing more training awareness
- CAMHS does not see the represent of BME communities in.....
- Community development post funded ended
- Ethnic diversity/gender not on CAMHS Mapping
- Primary Mental Health workers role, raise awareness in schools
- LEA not statementing children under the age of 16
- Working in partnership with voluntary organisations
- Event – working groups on current issues – look at funding bids
- Child Mental Health tsar for.....

NEEDS OF THE CHILDREN, YOUNG PEOPLE, FAMLIES & CARERS

The Green Needs of the Children, Young People, Families & Carers

- Information & support on healthy diets and being active
- Physical health drop-ins at school
- Support of ASD children with post education
- Nursery Nurses provision within waiting room (parents/carer)
- Bring the high achievers from the borough to motivate our Young People
- Role Models
- Access to decent/safe housing
- Food/shelter/warmth
- Need to motivate the parents further – How?
- For the father to stop drinking alcohol in excess
- More police, more neighbourhood watch to help the families
- Mental Health
  - Hope & recovery focused care
  - Mental Health Screening for identified parents
- Be healthy – General health specialists in specialist CAMHS
- Physically healthy – regular check ups
- To have access to means of personal hygiene (assisted where necessary)

The Amber Needs of the Children, Young People, Families & Carers

- Accessing leisure/educational activities (sign posting)
- Awareness & Education
- Experiences of bullying to be taken seriously and addressed
- Enjoy & Achieve
  - Rewards based system focusing on all areas of achievement
  - ADL
- MLD/ASD Leisure, recreational priorities
- Confidential support/advice for under 16s (that can be accessed without parental consent)
- MLD Support Services

- Develop closer liaison with drug & alcohol teams
- Support for ASD children with poor social skills? Group

The Red Needs of the Children, Young People, Families & Carers

- Social Services to be active and deliver their service as expected
- Safeguarding measures that are preventative & supportive rather than reactive
- Individualised therapy
- Emotional development to be encouraged whilst at school
- Emotional support
- Positive role model
- Community leaders being a part of the service development
- Need celebrities to increase the profile for our Young People – to achieve and be successful
- Confidence in own ability
- Post – ASD Support Services
- Stay Safe – More service for children with emotional neglect, Family Based therapy
- Safety training e.g. first aid, bullying awareness, emotional wellbeing
- Access to after school clubs
- Group working
- Enjoy & achieve Group work – Social activities group
- Access to appropriate health & Mental Health care by a well trained workforce
- Positive father figure who wants to spend time with his child
- Access to health professionals
- Holiday

Remaining Changes

- Meaningful employment for the individual
- Employment schemes
- More employment opportunities, training, workshops
- To have adequate financial resources
- Less state benefits dependency
- Achieve economic well being – Strategic Planning team mandatory, attendance of all agencies who have vested interest in Universal CAMHS to meet regularly
- Health promotion materials
- Proactive not reactive
- Play areas
- Self esteem training
- Allowed to capitalise and build on strengths
- Improved planning to meet changing health needs (LD)
- Sense of safety
- To live in a safe house environment
- Make junior school more enjoyable and increase our activities for our young people
- To attend school
- Need a specific service for young people on the verge of expulsion or expelled from school

THE 20 PRIORITYNEEDS OF CHILDREN, YOUNG PEOPLE, FAMLIES & CARERS

Priority Needs		Who currently meets the need	Who could/should meet the need
1.	Families/carers/children to be listened to	Everyone	Frontline staff e.g. admin, young person forum, Primary care services – GP's/Health Visitors/Nurses
2.	More knowledge about medication, side effects etc. for families & carers & diagnosis	Medics (side effects) (SLD) community nurses Autism West Midlands ..... leaflets (Psychology)	Raise use of resources (e.g. patient work) Developing own resources (Psychological Education) Resources (leaflet) in waiting areas Joint working Information pack (diagnosis, info etc.)
3.	More Carers, support networks/groups	Young Carer's referrals Understanding challenging behaviour group Social Services/Children's Centres Autism West Midlands	Venue and facilitation of support groups (e.g. ADHD) Containment/mindfulness groups Option to meet team – debrief/recognise referral to other services
4.	Improved inclusion of service users (or their representatives) in planning services/evaluation – SLD/specialist services	Annual audit Involved in CTCYP days Involved in interviews PALS Outcomes measures	PALS/Advocacy holding events – proactive (not just complaint) e.g. Autism West Midlands – external facilitation Inclusion of schools (prevention) Youth Inclusion support Youth Services Service User Forum
5.	Develop greater links with other agencies to promote our services	Admin – Response to enquiries (frontline) Deliver interventions at venues e.g. schools	Open day/event – promotion of service Involved in days e.g. OT week, CAMHS, Black & Mental Health Awareness Presentations to other services – Secondment into Education e.g. Psychology Police & ASD
6.	Make a positive contribution – Focus Groups	..... Families of Disabled Children Autism West Midlands Service User Questionnaires information	Carers Support Service to extend to Young People By Trust Managers Focus groups CAMHS/non-head – head clinical populations
7.	Build trusting supporting relationships	All by 'duty of care' code of conduct	Internet Communication & mobile communication by Trust/IT
8.	Learning Parents & children how to play	By Family Therapy and Parenting skill training	Play groups, Nursery Nurses, Play workers employed

	- Improve relationship - Promote social & cognitive emotional developments	groups	Enhance the work of Sure Start
9.	Ability to choose gender of worker	Some flexibility	Recruitment and training development of proportionate number of gender appropriate professionals
10.	Post diagnosis also develop multidisciplinary ADHD diagnosis & management plans with schools	Medics & information from school	Resource Issue! Could do with resources
11.	Young Persons Forum	Making a difference meeting (for older adults) – psychology led – non currently known within CAMHS	P.M.H.W. facilitate for service user participation. V.I.K. Very important kids lead
12.	Need to increase the awareness and help the teachers and SENCOs to accept the mental health difficulties for Young People	P.M.H.W	Inclusion support Education Psychology T2/T3 Professionals to involve in training
13.	Emotional Containment (both Children & Young People and Caregivers	Health professional, allied professionals, statutory & non-statutory services, voluntary services, charitable organizations (Everybody should)	Improved awareness for early years workers, Health Visitors – additional training needs through education.
14.	Be healthy parenting skills for parents	Triple P, Mellow parenting ..... approach, voluntary organizations i.e. Woman's aid, Sure Start Children Centre's, A.R.C. Tier 1 – 4	Mentoring service Early years workers Maintain the services Social workers
15.	Weekend and evening services	Y.O.S. Leaving Care Team (outreach services) E.D.T. (emergency duty team) Children, Young People & Family Services Voluntary Services LAC Services	Specialist CAMHS & Universal CAMHS not mentioned on left hand side
16.	3 x Primary Mental Workers	0.7WTE from CAMHS	+2.3 workers
17.	Race & Cultural awareness	Challenging services RECC training (cycle not complete) SAFSS	Strategy is key CAMHS should do this

18.	Vocational/training courses. Closer working with connexions	AWM (only >18 years) Schools offer brokerage in Year 11 Connexions sign post Colleagues	Primary Mental Health Workers (x3) to liaise with agencies
19.	Mental health awareness training in schools	1WTE Clinical Psychologist 0.7WTE PMHW – links with school nurses	Mental Health leaflets in school. Mental Health pays – CAMHS to participate in schools
20.	Respected as an individual	All of us are	All of us should
21.	Not keeping in services longer than necessary	Achieved through supervision	Case load management CAPA

STEP 4 - CREATING A NEEDS LED WORKFORCE

WHAT NEEDS TO CHANGE? - (Based on the information gathered throughout the process and from diary sheets, 20 priority needs, individual capability profile, working differently handout and team capability profile)

New ways of working

When

- Flexible hours outside of 9-5
- Work outside of 'normal' hours
- Out of hours clinic and admin support
- 24/7 cover – on call
- Out of hours – flexible working (admin support via other services)
- More services outside 9-5 – perhaps something available at weekend
- Flexible working times (e.g. late evening clinics)
- Flexible working hours (staff and service users)
- Assess need/demand for out of hours service/weekend service – with cut off point, not crisis intervention, needs monitoring – only cover needs not covered by other services – consider issues of safety/practicalities
- Emotional befriending schemes to be delivered out of hours (like head to head)

Where

- Drop-in's at CAMHS (CAB)
- More accessible service e.g., Drop in or more community working – in peoples own areas, etc (plus involve Primary services more raising awareness)
- Using CAMHS office base for other agencies to hold sessions/drop in's
- Outreach – increase capacity to see young people in their own environment
- Consultation – locally based services
- Mobile clinics – CAMHS on the go!!!

How

- Groups to address specialist areas, e.g. behavioural strategies (mirror SLD work)
- Drop in services in community facilities e.g. library, GP surgeries – contact other services to see if they require this – PMHW as link worker to specialist CAMHS

- Clinics – ADHD/ASD with focus groups before and after. Appointments-captive audience and no need for C&YP to attend separate times
- Increase access to psychological therapies to BME population
- Create one stop shop (get rid of Tiers)
- Care pathways – prevent crisis/ relapse prevention
- Signposting (CAB, Housing)
- Effective case management
- Having a 'holding' role
- Adult MH workers in CAMHS to support parents with MH issues who attend CAMHS

With

- Community working – resources V skilling up training > expectations
- Increase partnership working – Audit of BME via SEN Dep
- Identified Link workers to outside agencies/organisations
- Working more in partnership with school nurses/school health visitors, etc.
- Protocol for partnership working – outreach
- Involve school more in ADHD assessments (school meeting, with parents)
- What we need to do better – involve existing CAMHS service
- Make links with community to fund age specific Christmas presents
- Screening – inviting school health nurses/partnership agencies
- Partnership working > liaison/marketing/clarity/get commissioners into service
- Working in partnership with voluntary organisations

New roles

Improve skill mix/balance/Potential for new roles:

- PMHC Team
- STR Workers (or similar workers would increase the capacity of the team overall.
- Lower grade staff
- Administration
- PMHW (Team) – Gateway
- Parental MH Worker
- Post diagnosis/assessment workers e.g. ASD/ADHD
- Primary Mental Health Workers
- Transition worker – developing new roles from existing one – i.e. current vacancies
- High end trauma practitioners
- Generic CPN's
- Alternative therapist – music, drama, art
- Support worker (3-4) SLD
- CPN's – Primary Health Workers
- ASD worker (3-4)
- Duty worker
- Parent M/H workers
- 2 workers per team are in ..... + 1 WTE co-originator - PMHW
- Separate skills/role assessment role > intervention role
- CAMHS crisis team
- MAA – for ADHD
- BME development worker with specific CAMHS training
- Four WTE vacancies possibility of lower bands, but roles are usually prescribed by commissioners

- Speech and language specialist

Learning and development

- Increase awareness of demographics
- Sharing good practice (Across all services)
- CAMHS spreads the word - training
- Continual continuous dev. Professional Training
- Team forum to discuss complex cases/ethical dilemmas
- Raise awareness and skills increase capacity at Tier 1.
- CPDG Development – EBP (clinical)
- Improved awareness of MH for early years workers & HV – additional training needs through education
- CAMHS cultural competency training
- CAMHS to do MH awareness training for connexions in addition to in-service training
- 10 ESC to be rewritten for admin
- Deliver presentation to other services
- Secondments/shadowing in other services education/police etc
- We should be providing more training awareness

Other

User & carer involvement

- Service user/young persons forum
- Carers Support Service to extend to Young People
- Providing Service User Centred Care – Open days to promote service and get feedback
- Evaluate service user's experiences
- CAMHS BME strategy needs to be in place in trust
- CAMHS does not see the represent of BME communities in Example
- Need to find out more / develop links with CDW role
- Involving service users in service planning
- Outcome measures
- Very important kid (VIK) increase awareness/involvement and training re this initiative/ invite to forums
- Facilitate development of parent support groups
- Option for parents/carers to meet team – debrief/recognise referral to other services
- Youth Inclusion services /youth Services
- Containment/mindfulness groups
- Post diagnosis care – implications, advice
- CAPPA
- Challenging Trust policies – doing the 'right' thing
- Commissioning V's service re-design
- Commissioning – influence of/multiple funding streams
- Consent for treatment/intervention form
- Respecting Diversity –On screening form – reminder question and integrated into the assessment
- Change of name re: Example CAMHS
- Redesign service - full stop! TOP HEAVY 80/20
- redesign current workforce
- Ethical committee

- Ground rules – but when something needs sharing – do share skill mix
- Greater links with community to raise funds
- Apply for other types of funding (big lottery/tenders)
- Roll out psychological therapies strategy (ensure admin is part of this)
- Develop multilingual information pack for clients
- Hold regular open days (advance notice) – target more BME groups – ensure language specific
- CAMHS to represent all cultures in waiting area
- IT resources and local papers available in waiting room
- Ensure environment is clean, tidy and child friendly
- Links with PALS/advocacy
- Develop information pack/resources to provide more information about diagnosis and medication side effects etc
- Mental Health leaflets in school.
- Case load management
- Mental Health pays – CAMHS to participate in schools
- More discussion with commissioners to enable them to understand the service

Need / Staff Initials																			
1	Listen to families and carers	√	√	√	√	√	√	√	√	√	√	√	√						
2	More information about medication and diagnosis for families and carers	D	D	N	D	D	X	D	N	√	√	D	√						
3	More carers support groups / networks	D	C	D	C	D	X	N	N	N	√	√	C						
4	Improved inclusion of service users (or reps) in service planning and evaluation	D	D	D	D	√	H	√	D	N	D	D	√						
5	Develop greater links with other services to promote services	√	D	C	D	√	C	D	D	N	D	√	D						
6	Make a positive contribution - focus groups	N	N	D	N			D	C	N	D	D	D						
7	Build trusting, supporting relationships	√	√	√	√	√	√	√	√	√	√	√	√						
8	Supporting / teaching parents and children to play, improve relationships, promote social and cognitive developments	√	√	H	√	√	√	C	D	D	D	D							
9	Ability to choose gender of worker	N	N	C	√	√		N	N	D	D	N	N						
10	Post diagnosis MDT ADHD Diagnosis and management plans for schools	C	C	D	C	C	X	N	D	N	X/C	D	N						
11	Young persons forum	C	C	D	C	C	D	D	C	N	C	D							
12	Help teachers and SENCO's to understand MH difficulties of young people	C	C	C	C	√		D	D	D	D	D							
13	Emotional containment (children, carers)	√	D	√	√	√	√	N	√	D	D	√	√						
14	Be Healthy - parenting skills for parents	√	C	D	√	√	C	√	√	√	D	D	√						
15	Weekend & evening service	D	C	D	C	C	H	N	N	N	X/C	C	N						
16	3 x Primary MH workers	D	N	D	N	N		N	N	N	N	N	√						
17	Race and cultural awareness	√	√	D	D	√	√	D	√	D	√	D	√						
18	Vocational training courses - link with Connexions	N	C	D	C	√	X	√	D	N	D	D	D						
19	MH Awareness training in schools	C	C	D	C	√	X	D	D	D	D	D	D						
20	Respect as individual	√	√	√	√	√	√	√	√	√	√	√	√						
21	Not keep in services longer than necessary	√	√	D	D	D	√	D	√	D	D	D	D						

✓ = Have and need X = don't have and don't need N = Need but don't have H = Have but don't use C = Could do in the future D = Need to develop

All identified green changes

Parents with mental health difficulties to be supported

- **Parental Mental Health Audit to be repeated (by ……..), this will inform Mellow Parenting Programme. Service Manager to approach PCLT on return to work.**

To get feedback from the monitoring forms

- **Work in progress. Team Leader (and CAPA Project Worker) will approach Commissioners. Conversations have already taken place with …… Business Support Managers) re working 'with' Commissioners to reduce duplication in data reporting.**

Creative ways of advertising the issue of gender / choice

- **Team felt that this was not a priority at present. They agreed however to review and redesign CAMHS leaflet that accompanies appointment letters (this could include advertising gender and choice in future). The introduction of CAPA will also impact upon the 'choice' discourse.**

Develop screening clinics (3 / 4 clinicians)

- **These are already up and running and will be re framed as 'Choice Appointments' in due course (to complement the introduction of CAPA in the coming months). An emphasis on developing 'Partnership Appointments' (Phase 2 of CAPA) will be taken forward by Emma (as CAPA Project Manager).**

Establish CAMHS BME Strategy

- **Links now established with diversity lead**

Referral Officer role to be updated in light of CAPA

- **Due to necessary Secondments within the service the referrals officer role will be dissolved to the team. This process will be reviewed as CAPA is developed.**

Make links to Carers Support "All Saints Way"

- **The idea of improving links with Primary Care Services on a whole will hopefully be taken forward by the imminent recruitment of Primary Mental Health Care and TAMHS Workers to the team.**

Share information in team

- **Information sharing will be taken forward by re investment in our teams Clinical Practice Development Group.**

All identified amber changes

Create comprehensive multi disciplinary ASD / ADHD / SLD Services

- **We currently have a Multi Agency Assessment process for Autistic Spectrum Disorders and Dr S informed the team that this appears to working well.**

- **Dr J will be completing an Audit on ADHD and will report back on the outcome of this process in due course. She also advised that the borough now has an Attention Deficit Hyperactivity Disorder (ADHD) Support Group. The development of our Primary Mental Health Service could well impact here as it becomes more established.**

- **We already have a Severe Learning Difficulties (SLD) Service headed by …… at ….. House,**

Improve access / explore needs of Polish / Slovaki communities

- **This will need to be seen in context of overall BME strategy. Links with Trust Diversity Leads established.**

Co-ordinate into large BME Strategy

- **Links with Trust Diversity Leads established.**

Increase competency, skills and confidence within Team

- **Jane Thomas reported that we already have a system in place (through the Screening (Choice Appointments) Clinics for peer supervision. Formal channels for Clinical / Management Supervision are also in place.**

- **The team felt that re investment in our local CPDG (4th Thursday of each month) will help in the development of the above.**

- **Team leader confirmed that the team had now had the opportunity to develop skills in the ……. Approach and Solution Focussed Brief Therapy. He also identified that a local Eating Disorders Interest Group has also been formed.**

- **Team leader has kindly agreed to explore how we can make better use of internal resources to bring about core training in Cognitive Behavioural Therapy (CBT).**

Raise awareness skills and capacity at Tier 1

- **This will be taken forward by the PMHCW / TAMHS Team.**

Identify which secondary schools have the most CAMHS children attending

- **A conversation has now taken place with OASIS who will forward a document to the team that will show how Schools can be entered on OASIS. This should the make it possible in future to run a report.**

To have a late night clinic / weekend working

- **Administrations Manager will report on expressions of interest from administration staff to help facilitate the above. She will report back in due course.**

Drop-in CAB service held at Lodge Road

- **The team felt that this was no longer a priority of should be removed from the CTCYP Working Document.**

Improve relationship with commissioners and increase knowledge base of commissioners

- **The team felt that as we have been instructed by the Trust not to communicate direct with our Commissioners we cannot action this target. We hope however that the recent appointment of CAPA Project Manager and the introduction of CAPA longer term will influence this relationship. The efforts by ……., …… and …….. to develop less duplication in data reporting might also impact here.**

Mobile clinics to support existing clientele (e.g.; ..... PCT)

- **The team felt that this was no longer a priority of should be removed from the CTCYP Working Document.**

Look at mobile services e.g.; mosques, schools, difficult groups to engage in services

The team felt that this area could be taken forward by the PMHC and TAMHS Workers

All identified red changes

Enable people to access specialist therapy including music, art, drama, psychotherapies.

- **Access to Child Psychotherapy and EMDR was seen as essential. J will report back on this issue in 6 months time.**

? Link in with Focus Group

- **The team felt that this area could be taken forward by the PMHC and TAMHS Workers**

Recruit CPN's

- **We have now recruited to the PMHC and TAHMS Worker posts and plan to interview for the vacant Youth Offending Team Post by the end of July 2010.**

Triple 'P' Training

- **There are no current training places available**

To have an MLD Service (Moderate Learning Disabilities)

- **Dr R informed the team that we already have a business plan for the above and that this is currently being examined by the Trust**

To recruit Band 3 / 4 Support Workers

- **It is unlikely that given current resources and planning we will be in a position to action the above therefore the team felt it should be removed from the CTCYP Working Document.**

To recruit PMHW (Primary Mental Health Worker)

- **This has now been achieved**

Youth Forum Activity Group

- **It is unlikely that given current resources and planning we will be in a position to action the above therefore the team felt it should be removed from the CTCYP Working Document.**

2 Priority red changes

To have an MLD Service (Moderate Learning Disabilities)

- **Business Plan is with the Trust**

To recruit PMHW (Primary Mental Health Worker)

- **This has been achieved.**

CTCYP Action Plan – Green Changes (quick wins, easy changes, can be achieved by team)

Aim (What)	Objective (How)	Lead Person(s) (Who)	Target Date (When)	Resources Required	Progress to Date
Parents with mental health difficulties to be supported	Mellow Parenting feedback Audit to be done to see number of parents with MHI and if they are receiving support Approach PCLT to judge next step (ie; secondment of worker into CAMHS / set-up clear signpost pathways)	Rohesia B..... Service manager and team leader	Mar 2010 Jun 2010 Mar 2010	Time Admin support Collation of information Links	**Parental Mental Health Audit to be repeated (by Natasha), this will inform Mellow Parenting Programme. Service Manager to approach PCLT on return to work.**
To get feedback from the monitoring forms	Service Manager receives report. To bring to business meeting	Service Manager	Mar 2010	Time Meeting attendance	**Work in progress. J & CAPA Project Worker) will approach Commissioners. Conversations have already taken place with S, J and Business Support Managers re working 'with' Commissioners to reduce duplication in data reporting.**
Creative ways of advertising the issue of gender / choice	Consultation Joint team working Access the services available (e.g.; SODA or Link in with the services already available)	Service Manager	Apr 2010	Time IT	**Team felt that this was not a priority at present. They agreed however to review and redesign CAMHS leaflet that accompanies appointment letters (this could include advertising gender and choice in future). The introduction of CAPA will also impact upon the 'choice' discourse.**

	Develop an "operational framework"				**The development of a revised Operational Framework will be taken forward by Service Manager on his return to work,**
Develop screening clinics (3 / 4 clinicians)	Identify common screening times (via liaison with admin) Team to commit to ½ hr before and after sessions	Team Members	Mar 2010	Diary time Admin time / commitment	**These are already up and running and will be re framed as 'Choice Appointments' in due course (to complement the introduction of CAPA in the coming months). An emphasis on developing 'Partnership Appointments' (Phase 2 of CAPA) will be taken forward by Emma Davenport (as CAPA Project Manager).**
Establish CAMHS BME Strategy	Make links with Trust Diversity Lead (Emma Louis)	Dr S	Mar 2010	Time	**Links now established with Trust Diversity Lead**
Referral Officer role to be updated in light of CAPA		M to lead in conjunction with Team Members			**Due to necessary Secondments within the service the referrals officer role will be dissolved to the team. This process will be reviewed as CAPA is developed.**
Make links to Carers Support "All Saints Way" (SMHFT) Share information in team	Establish working links with Carers Team	Service Manager to meet with Carers Team	Feb 2010	Time	**The idea of improving links with Primary Care Services on a whole will hopefully be taken forward by the imminent recruitment of Primary Mental Health Care and TAMHS Workers to the team.** **Information sharing will be taken forward by re investment in our teams Clinical Practice Development Group.**

CTCYP Action Plan – Amber Changes (need time and may need reallocation of resources)

Aim (What)	Objective (How)	Lead Person(s) (Who)	Target Date (When)	Resources Required	Progress to Date
Create comprehensive multi disciplinary ASD / ADHD / SLD Services	Develop protocols for ADHD MDT's Develop comprehensive assessment and post-assessment care	ASD – M R ADHD – Dr J SLD – S	Jun 2010	Time Admin support	**We currently have a Multi Agency Assessment process for Autistic Spectrum Disorders and Dr Smith informed the team that this appears to working well.** **Dr Jones will be completing an Audit on ADHD and will report back on the outcome of this process in due course. She also advised that the borough now has an Attention Deficit Hyperactivity Disorder (ADHD) Support Group. The development of our Primary Mental Health Service could well impact here as it becomes more established.** **We already have a Severe Learning Difficulties (SLD) Service headed by Sarah at .....**
Improve access / explore needs of Polish / Slovaki communities Co-ordinate into large BME Strategy	In line with plan regard BME links / develop strategy Links with Trust Diversity Lead (Emma Louis) Co-ordinate into larger CAMHS BME Strategy	Dr ..... / Mike	Jun 2010	Time Needs analysis Strategy will need working group	**This will need to be seen in context of overall BME strategy**. **Links with Trust Diversity Leads established with Emma Louise.**

Increase competency, skills and confidence within Team	Non-management supervision / reflection In-house training sessions (e.g.; SFT, CBT) Develop support groups (e.g.; Eating Disorder Group) Review existing groups (e.g.; case presentation)	Team leader June 2010	Jun 2010	Supported staff time (Service Manager to agree)	**Jane reported that we already have a system in place (through the Screening (Choice Appointments) Clinics for peer supervision. Formal channels for Clinical / Management Supervision are also in place.** **The team felt that re investment in our local CPDG (4th Thursday of each month) will help in the development of the above.** **Team leader confirmed that the team had now had the opportunity to develop skills in the ..... Approach and Solution Focussed Brief Therapy. He also identified that a local Eating Disorders Interest Group has also been formed.** **Jane has kindly agreed to explore how we can make better use of internal resources to bring about core training in Cognitive Behavioural Therapy (CBT).**
Raise awareness skills and capacity at Tier 1	Via training Via liaison Via consultation Via existing PMHD post Via recruitment into new PMHD posts	Team Member Service Manager	April 2010	Resources identified Lots of time	**This will be taken forward by the PMHCW / TAMHS Team.**
Identify which	Collect information at			Free up time	**A conversation has now taken place with**

secondary schools have the most CAMHS children attending	screening, via notes, referral form, letter Get admin support	M / supported by Student	April 2010	for work to be undertaken	**Jane (OASIS) and she will forward a document to the team that will show how Schools can be entered on OASIS. This should the make it possible in future to run a report.**
To have a late night clinic / weekend working	Collecting evidence to support late night clinic / weekend working To explore financial implications to the service To have set of guidelines on working hours / TOIL To do feasibility study Explore other venues ie; Anchor, Lyng, YMCA, N..... Court, etc	Team leader(to ask) / admin To establish working group	Jun 2010	Time Liaison with appropriate personnel within the Trust	**Administrations Manager will report on expressions of interest from administration staff to help facilitate the above. She will report back in due course.**
Drop-in CAB service held at Lodge Road	Feasibility Study	R…….	Aug 2010	Time	**The team felt that this was no longer a priority of should be removed from the CTCYP Working Document.**
Improve relationship with commissioners and increase knowledge	Arrange Open Morning to showcase CAMHS	Service Manager	July 2010	Links with Media Consultant in Trust	**The team felt that as we have been instructed by the Trust not to communicate direct with our Commissioners we cannot action this target. We hope however that the recent appointment of Emma Davenport (CAPA Project Manager) and the introduction of**

base of commissioners					**CAPA longer term will influence this relationship. The efforts by Sandra Harris, Jane Chambers and Karen Yates to develop less duplication in data reporting might also impact here.**
Mobile clinics to support existing clientele (e.g.; ..... PCT)	Liaise with Wolverhampton PCT	Team member	June 2010		**The team felt that this was no longer a priority of should be removed from the CTCYP Working Document.**
Look at mobile services e.g.; mosques, schools, difficult groups to engage in services	Raise at Emotional Group to canvas support	Service Manager/Team member	March 2010	Awareness of potential venues	**The team felt that this area could be taken forward by the PMHC and TAMHS Workers**

CTCYP Action Plan – Red Changes (long term/complex changes, may require SMT approval)

Aim (What)	Objective (How)	Lead Person(s) (Who)	Target Date (When)	Resources Required	Progress to Date
Enable people to access specialist therapy including music, art, drama, psychotherapies.	Through sessional workers - informed by an audit of need - business case	To ask J / A	April 2010 July 2010	Money Allocation of time (A/ Js) Identify sessional workers	**Access to Child Psychotherapy and EMDR was seen as essential. J will report back on this issue in 6 months time.** **The team felt that linking in with focus groups could be taken forward by the PMHC and TAMHS Workers**

? Link in with Focus Group.					
Recruit more generic CPN's	Currently approx 3.4 wte 2 x generic CPN's per locality (extra 2.5 needed) Business planning Locality – community work (5/6) To look at ratio's for other teams	Service Manager and J	April 2010	Money Office space Writing business plan	**We have now recruited to the PMHC and TAHMS Worker posts and plan to interview for the vacant Youth Offending Team Post by the end of July 2010.**
Triple 'P' Training	Train staff	Team members	Jun 2010	Finance Time to attend course	**There are no current training places available**
To have an MLD Service (Moderate Learning Disabilities)	Revise the current business plan costings Ensure revised plan is a high priority on the Business Planning and Performance Group agenda Link in with 'Changing Young Lives'	Service Manager L A CR to ask) M R	Jan 2010 Jan 2010 Jan 2010	Time Admin Support Attendance at the meeting Time Information	**Dr S informed the team that we already have a business plan for the above and that this is currently being examined by the Trust**
To recruit Band 3 / 4	Make a business case	S P / M R		Assistance from Service Manager	**It is unlikely that given current resources and planning we will be in a position to**

Support Workers	To identify specialist areas to work in To investigate and compare other CAMHS services	Service Manager	Apr 2010	Time Admin Support E-mail out for information on different teams within service	**action the above therefore the team felt it should be removed from the CTCYP Working Document.**
To recruit PMHW (Primary Mental Health Worker)	To continue and promote the business plan	Mick / Service Manager	On-going TBA by CR	As above	**This has now been achieved**
Youth Forum Activity Group	Gather young people's views, thoughts, etc Provide opportunities to experience success and *** community existing resources • Via neutral venue • 6 sessions then review • Timetabled sessions • Evening / after school sessions • Legal issues would need to be addressed • Staff given dedicated time to set up and deliver • Partnerships • How to recruit • Tapping into existing	M	April 2010	Financial support Time allocated Legal support How recorded on OASIS STR Worker(s)	**It is unlikely that given current resources and planning we will be in a position to action the above therefore the team felt it should be removed from the CTCYP Working Document.**

	community resources • Pots of money • Use of volunteers e.g.; sports • Make links with VIK (Very Important Kids)				

Aim (What)	Objective (How)	Lead Person(s) (Who)	Target Date (When)	Resources Required	Progress to Date
To have an MLD Service (Moderate Learning Disabilities)	Revise the current business plan costings Ensure revised plan is a high priority on the Business Planning and Performance Group agenda Link in with 'Changing Young Lives'	Service Manager L A (CR to ask) M R	Jan 2010 Jan 2010 Jan 2010	Time Admin Support Attendance at the meeting Time Information	Revised Jan 2010 Business Plan submitted to Trust Board Jan 2010 Meeting arranged with VIK Co-ordinator 2nd March 2010
To recruit PMHW (Primary Mental Health Worker)	To continue and promote the business plan	Team leader / Service Manager	April 2010 recruitment to begin	As above	JD & PS Completed Jan 2010 **This has been achieved.**

The Team Profile and Workforce Plan is completed throughout the CTCYP capturing the team's journey from Step 1 to Step 5. The final document will identify:

- The team staffing, function and core values
- The skills, knowledge, qualifications and experience within the team
- The key implications of the local population
- The domain needs of the Children, Young People, Families & Carers
- The 20 priority needs of the Children, Young People, Families & Carers
- How the needs are currently being met
- What needs to change to improve the way the service is delivered in the future ensuring that:
  - **It meets the needs of the Children, Young People, Families & Carers**
  - **It is cost effective and value for money**
  - **Resources are being used effectively**

Specific aspects of the team profile and workforce plan will be relevant and informative to a variety of departments within the organisation e.g.

- Workforce planning
- Workforce development
- Operational services
- Education and training departments

Although key information can be subtracted from the document it will also be a valuable source of information to share the complete document to demonstrate how the team arrived at the final actions.

The TPWP should also be retained and used by the team as a template to measure, support and evidence change, whilst also acting as a benchmark for the future