National CAMHS Support Service

National Workforce Programme

INTEGRATED WORKFORCE PLANNING FOR COMPREHENSIVE CAMHS: A MODEL PLAN













Foreword

Modernising and strengthening the workforce is a central feature within current policy guidance relating to children, young people and families. The vision for the children's workforce is for a 'modern, skilled, competent, adaptable and flexible health, education and social care workforce providing a focused response to meet the needs of children and young people and their families'. The diversity of professions and occupations that make up the children and young people's workforce is a key part of its strength.

Workforce planning and development is a dynamic process, and the way we undertake workforce planning and development will evolve over time, as priorities, processes and capabilities develop. It is vital that an organisation knows strategically the direction of travel for the service and the workforce capacity needed to produce the service activity, only then it can begin to plan around the demands placed upon it.

With the increasing demands upon the current workforce, future workforce development and planning must ensure it supports continued improvement in quality and productivity, and that it delivers the best possible outcomes for the local population. Simply doing the same things in the same way may not deliver the vision of ensuring a world-class children and young people's workforce. We know we are facing challenging times with significant shifts happening across public services in what is a particularly difficult financial climate. The focus on improving quality and productivity through creative and innovative ways of working will mean significant change over coming years. If successful, these changes and shifts will have a considerable impact on the way services are provided and delivered and will need to be embedded to ensure they continue to meet new challenges and demands.

In order to support future workforce planning and development such changes will need to be quickly and reliably implemented so that organisations have a workforce equipped to respond effectively and flexibly to the new models of service delivery as they emerge. We will continue to rely on committed staff, working differently to provide the high quality affordable services to children and young people. Planning and developing the workforce effectively is the foundation for this.

Barry Nixon

National Workforce Lead - CAMHS

Introduction

This Model Plan has been produced by the NCSS National Workforce Programme to demonstrate how the Comprehensive CAMHS Integrated Workforce Planning Tool (IWPT) can help you build and successfully complete your own plan. http://atlas.chimat.org.uk/IAS/camhs

The Model Plan follows the Workforce Planning Template provided in the tool and guides you through the stages of integrated workforce planning process. It utilises the data workbook, training modules and audit tools provided in the IWPT. It demonstrates the outcomes that can be achieved if you engage partners and gain their input and advice, collect and analyse data and build workforce planning capacity and capability amongst your provider and commissioner organisations.

The locality of Middleshire and the names used in this Model Plan are fictitious. The Model Plan has used information from the data workbook and website links provided in the tool to create a pastiche from several CAMHS services to form the fictitious Middleshire Comprehensive CAMHS.

The Model Plan demonstrates, in depth, how you can populate each part of the template with data and information from the IWPT. All the websites referenced in the Model Plan are 'real' and the ones that have been utililised are hyperlinked so you can go directly to the source of information to create a plan for your local area.

This Model Plan uses all of the data workbook graphs and tables and all of the optional cut and paste policy inserts provided in the tool. However your plan may not need to be completed to this depth nor use all of the optional data tables, graphs, web sites and policy provided.

It is important to note that at the time of writing this Model Plan the Coalition Government are establishing new policies and departments and that some of the terms used within this Model Plan will become obsolete.

We would recommend using this Model Plan as a template and that the local plan you build will need to take account of new language, structures, functions and policy as they emerge.

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	PAF	RT 1:
About this	workforce	plan

1. This is the vision for the Comprehensive CAMHS Integrated workforce:

'The Whole is more than the sum of its parts'. Aristotle

The CAMHS Partnership believe that with careful planning and consideration of the choices available to us, there is every reason to believe we will have the freedom to really shape the future of our Integrated Services.

Our future workforce will look very different from the one with have at present. Our Needs assessment has highlighted changing demographics which will mean new ways of working with new processes that will affect everyone. The financial climate and the challenges this brings means we will ensure we make best use of our qualified, un-qualified and support workforce, appreciate the value of experience that all our skilled workforce currently bring and recognise the knowledge of our older workforce who bring their organisational memory and experience.

We will ensure we have sufficient workforce capacity, with the right knowledge, skills and competencies to support the delivery of choice and good outcomes, through effective integrated and cohesive strategic and operational workforce plans which are underpinned by sound financial planning, service activity planning and performance reporting.

1.1 Workforce Team

The CAMHS Partnership has responsibility for developing the Comprehensive CAMHS Integrated Workforce Plan (IWP). The Partnership's established work streams report monthly into the CAMHS Partnership Board, the Board report bi-monthly to the Children's Trust.

The Comprehensive CAMHS IWP workforce team has been identified as a time limited, task focussed group as part of the Workforce work stream. Their role will be to deliver a workforce plan which describes a Comprehensive CAMHS which will deliver better outcomes in children and young people's mental health and emotional well being, across the spectrum.

Workforce team membership:

Gareth Gerrard Joint CAMHS and Vulnerable Children's Commissioner

Gillian Hay Head of Children's Services & Acting Assistant Director

of Children's Services

Xavier Cugat Workforce Information Manager, Middleshire Partnership

NHS Foundation Trust (MPFT)

Steve Barry Children's Workforce Development Planning Manager,

Middleshire Community Workforce Team

Alison Tomley Operational Manager Specialist and Highly Specialist

CAMHS, MPFT

Marie Walker Service Manager MALOT

Mo Lang Health and Wellbeing Manager, Middleshire

Community Health

Heather Sunders Children's Centre Manager

Stewart Booth Service Manager/TaMHS Coordinator, Middleshire

County Children's Services

Sarah Moonly TAMHS Project Manager, Middleshire County

Children's Services

Dr Knox Child and Adolescent Psychiatrist

(CAMHS LD and In- Patient)

Annelize Timpson Consultant Child Psychologist MPFT

Dr Nixon Community Paediatric Consultant

Dr Ambekari Director Juliet Centre

Dhavinder Singh Principal Educational Psychologist

Dr Sorour Deputy Director of Public Health – co opt

Jayne Simpkins GP representative PCT – co opt

Dave Harlington General Manager – Adult Mental Health Service MPFT co opt

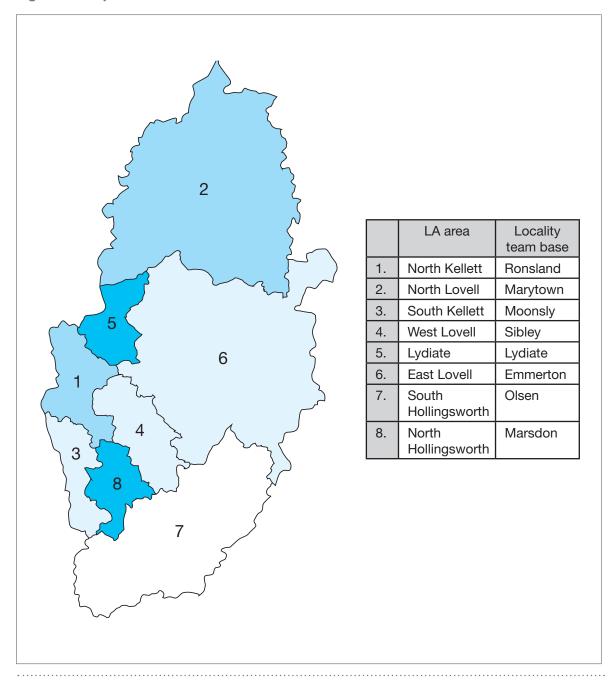
HR MPFT and LA co opt

Finance MPFT and LA co opt

1.2. Positioning of the plan

The plan covers the period 2011-2014, compatible with the Comprehensive CAMHS strategy and the Children and Young People's Plan (CYPP) with a review to be held in 2014 for the geographical area (Figure 1) served by Middleshire Children's Trust, covering the County of Middleshire. The geographical area is co-terminus with the boundaries for the County Council the Primary Care Trust (NHS Middleshire is currently the sole commissioning body for healthcare in Middleshire) and the Middleshire Partnership NHS Foundation Trust (MPFT) as provider of Targeted and Specialist CAMHS services, Adult Mental Health Services, Substance misuse services, Learning disability services and Forensic services.

Figure 1: Map of Middleshire:



1.3. The meaning of Comprehensive CAMHS as it is used within this document:

The Integrated Comprehensive CAMHS model for Middleshire uses the framework of Universal, Targeted and Specialist levels of service to meet the comprehensive mental health and psychological well-being needs of children and young people.

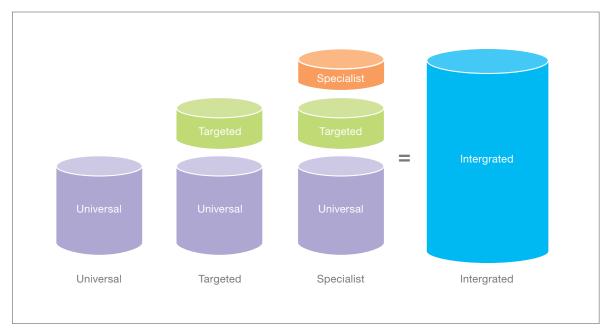
With Children in Mind: The final report of the CAMHS Review

Universal services work with all children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include early years providers and settings such as childminders and nurseries, schools, colleges, youth services and primary health care services such as GPs, midwives and health visitors.

Targeted services are engaged to work with children and young people who have specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. Within this group of services we also include CAMHS delivered to targeted groups of children, such as those in care.

Specialist services work with children and young people with complex, severe and/or persistent needs, reflecting the needs rather than necessarily the 'specialist' skills required to meet those needs. This includes CAMHS at Tiers 3 and 4 of the conceptual framework (though there is overlap here as some Tier 3 services could also be included in the 'targeted' category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need – for example, in pupil referral units (PRU), special schools, children's homes, intensive foster care and other residential or secure settings. (DCSF/DH, 2008 (2), page 18).

Figure 2: Middleshire model of Integrated Comprehensive CAMHS



The CAMHS Partnership vision and the subsequent delivery of our Integrated model is predicated on effective partnership working to ensure that the wide range of services are all involved in supporting children's emotional wellbeing and mental health within the different levels of service. The Partnership Integrated service model builds targeted and specialist services on top of universal services by drawing down knowledge, skills and resources around the child, young person and family/carer.

The Partnership conceptualisation of the integrated model is built on integrated practice, increasing participation of parents and children: seeking views and experience to inform service design and delivery, improved continuity and consistency of care, using the evidence base to improve and monitor outcomes, deliver quality and cost effective interventions.

Data is key to help us understand our population, its needs and the workforce capacity and capability to meet those needs. The Partnership is mindful that CAMHS Needs Assessment gives prevalence and incidence rates using the Four Tier model which has been used for over a decade to conceptualise the planning and delivery of mental health services. The data from Children's services mapping provides benchmarked information reported against the Four Tier model. Currently the configuration of the largest provider of Targeted and Specialist CAMHS services to Middleshire does correspond to the Four Tier model, providing community services at Tier 2 and 3 and In-patient services at Tier 4. Therefore the Four Tier model is given below to help readability across to Universal, Targeted and Specialist services.

Four Tier model: Original source DH and DES (2004).CAMHS Standard, NSF for Children, Young People and Maternity Services, p.46

With Children in Mind: The final report of the CAMHS Review

The four-tiered model has been used for over a decade to conceptualise the planning and delivery of mental health services. We recognise that this model is well embedded within the culture and the systems of health services. Across children's services more widely, there has been a more recent move to the concept of universal, targeted and specialist services. Both models are subject to local interpretation and differences in understanding, although they share the basic aim of helping people understand which services are available to everyone and which are available to some.

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

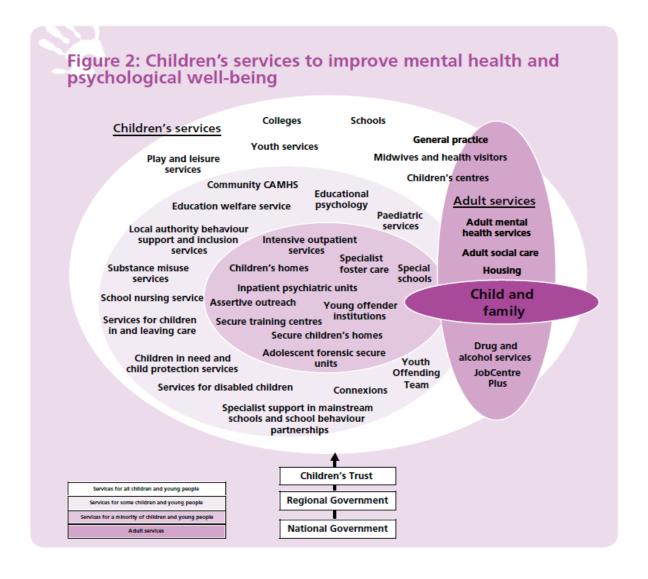
Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area (DCSF/DH ,2008(2), page 17).

We as a partnership recognise that this model is well embedded within the culture and the systems of health services, when it comes to local planning and delivery of services we use the illustration from *Children and young people in mind* to conceptualise our integrated approach.

Figure 3: Services illustration Source: Children and young people in mind: the final report of the National CAMHS review 2008 figure 2, p28



1.3.1 This plan addresses the recruitment and retention of staff in Targeted and Specialist CAMHS (Tiers 2, 3, 4).

Scenario Planning is a key area for continued improvement within Middleshire CAMHS Partnership. Commissioning support through action learning sets from Pearl University has enabled us to undertaken a considerable amount of work over the life time of our previous CAMHS strategy (2007-2010). Development of current commissioning capability will be focused on those areas of skill mix identified through scenario planning action learning sets, the relevant action plans created around recruitment and retention are incorporated into this Integrated Workforce Plan.

The Partnership is aware that across the Comprehensive CAMHS workforce we are still only managing to recruit a very small number of disabled staff. The fact that the proportion of successful candidates is similar to the applicant profile is encouraging, but the Partnership needs to improve its ability to outreach to disabled candidates. All partners are committed to making whatever adjustments possible to support our disabled workforce and the MPFT Equality and Diversity action plan does include work with disability groups to improve ability to recruit disabled people.

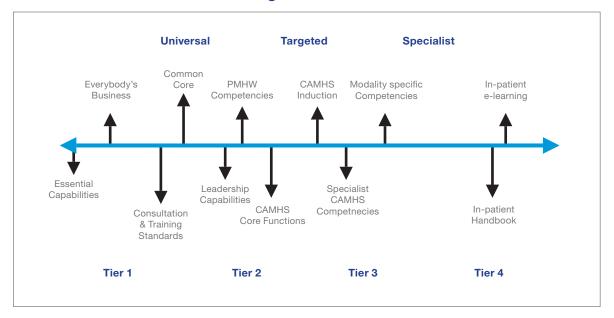
1.3.2 The plan also covers the education and training, as it relates to Comprehensive CAMHS, of staff working in all universal, targeted and specialist services (Tiers 1, 2, 3, 4)

Common across all strands of current children's policy is the need to ensure that all those working with children and families have the necessary values, competences, skills and ongoing learning and development to enable them to recognize and respond to the identified needs of children.

Few would disagree that all professionals who are responsible for the health, education and welfare of children and young people should possess the knowledge, skills, competences and capabilities needed to address the mental health needs of those for whom they are professionally responsible. A wide suite of policy and practice guidance, strategy and public inquiries have set the context for the learning and development needs of professionals who work with children who have mental health problems.

The vision of all future learning and development should facilitate the development of a unified culture for CAMHS with true inter-agency working. The education and professional development provided for staff must be accessible and useful at all levels from unqualified support staff to professionally qualified workers. The structure within which professional development will be provided will therefore need to be flexible and based upon a common core framework of knowledge, skills and attitudes https://www.chimat.org.uk/camhs/workforce

Continuum of Education & Training



Most importantly children, their families and carers expect those professionals working to address their needs to be adequately trained and to possess the necessary skills, competences and knowledge to provide effective care and treatment. It is now widely acknowledged that the development of a competent and capable children's workforce is a long-term strategy.

The Self Assessed Skills Audit Tool (Nixon & Walker 2011) was developed to be used as part of the Integrated Workforce Planning Tool, providing organisations, teams and individuals with a process and tool to support the initial, albeit significant step of gathering self-assessed information, not objectively measured, mapping the usage of the identified skills and highlighting any training gaps. Organisations can use the information gathered to respond effectively and flexibly to education and training needs as they emerge and to inform current and future education and learning commissioning and provision.

Learning and development for those who work with children and young people must be consistent with wider children's workforce strategy. CAMHS learning and development should be commissioned, provided and evaluated in an interagency context. Wherever possible, learning and development in child and adolescent mental health must fit seamlessly with broader children and young people's workforce training initiatives.

Workforce development in CAMHS is not only about skills and competences, but also about creating a shared understanding, shared vision and effective partnerships.

1.4. This workforce plan is underpinned by national, local policy and directives:

1.4.1 National policy and guidance

Department of Health (2010) Equity and excellence: Liberating the NHS

A top-down management approach led by the Department of Health does not allow accountability for decisions affecting workforce supply and demand to sit in the right place. It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training.

No Health without mental health - A cross-government mental health outcomes strategy for people of all ages.

This strategy spells out the Coalition Government's commitment to improving mental health and mental health services. To achieve this, the Government has agreed six high-level objectives with partner organisations, which set out the joint determination to improve mental health outcomes for all. This strategy also describes a number of specific commitments to:

- improve the mental health and wellbeing of the population;
- keep people well; and
- ensure that more people with mental health problems regain a full quality of life as quickly as possible.

These outcomes will be delivered by putting more power into people's hands at local level to ensure effective planning and commissioning of services that meet locally agreed needs. Accountability is a key driver of the current reforms. The public sector, including the NHS, and public health and social care organisations, has a responsibility to the public and users of services that goes further than how services are provided. The public and service users will play an active part in decisions about how priorities are determined, how public money is spent and how discriminatory attitudes to mental health can be effectively challenged.(Department of Health 2011 p68)

Department of Health (2004) Core Document, National Service Framework for Children, Young People and Maternity Services

The main policy driver for CAMHS and children's health, this document states:

Implementation of the NSF is dependent on having an adequately resourced, trained and motivated workforce, which means having the right numbers in the right place with the right skills. Workforce capacity is currently a significant issue in children's services across health and social care, with shortages and problems with retention being experienced in many of the staff groups providing services to children. These pressures will need to continue to be addressed both centrally, through national workforce planning processes, and locally, through the development of all-agency workforce, recruitment and retention strategies, based on a proper understanding of the needs of local populations, starting with the child and family rather than professional groups, and matching the skills and deployment of staff to the particular needs of each area.

These staffing constraints, along with the need to respond flexibly to rapidly changing demands on services, mean that there is a continuing requirement to look at workforce modernisation and role redesign. A range of new, and amended, roles need to be developed, with staff working in new ways across agencies and within multi-disciplinary teams. (Department of Health, 2004 page 17)

Talking therapies: A four-year plan of action. A supporting document to No health without mental health: A cross- government mental health outcomes strategy for people of all ages.

The aim is to develop talking therapies services that offer treatments for depression and anxiety disorders approved by the National Institute for Health and Clinical Excellence (NICE) across England by March 2015, the end of the Spending Review period. This involves:

 initiating a stand-alone programme to extend access to psychological therapies to children and young people, building on learning from the IAPT programme and using NICE-approved and 'best evidence'-based therapies where NICE guidelines are pending

The scope of the programme for children and young people is still to be determined. This will involve discussions with a wide range of stakeholders. Our emerging approach, to be further tested and refined, will seek to address this chiefly through transforming practice in existing tier 2 and 3 CAMHS provision, alongside a limited expansion of capacity, to improve access to evidence-based therapies by:

- involving clinical leaders, including GPs, and leading children's mental health charities in building the capability of the CAMHS workforce through an education and training programme that includes:
 - competency frameworks, curricula and training materials for the NICEapproved and evidence-based interventions
 - commissioning training for existing staff and a limited intake of new staff, beginning in 2011/12;
 - making best use of the existing IAPT education and training infrastructure, adapting it for children and young people and their families;
- establishing a change programme in early adopter sites, ideally in every strategic health authority (SHA) area, to:
 - provide supervised practice in the relevant therapies for both existing staff and new staff who are in training;
 - provide training in assessment for senior staff;
 - transform supervision and outcomes-focused service feedback processes, with the full participation of children and young people and their families who use the service;
 - test and refine the approach to service transformation, with a view to establishing a second and third wave in years 2 and 3; and
 - develop care pathways, service models and interfaces with adult IAPT services, together with an understanding of the level of unmet need for these services;

• involving children and young service users and their families in developing valid, user-focused and patient reported outcome measures (PROMs) at every session. These will form part of a routine outcome measurement framework that provides standardised assessment of each child's clinical improvement/ development and recovery (Department of Health 2011 p 17-18)

Middleshire was one of the early adopter sites for the Adult IAPT programme and has expressed an interest in being an early adopter site for the CAMHS IAPT programme. The Partnership feel well placed as all Targeted and Specialist CAMHS providers undertook the Self Assessed Audit Tool (SASAT) in 2007 and annually refresh their profile to identify training gaps and needs.

The initial audit in 2007 enabled the Partnership to use the National Continuous Quality Improvement Framework (NCQIF) http://www.chimat.org.uk/camhs/workforce to Commission training through the Learning Beyond Registration (LBR) contract with 5 Universities. Training in CBT has been the biggest commission to our regions Higher Education providers to ensure services have capacity and capability to practice at Certificate up to Masters Degree level.

Interpersonal Psychotherapy – Adolescents (IPT-A) training has also commenced locally, however the supervision elements need to be commissioned more formally as a recent audit has shown that currently this has just developed as a 'good will add-on' to existing job plans.

Middleshire Targeted and Specialist services are members of CAMHS Outcomes Research Consortium (CORC) and use clinical outcome measures in routine practice. Middleshire Specialist CAMHS were recently awarded Innovation monies to develop a session use Patient Reported Outcomes Monitoring (PROM), the project team have just been established and they form part of the Outcomes work- stream in the CAMHS partnership.

The Children's Commissioner for England, (2007) Pushed into the Shadows – young people's experience of adult mental health facilities.

All staff should treat patients with respect, whatever their age. It is of vital importance that staff working with children and young people are appropriately trained and can support the young people throughout their admission and planning for discharge. This is highlighted by the Mental Health Act Commission report which notes:

"If the ward is designated to admit young patients between the ages of 16 and 18 years on a regular basis, ensure at least some of the ward staff are provided with specialist training in the care of adolescents with mental health needs."

Recommendation 10

All young people admitted to adult wards should have regular access to a named key worker/lead professional who has received training in working with young people and who has responsibility for liaising with CAMHS and ensuring that young people's care is properly planned and they are fully supported throughout their stay. (pages 96-97)

On occasions of high demand there has been insufficient numbers of adolescent beds in Middleshire; some young people have needed to be cared for in adult psychiatric beds. There is close collaboration and liaison with adult mental health services; transfer protocols have been agreed between CAMHS and adult psychiatric services. When children and young people are unavoidably placed on adult psychiatric wards, there is collaboration and joint working between the child health, adult mental health and CAMHS professionals. There is a shared aim to ensure a timely and appropriate placement, if required, in a child or adolescent inpatient unit.

Mental Health: New Ways of Working for Everyone

Essentially, this work, along with the Creating Capable Teams Approach, will help organisations, providers and commissioners, plus service user and carer groups, to engage with clinicians and other practitioners at a local level in reviewing current working practices, in thinking about how roles can be extended and in considering how new people can be brought into the workforce through new roles.

The outcome we should be seeking is the creation of capable, multidisciplinary teams that are focused clearly on meeting the needs of service users and carers by:

- supporting service users towards recovery and self-management, where possible, with the right level and type of worker with the appropriate competences and skills;
- having specialist mental health professionals to support the voluntary sector and primary care by providing assessment, treatment and the care navigator function for those with more complex problems; and
- making the best use of resources.

NWW should be an explicit strategy and direction for the whole of the mental health workforce. (CSIP/NIMHE,2007)

Capable Teams for Children and Young People (CTCYP 2011) https://www.chimat.org.uk/resource/view.aspx?QN=CAMHS_WORKFORCE_SKILL was adapted from the CCTA. In 2010 one of Middleshire's Special schools, one of our Specialist CAMHS teams in Emmerton and Oak House undertook the process. This gave the Partnership the opportunity of using the approach within education, residential and health care teams. Using the 5 Every Child Matters Outcomes to identify priority changes has helped us to understand our care pathway development from the perspective of children, young people and carers who participated fully in the process.

The priority changes identified the need to create a Needs led workforce focussed on new roles, which the Partnership are already aware of, such as Family Support Workers (FSW) in Targeted CAMHS.

The CTCYP helped identify that the Partnership HR departments were duplicating recruitment processes and that job descriptions were very similar but did not allow for transferability of roles nor the FSW to work across professional boundaries.

Health Visitor Implementation Plan 2011–15 A Call to Action.

The start of life is a crucial time for children and parents. Good, well resourced health visiting services can help ensure that families have a positive start. The new health visiting service maximises the contribution of health visiting teams at community, family and individual level. In doing this, existing and new health visitors will work closely with Sure Start Children's Centres, FNP teams, other early years services, GPs, midwives, specialist services and, where appropriate, social care services.

This programme commits to investment in workforce expansion – an extra 4,200 health visitors (full-time equivalent) – to put this right. It calls on the profession, those who commission health visiting services, and those who provide them to promote a revitalised service, one which ensures that all families are offered a core programme of evidence based preventative health care with additional care and support for those who need it. As well as bringing in new recruits, the programme will offer existing health visitors the opportunity to refresh and develop their skills. For example, we will make sure that the learning from the Family Nurse Partnership (FNP) and other evidence based programmes and methods aimed at helping families with complex needs is available to all, alongside a new programme to update knowledge and skills in community health.

The Plan sets an ambitious pace. It will require innovative approaches to training and development, and rapid spread of learning. Some elements need national planning, such as managing the transition from the existing NHS structure to the new one. But change will ultimately be delivered locally by commissioners and providers of service, and above all by health visitors and their partners working with families and their communities. (Department of Health February 2011)

The review of the FSW role and function in Children's Centres and the targeted CAMHS MALOT function is important as part of the Partnership commitment to ensuring that the Health Visitor Universal Partnership Plus element of service delivery can be supported. The re-design will form part of the Integrated Care pathway around maternal and Infant mental health and be supported by all partners in, through and around Children's Centres.

1.4.2 Local policy and guidance

Middleshire Children and Young Peoples Plan 2008/2011

The review of the Children and Young People's Plan in 2008 resulted in the Children and Young People's Board agreeing the following priorities for the remainder of the Children and Young People's Plan timeframe:

- Preventative and early intervention support for children and families at risk of harm and other harmful outcomes (for example, care, exclusion or truancy from school, offending, drug and alcohol misuse, teenage pregnancy, Not in Education or Employment (NEET)
- Raising the educational aspiration, achievement and enjoyment of all pupils with a particular focus on vulnerable and/or underachieving groups of children and young people. Continue to focus support and intervention to improve Middleshire attainment in relation to statistical neighbours
- Improving sexual health, reducing unwanted teenage conceptions and improving support for teenage parents
- Strengthening support to improve the emotional and mental health/wellbeing of all children and young people thereby reducing the incidence of behaviour difficulties, conduct disorders, mental health difficulties; with particular focus on tackling the problem of bullying
- Improving outcomes for children, young people and families in areas of deprivation including rural deprivation/isolation
- Ongoing engagement and participation of children, young people and families in the development of services.

Middleshire Partnership NHS Foundation Trust. - Workforce Strategy – core principles

- Develop the organisation to support the Trust's business plan
- Be an employer for which staff actively choose to work by implementing best practice in managing people and supporting managers in developing effective staff management arrangements
- Plan for our workforce and, where appropriate, re-design roles to meet changing service needs
- Develop and improve the Workforce Service and Strategy, based on best practice and measurable outcomes
- Work with staff and their representatives to foster a positive working relationship in planning and delivering services
- Ensure that those people with the most complex health and social care needs have their care delivered by staff with the most highly developed set of competences
- Commission and provide training, education and development to meet organisational, team and individual needs
- Work with local education providers to ensure staff are able to access high quality development opportunities
- Work with Royal Colleges and professional bodies to influence education and the workforce of the future
- Treat staff consistently, fairly, reasonably, with dignity and respect
- Make sure that staff work in a safe and healthy environment
- Provide for the physical and emotional well-being of our staff
- Have a workforce which reflects the make-up of our local population
- Promote effective partnership working with staff, staff-side representatives and staff governors
- Recognise and reward the contribution which individuals and teams make to the provision of excellent services
- Support and develop staff who are in supervisory, management and leadership roles to successfully fulfil their responsibilities
- Agree and set performance targets to measure the effective use of staff resources
- Actively participate in programmes which enable service users to gain employment with the Trust and to provide opportunities for volunteering and supported employment

NHS Middleshire strategic plan is set in the context of local needs identified from the JSNA and Middleshire's Director of Public Health's Annual Reports. The Strategic Plan sets out the four goals for improving health and health services:

- Keep improving the health of everyone living and working in Middleshire
- Make sure everyone in Middleshire has better access to a wider range of health services, especially urgent care
- Improve the way people with long term conditions receive care so that they benefit from a more personal service that better meets their individual needs
- Ensure that every patient is treated with dignity and respect.

Specific work - streams have been set up:

- Paediatric Redesign Undertake a Paediatric services review and Child Health Promotion Programme
- Deliver care closer to peoples homes Access to psychological therapies
- Integrated pathways Undertake a Maternity Services Review

1.5 Seven principles of Comprehensive CAMHS Integrated workforce planning

1.5.1 Workforce design and planning

Having effective Workforce Design and Development practices in place combining need, service models to meet that need and workforce consequences across all agencies is fundamental to enable services to be staffed appropriately over the coming years.

1.5.2 Recruitment and retention

For mental health services to grow and develop, it is vital to recruit and retain good quality staff that reflects the make- up of the community they serve. Currently, mental health is not seen as an attractive place to work. We need to tackle this stigma by showing that it actually provides intellectual stimulus, good career opportunities, a fair rate of pay for the job and good support networks including a family friendly working environment. If there are insufficient staff we will continue to waste resources on agency and locum staffing, we will be unable to provide effective services for users and their carers and government targets will not be achieved.

1.5.3 New ways of working

New ways of working are essential because services are changing, are largely multi-disciplinary team based, with a need to provide a clear pathway for the service user and carer. The pressure from demand for services and insufficient supply of professionally qualified staff mean that traditional practice must be reviewed to ensure that the best use is being made of highly trained professionals. It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered.

1.5.4 New roles

We need to recruit from a different pool of people if we are realistically to expand the workforce to the extent required. This may involve targeting people aged 25-60 who do not have GCSE's or graduates, particularly in health and social sciences. Many of these potential recruits do not want to enter the traditional professions, but with the appropriate training and supervision could take on important roles in services to support and release time from professionally qualified staff based on an analysis of the capabilities required.

1.5.5 Leadership

Having effective leadership in place at all levels across all agencies is crucial to facilitating the engagement of both staff and organisations in modernising mental health services.

1.5.6 Education, training and other learning opportunities

Numbers are necessary, but not sufficient. A well educated, capable and supervised workforce committed to continuing learning is key to delivering effective services, which are valued by service users and their supporters.

1.5.7 Develop the skill mix, capability and competences

Commissioners and providers of services develop the skill mix, capability and competences of staff to deliver all the assessment and treatment components of comprehensive CAMHS.

PART 2: Local population profile and mental health need of children and young people

2.1 Local population profile and mental health need of children and young people

A number of socio-demographic risk factors are known to relate to the demand for Comprehensive CAMH services, e.g. socioeconomic status, overcrowding or large family size, low maternal education, limited employment skills by the head of the household, and welfare status (Garmezy, 1993). However there is no established index that can be used to predict demand for Comprehensive CAMH services.

2.2 Local geography

Middleshire has just under 700,000 total population. Middleshire is geographically the third largest County in England, covering 6,122 km2. The County is sparsely populated with 118 people per km2, compared to 284 people per km2 in the Eastern Midlands. There are 6 Ministry of Defence bases located in the County.

This County is classified as one the most rural in England by the Department for Environment, Food and Rural Affairs. Four of the eight Local Authority Districts in Middleshire have been classified within the most rural category, 'Rural-80', identifying that at least 80% of the respective populations live in 'rural settlements and larger market towns'. Only the City of Lydiate has been classified as an urban area, listed as 'Other Urban'. This is the smallest category of urban area meaning that fewer than 37,000 people, or less than 26%, of the population live in 'rural settlements and larger market towns'.

The fact that Middleshire is such a sparsely populated County understandably presents a number of difficult issues in striving to make services safe, accessible and affordable.

2.3 Child population

Population estimates show that Middleshire has a lower proportion (22.6%) of 0 to 19 year olds than the Regional and National averages, 23.8% and 24.0%.

Table 1: Middleshire population

		Middleshire				
Age	Number	% ofChild population	% of total population			
0	7,500	4.8	1.1			
1-4	29,000	18.4	4.2			
5-9	35,300	22.4	5.1			
10-14	41,100	26.1	5.9			
15-19	44,600	28.3	6.4			
Total Child population (under 19)	157,500	100.0	22.6			
Total Population	697,900		100.0			

The number of live births in Middleshire has fluctuated in the period 2000 to 2008 but with an overall average annual increase of 1.9%; this is above both the Eastern Midlands (1.5%) and England (1.6%) change rates. Emmerton has seen the largest increase, most marked since 2003, with an overall average annual increase of 5.1% from 2000. This may be a reflection of the changes in population in these areas due to migration of younger people predominantly from Eastern Europe. The increasing birth rate will have an impact on the demand for a number of services, such as maternity care services, pressures on primary care services, housing needs and an increased demand for school places in future years.

2.4 Figure 4: Indices of multiple deprivation (IMD) - Middleshire

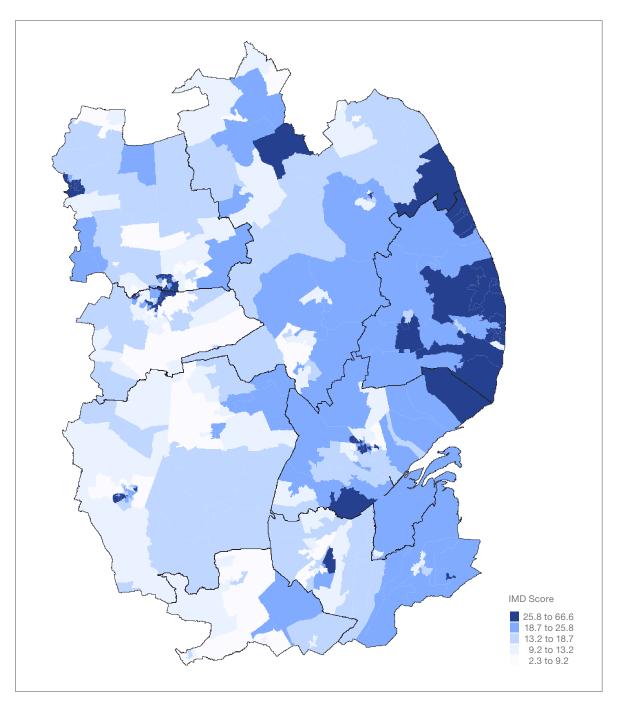


Table 2: Middleshire IMD average score

Middleshire – 8 Local Authorities	IMD average score	Rank (1= most deprived)
Lydiate	29.73	49
East Lovell	26.56	70
North Hollingsworth	10.26	296
West Lovell	16.21	194
South Hollingsworth	24.61	88
North Lovell	16.75	184
South Kellett	11.49	270
North Kellett	22.75	109
Middleshire	Overall	98

Emotional health and mental wellbeing needs are likely to be affected by the life circumstances in which children grow up. Deprivation, social stability, employment, ethnicity, migration and general health problems in a local area can influence the numbers of children needing support. These factors can also help to predict where within the boroughs the needs are likely to be higher.

In 2009 Lydiate was ranked as the 49th most deprived local authority in England compared with North Hollingsworth which was ranked as 296th out of 353 local Authorities.

The most notable pattern of deprivation in Middleshire remains the distinct east / west divide. There are high levels of deprivation on the East Coast and in Lydiate. Figure 4 shows that the levels of deprivation were highest on and around the East Coast.

Over 40% of those living in the East Lovell and South Hollingsworth GP Cluster live in areas among the 20% most deprived in the country. North Hollingsworth and South Kellettt have no deprivation to speak of when compared nationally.

It is likely that the prevalence of emotional health and mental well-being needs will be higher in the areas of high deprivation. For this reason the CAMHS partnership chose to locate its TaMHS pathfinder on the East Coast.

2.5 Child Health Profile summaries

The Child Health Profiles show performance against a range of indicators and allow us to make comparisons locally, regionally and nationally. They show how each of our local areas compares to the England average across a range of indicators. They are designed to support our Local Authorities and Primary Care Trusts to improve the health of children and to tackle health inequalities in our area.

Table 3: Child Health Profiles

		England Average	Lydiate	East Lovell	West Lovell	South Kellett	North Kellett	North Hollingsworth	South Hollingsworth	North Lovell
	Infant Mortality rate	4.90								
	Teenage conception rate (age <18 years)	41.20								
	Hospital admissions due to alcohol specific conditions (all ages)	70.23								
thy	Breast feeding initiation %	72.46								
lealt	Obese children (aged 4-5) %	9.6								
Be Healthy	Obese children (aged 10-11) %	18.30								
	Decayed, mssing or filled teeth (age 5 years) %	1.11								
	Hospital admissions due to drug misuse (15-24)	75.10								
	Child mortality rate (age 1-17)	17.40								
	Pupils who say they have been bullied %	48.00								
Stay Safe	Rate of family homelessness %	1.91								
Stay	MMR Immunisation (by age of 2 years) %	88.20								
	Hospital admission rate due to injury (age under <18 years)	1440.26								
9V6	Participation in 2 hours sport/PE (%)	49.62								
chie	GCSE pass rate (5 A*-C) %	74.80								
ρ	GCSE pass rate (5 A*-G) %	92.60								
Enjoy and Achieve	GCSE achievement (5 A*-G) children in care %	49.30								
Ш	Children working securely at foundation stage %	47.00								
e a tive oution	Voted in school election %	42.50								
Make a Positive Contribution	First time entrants to the Youth Justice System	17.90								
ving omic eing	Children living in poverty 2005	22.40								
Achieving Economic Well Being	N.E.E.T. (aged 16-18 years) %	6.40								
Significan	ce compared with Engla	nd averaç	je:							

2.6 Childhood obesity and being underweight

The National Childhood Measurement Programme (NCMP) was established in 2005 and measures children across England in Reception (aged 4 to 5 years) and Year Six (aged 10 to 11 years) classes. The NCMP covers all state schools in England. In the 2008/09 school year for Middleshire, 91% of eligible children were measured as part of the NCMP. Within the Reception classes 14.4% were recorded as being overweight and an additional 8.9% as obese. The results for Year Six showed that 14.0% were overweight and an additional 16.5% were obese.

The NCMP also measures the number of children classified as underweight. Being underweight can also put health at risk, young women are at risk of anaemia (lack of iron) while insufficient calcium can lead to osteoporosis in later life. Amenorrhoea (missing menstrual periods) is also common among women who are underweight and can lead to infertility. The percentage of children in Reception classified as underweight has increased from 0.8% in 2007/08 to 1.6% in 2008/09, and is now slightly above both the Eastern Midlands (1.2%) and England (1.0%) averages. The number underweight in Year Six has remained static at 1.1% between 2007/08 to 2008/09, and remains just below the Regional (1.2%) and National (1.3%) averages.

The evidence shows us that young peoples' diet and appetite can be affected by stress, worry or tiredness. Worries about weight, shape and eating are common, especially among young girls. NICE guidance (2004) suggests that nearly 1% of women in the UK between the ages of 15 and 30 suffer from anorexia nervosa, and between 1% and 2% have bulimia nervosa. Eating disorders start most commonly in adolescence and are associated with high levels of mortality, physical health problems and psychological distress, as well as impaired quality of life. Access to high-quality mental health care, based on the best available evidence and delivered by staff with an appropriate range of skills and competencies, is critical to meeting the specific needs of this group of young people.

2.7 Wellbeing of Children and young people

The CAMHS Partnership has been using the National TellUs surveys to identify what children and young people are saying about their health and well-being in Middleshire TheTellus3 survey of young people in school suggests that children are generally happy and have good relationships. The survey indicated that more children in Middleshire have smoked a cigarette that the National average. The survey also shows that more children in the County have drunk alcohol and taken drugs than the England average. Surveys indicate that a higher proportion of children across Middleshire have been bullied than the England average.

The highest rates of concern about bullying particularly were in Emmerton on the East Coast. The project team have worked with Emmerton schools workforce to use the Sociogram tool, http://www.sussex.ac.uk/Users/robinb/socio.html to understand more about pupils peer relationships and has helped identify...

...children at risk and those currently isolated. Infant and junior teachers, Sencos and mid-day supervisors have used the tool to develop group work and individual work with children on social skills and friendship skills. The CAMHS Partnership is exploring how the tool and the training in its usage can be mainstreamed across all schools.

There are now several well established participation groups supported by Children's services and by Specialist CAMHS. Addressing and reducing stigma was identified by the CAMHS partnership as a work stream in response to this being raised by the 'Healthy Minds – text us your issues 'project run by Lydiate City Council. The participation groups worked with the National CAMHS Support Service as a pilot site for the 'Tackling Stigma' project.

http://www.chimat.org.uk/tacklingstigma.

2.8 Housing

The 2001 Census showed Middleshire having a percentage (73.5%) of housing owner occupied comparable with the Regional average (72.1%) and higher than that nationally (68.7%). North Hollingsworth and South Kellett have the highest percentage (77.1%) owner occupied and Lydiate the lowest (63.1%), the latter again reflecting the student population.

The rate of statutory homelessness, (2.19) in Middleshire is below both the Eastern Midlands (2.54) and England (2.82) rates. Lydiate has the highest rate of homelessness per 1,000 households (4.65), more than twice the County average, with South Kellett having the lowest rate of 0.72.

2.9 Incapacity Benefit

Long term health conditions in adults have an impact on the environment in which children grow. If parents are affected they may be less likely to be in employment, more likely to have high levels of health service use and there can be an expectation of a medical response to health challenges rather than a self care response. Children can be affected by the mental health challenges in their parents and are more likely to become young carers. This has been shown to have emotional health and mental wellbeing challenges for young people due to anxiety and increased responsibility.

2.10 Ethnicity and diversity

This section examines the representation of minority ethnic communities in the population and on the CAMHS Teams caseloads. Figure 5 shows the overall comparative representation of all ethnic communities except White British. This group has been excluded from the chart because it would skew the diagram, being by far the majority of most local populations.

Comparison of diversity in the population Middleshire East Midlands 3.5 2.0 1.5 1.0 Mixed: White and Asian Other White Mixed: White and Mixed: White and Black Caribbean Black African Mixed: Other Mixed Pakistani Bangladeshi Other Asian Black Caribbean Other Black Black Africar

Figure 5: Comparison of diversity

The ONS released experimental population estimates by ethnic group in 2009, covering the period between mid-2001 and mid-2007. The data shows that between 2001 and 2007 all of Middleshire's ethnic populations have increased as a proportion of the overall population. The County's White British Population increased by 25,000 but fell as a proportion of the overall population from 97% to 94.2%.

The Pakistani group showed the largest percentage change in Middleshire an increase of 475% (equating to 1,900 people between 2001 and 2007). However, this group still only accounts for 0.5% of the County's population.

The group with the largest increase (excluding White British) has been White Other. This group has increased from 7,000 in 2001 to 11,900 in 2007, an increase of 70%. The rate of increase over this period has been steady and is mainly due to migrant workers arriving from other EU countries.

Figure 6 shows the ethnicity of users of the Specialist CAMHS service. Data has been suppressed from the chart for ethnic groups where the numbers on CAMHS caseload is below 5 children/young people. White groups form 94.2% of the county population and 98.6% of the Dedicated, Targeted and Specialist CAMHS caseload.

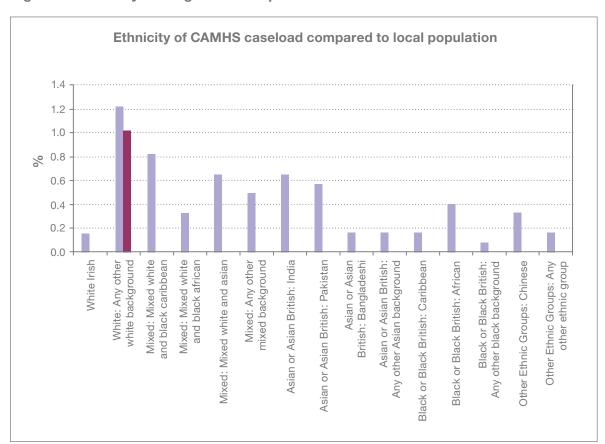


Figure 6: Ethnicity of Targeted and Specialist CAMHS caseload

One possibility is that inequities in access, particularly under-representation of all the ethnic groups, may be related to a mismatch in the staffing of services compared to that of the local population, particularly that a low relative level of staff with a common cultural background, language might affect engagement with the service. Another possibility is that 15% of cases in Middleshire are recorded with ethnicity 'not stated'. This affects the reliability of these figures, a recommendation that reasons behind level of ethnicity recording should be investigated with a view to improving recording and analysis.

The Partnership is committed to ensuring that the workforce reflects the Community it serves. MPFT undertake regular analysis of recruitment across all their services. In 2009 there was a high proportion (21%) of non-White British applicants in comparison to successful candidates (4%). On further investigation it was found that because MPFT advertises posts on the world- wide web, a large number of foreign nationals applied for posts but did not have the relevant visas and work permits. This was especially true of applicants from India. This, along with the high proportion of undisclosed ethnicity in the starter figures (caused by difficulties within our Electronic Staff Records system which are currently being dealt with) makes it difficult to analyse the information to a great degree. However, the proportion of applicants and successful candidates from the "White Other" category is in line with the profile of Middleshire, as much of our ethnic population come from new arrival EEC communities.

2.11 CAMHS Needs assessment

http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=4&geoTypeId=15

2.11.1 Prevalence of Mental health problems

Table 4: Estimated number of children with disorders

	Middleshire mental health
Conduct Disorders (5.3%)	4975
Emotional Disorders (4.3%)	4036
Being Hyperactive (1.45)	1314
Less common disorders	1220

The 1996 publication 'Treating Children Well' (Z. Kurtz, Mental Health Foundation) provides an estimate of the number of children / young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4. Table 5 shows these estimates for the population aged 17 and under of Middleshire Mental Health.

Table 5: Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS

	Middleshire mental health
Tier 1 (15%)	19611
Tier 2 (7.0%)	9152
Tier 3 (1.85%)	2419
Tier 4 (0.075%)	98

2.11.2 Learning disability

Estimation of the population prevalence of learning disability is problematic and should be treated with caution. One study estimated that 2% of the total population has a learning disability. They have further calculated age related prevalence as follows; 5 to 9 years (0.96%), 10 to 14 years (2.26%) and 15 to 19 years (2.67%). The estimated total number of children with specific disorders in Middleshire Mental Health is shown in table 6.

Table 6: Estimated total number of children with a learning disability

	Middleshire mental health
Ages 5 to 9	339
Ages 10 to 14	928
Ages 15 to 19	1191

These age-specific rates reflect the increasing identification of children with mild learning disabilities with age. On the basis of a 40% prevalence of mental health problems associated with learning disability, (this is the rate quoted in the Foundation for People with Learning Disabilities publication "Count Us In", the following number of children with mental health problems might be expected in Middleshire Mental Health ages 5 to 9 - 138, ages 10 to 14 - 377, ages 15 to 19 - 480.

2.11.3 Autistic Spectrum Disorder (ASD)

A recent study in South East London, (Baird et al, Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP), The Lancet 2006; 368:210-215) estimated the prevalence of childhood autism at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000 or approximately 1%. This study supersedes the Medial Research Council study which estimated the prevalence of ASD at 60 per 10,000 population aged less than 8 years.

If the prevalence rate found by SNAP were applied to the population aged 5 to 16 years of Middleshire Mental Health this would estimate approximately 952 cases.

2.11.4 Self harm and suicide

A conservative estimate is that there are 24,000 cases of attempted suicide by adolescents (of 10-19 years) each year in England and Wales, which is one attempt every 20 minutes (Hawton et al, 1999). A Samaritans study found that four times more adolescent females self-harmed than adolescent males (Samaritans, 2003)

The most recent data from the Office for National Statistics (ONS) indicate that in 2005 there were 125 deaths of 15 to 19 year olds from suicide or undetermined injury in England and Wales. This is a rate of 3.6 deaths per 100,000 population aged 15 to 19 years (ONS Vital Statistics and 2005 ONS Mid Year Population Estimate).

If applied to the population of Middleshire Mental Health this would equate to an estimate of 2 deaths from suicide or undetermined injury per year.

Deliberate self harm (DSH) accounts for 35%, the largest, presenting problem for the In-patient service. (Figure 29) The TaMHS audit of Universal services workforce skills and knowledge highlighted a lack of confidence in understanding and managing self harm. An audit of admissions to Paediatric wards and the In-patient CAMHS unit identified crisis admissions on Friday evenings and short term admissions (less than 36) hours were increasing. The Self Assessed Skills Audit (SASAT) identified a low level of skills in risk assessment, Care Programme Approach and A&E assessment of DSH.

The Partnership has supported the development of a self harm care pathway across Comprehensive CAMHS. The pathway includes a training and education package for Universal services and will be utilising the 'Self harm in children and young people handbook' developed by the National CAMHS Workforce programme. http://www.chimat.org.uk/camhs/workforce

Middleshire Partnership NHS Foundation Trusts Adult Mental Health (AMHS) Crisis and Home treatment service now offers out of hours and support over the weekend to young people aged 16-18 years. A&E, Paediatrics, CAMHS and AMHS services will be undertaking joint training and developing shared protocols on assessment and evidence based interventions. The developing CAMHS Crisis/Intensive Home Treatment Service needs to be built on a shared understanding, shared vision and effective partnerships.

2.12 Vulnerable groups

2.12.1 Children supported by social care

Instances of children being referred to social care more than once in a 12 month period have fallen considerably from 25.26% in 2007/08 to 13.3% in 2008/09. This compares to our statistical neighbours average of 26.1% and the national average of 24.3% for 2008/09.

2.12.2 Looked After Children (LAC)

There were a total of 525 children and young people looked after in Middleshire. Children who have been placed in care are at much higher risk of developing emotional and mental health problems than the average. The outcomes for children in care on a range of indicators are poor. However there is evidence that the earlier that a child is brought into care the better the outcomes of care. The numbers of children in care represent a small proportion of the children in families with suboptimal care.

Table 7: Numbers of Looked After Children in Middleshire

Indicator	Lydiate	East Kellett	West Kellett	North Lovell	West Lovell	East Lovell	North Hollingsworth	South Hollingsworth			
Numbers of looked after children	188	36	68	43	54	62	10	30			
Date	1/10	1/10	1/10	1/10	1/10	1/10	1/10	1/10			
% of LAC per 0-17 yrs pop	0.90%	0.21%	0.25%	0.22%	0.18%	0.48%	0.04%	0.13%			

In 2003 the Office for National Statistics published data comparing the prevalence of mental disorders in children looked after by a local authority in comparison with a representative sample of children living in private households. Table 8 below shows these relative prevalence rates.

Table 8: Prevalence of mental health disorders: LAC and non LAC

	5-10	years	11-15	years		
	Looked after children	Non looked after children	Looked after children	Non looked after children		
Conduct disorders	11%	5%	40%	6%		
Emotional disorders	11%	3%	12%	6%		
Hyperkinetic	11%	2%	7%	1%		
Any childhood mental disorder	42%	8%	49%	11%		

Of the 525 children looked after, 45 of these children and young people were in residential care. A 40% prevalence rate would equate to a total of 208 children across all these settings who may experience some type of mental disorder in Middleshire. Over the past 6 months the number of Looked after children has increased in each borough although this has mainly been in the younger age groups and so is likely to impact on the numbers of children needing mental health services in the medium to longer term rather than in the short term.

Children living in care can be difficult to count as they can leave and return to care. Therefore the figures relate to a snapshot taken during January 2010 this was preceded by a very similar picture in both January 2007 and January 2008.

2.12.3 Children subject to a child protection plan:

For those children who ceased to be subject to a child protection plan during 2009/10 only 0.9% was longer than 2 years compared to 6.6% for our statistical neighbours and 6.15% nationally. This would indicate that children and their families are receiving the services necessary to bring about the required changes in the family situation which should lead to the child not needing to be the subject of a Child Protection Plan within a maximum of two years.

In 2009/10 Middleshire (20%) did not perform as well as both statistical neighbours (14.8%) and the national average (12.84%) for children becoming subject to a Child Protection Plan for a second or subsequent time. The Child Protection Plan should lead to a lasting improvement in a child's safety and overall well-being and therefore significantly reduce the likelihood of requiring a Child Protection Plan in the future.

2.12.4 Substance misuse

Substance misuse by young people is strongly linked with involvement in crime or anti-social behaviour, increased risk of failing at school and damage to both mental and physical health Middleshire has been above both the statistical neighbour and England average for the past 2 years.

2.12.5 Young Offenders

There are a number of studies which provide insight to the mental health of young people who have had contact with the criminal justice system. In Middleshire Mental Health there are 1642 young people on the caseload of the Youth Offending Service. The prevalence rates available apply to specific age bands.

Dolan found that 25% of juvenile offenders aged 10 to 17 years appearing before Manchester Youth Court had had recent contact with psychology or psychiatric services. If applied to the same age range on the YOS caseload this produces a prevalence of individuals who may have had recent contact with CAMHS. Vermeiren et al provide prevalence rates for the population aged 12 to 17 for specific disorders. When applied to the YOS caseload in this age range this provides the following estimates:

Table 9: Estimates of young offenders who have a mental health disorder

	Middleshire mental health
Conduct Disorders (53%)	870
Hyperkinetic Disorders (19%)	312
Substance abuse (24%)	394
Depression (14%)	230
Psychotic Symptoms (4%)	66

Multi Systemic Therapy

The Government is piloting Multisystemic Therapy (MST) for young people with severe conduct disorder. Some young people show signs of emerging difficulties at an early age, although it is not good practice to diagnose personality disorder before the age of 18. Some young people with severe conduct disorder may go on to develop antisocial personality disorder. NICE recommends MST for young people aged 12–17 years with severe conduct problems and a history of offending who are at risk of out-of-home placement in care or custody.

No health without mental health: Delivering better mental health outcomes for people of all ages DH 2011 p14

Whole-family approaches for families with multiple problems and needs, such as intensive Multisystemic Therapy (MST) and targeted parenting work, have been shown to improve the wellbeing and mental health of young people and their families. The Partnership believes that whole-family approaches in which all our children's services work more closely together will be effective in preventing young people going into Out of County placements, into custody and improve the outcomes of young people already in our Secure setting and YOS service. The importance of involving our Adult services colleagues will be particularly important in respect of the findings that this approach has also been effective in supporting young carers – a particularly at-risk group.

The Partnership is committed to developing MST and believes that the commitment shown by all our partners and in particular the NHS provider for Specialist CAMHS is in a adult and children's Health and Social Care Foundation Trust with a critical mass of Specialist Social Work in Targeted and Specialist CAMHS will give us the flexibility to use New Ways of Working, re-design roles and functions to deliver our MST.

2.13 Education

2.13.1 Children excluded from school

In January 2010, there were 6 Nursery Schools, 302 Primary Schools, 60 Secondary Schools, 21 Special Schools and 4 Pupil Referral Units across Middleshire. There is also a range of Independent Schools across the County. Within the Secondary Sector there are currently 6 Academies, which are not maintained by the Local Authority. Middleshire is a rural county and variation in school size is wide, from 13 to 626 pupils on roll in the Primary Sector. Several small schools have recently closed due to financial viability and falling pupil numbers.

Many children are excluded from school because of behaviour and this may indicate a need for support both to deal with the underlying issue and to enable the young person to access education and to enjoy and achieve. The number of permanent exclusions from schools (Figure 7) across Middleshire is below both the Regional and National averages.

12
10
8
8
6
4
2
Marytown Emmerton Lydiate Olsen Ronsland Sibley Moonsly

Primary Secondary Special

Figure 7: Permanent exclusions 2008/09

2.13.2 Children absent from school

The rate of absence is defined as the percentage of possible 'half day' sessions missed due to absence (authorised and unauthorised). The absence rate from maintained primary schools in Middleshire has increased between the years 2007/08 to 2008/09. The rate of absence at maintained secondary schools in the County has decreased in Emmerton, Ronsland and Marytown, but increased in the other Districts.

PART 3:

Integrated services to meet the mental health and psychological well-being needs of children and young people

3.1 Current Comprehensive CAMHS service description

The Universal children's workforce includes Education, Health, Social, family and community support, Youth justice and crime prevention, Sports and culture and Early years. Specific teams have responsibility for service delivering in;

- Fostering and adoption
- Safeguarding children
- Family information service
- Education, schools and transport
- Extended provision
- Children's centre's
- Children who need specialist help and support
- Teenage services
- Early year's services.

The Children's workforce deliver services through the eight localities and each member of the teams contribute to the agenda of emotional health and wellbeing.

Paediatric services are located in the two district general hospitals (Lydiate and Emmerton) two acute hospitals (Ronsland, Sibley) and community hospitals (Marytown, Olsen and Moonsly). Lydiate and Emmerton are seven day a week, 24 hour cover units. These units admit through the A&E department's children and young people who have Deliberately Self Harmed (DSH). The two CAMHS DSH nurses are co-located in these hospitals to offer Monday to Friday DSH assessments, the County Psychiatrist on-call rota covers out of hours and weekend.

Partnership commissioned *Counselling services* include the Juliet Centre which is a Lydiate based charity and opened in 1998 to offer counselling to children and young people 6-18 years who have experienced grief or loss. The Centre has 3 full time and 5 part time counsellors. The Partnership has commissioned a 2 year pilot from the Juliet Centre to undertake work with children and young people who have experienced domestic violence. New Direction and Headspace are part of a National Charity offering counselling services in the North and West of Middleshire. None of the charities are currently able to offer counselling to children and young people in the East of the County due to recruitment and retention difficulties.

Middleshire **Young Peoples Secure Unit** is run by local authority social services department, overseen by the Department of Health and the Department for Education. The focus of the secure home is on attending to the physical, emotional and behavioural needs of the young people they accommodate. The Secure unit is generally used to accommodate young offenders' aged...

...12 to 14, girls up to the age of 16, and 15 to 16-year-old boys who are assessed as vulnerable.

Targeted CAMHS-Learning disability (LD), CAMHS-Looked After Children (LAC) deliver services from one central base across all eight localities. CAMHS-Youth Offending Service (YOS) is delivered through the YOS teams.

Early Intervention in Psychosis service, Forensic and substance misuse services are provided by Middleshire Partnership NHS Foundation Trust. MPFT also provide **Crisis and Home treatment services** for aged 16 plus.

MALOTs are a targeted CAMHS service working in Primary care, providing capacity and capability building through consultation, training and co-working with Universal services. They comprise of health, social care and education workers (Primary Mental Health Workers, Family Support Workers, Mental Health teachers)

Over the past 3 years our *TaMHS* has given the Partnership the opportunity of developing joint working between the Education Psychology (EP) service and the MALOTs delivering interventions such as FRIENDS, Zippy's Friends, Managing Feelings, Nurture groups, Risk and Resilience, staff support, Peer Massage, Solihull Approach and Talking with Families into our County Junior and Senior schools. The Partnership will be supporting the mainstreaming of these targeted approaches over the next year through PCT monies for 3 Assistant Psychology posts to work along with the County's 6 EP's and MALOTs on roll-out into Lydiate schools.

The *MALOTs* have been re-designed over the past 2 years based on early findings of TaMHS and our vision that the MALOTs will be integrated to create a *School Community health team in each locality* comprising of school nurses, social workers, youth workers, educational psychologists, education welfare officers, cognitive behavioural therapists (once our CAMHS- IAPT programme has been developed), sick children's nurses, CAMHS- looked after children's, YOS and LD clinicians, speech and language therapists, play therapists and community paediatricians to effectively provide a comprehensive health service for the school aged population.

Joint investment from the PCT and ABG grant has increased capacity by funding Family Support Workers to work within Tier 2 and 3 of CAMHS. Findings from the TaMHS project has shown that the FSW's function is best delivered through the MALOTs, the FSW's will continue to be commissioned through the Local Authority Grant and the new Early Intervention Grant (2011-14) giving our local authority partners the ability to support targeted mental health provision for vulnerable children and young people, and to sustain any services previously delivered through TaMHS.

Scenario planning within the Partnership has identified a need to review the wider FSW roles across Children's services. The Integrated Comprehensive CAMHS pathway will need to take account, plan and develop the current FSW workforce already in each of the Children's Centres to support elements of the mental health pathway which will link into the Health Visitor Universal Partnership plus service.

Skill mix changes will result in Family Support Workers requiring a greater range of skills and competence, particularly in carrying out a defined range of interventions and reporting back to registered staff. For all the FSW's a clear framework which supports the education and training of this group of staff is essential in order to support competence acquisition and to provide career development.

Our Market Management analysis has identified that the voluntary sector will also need support to develop its workforce, this is particularly impacted by individual budget holders who may wish to purchase non-traditional services

Specialist Multi-disciplinary CAMHS deliver through the eight locality based teams and the *In-patient unit* provides a County wide service, and are commissioned from MPFT through the block contract with the PCT. The commissioning function of the In-patient unit will be moving to Regional Specialist Commissioning in April 2011.

The current position is that all of the additional services to evidence a comprehensive CAMHS are commissioned from the Middleshire Partnership Foundation Trust based on them already having a block contract with the PCT. Of those 50% of the PMHW workforce in the MALOTs is commissioned from the PCT grant, the remainder PMHW, FSW, and counselling service from the Local Authority Grant, TaMHS is funded by a DfE grant. This was done to maximise the grant and provide fit with the existing Mental Health Trust block contract. The vision is to develop a pooled budget and single specification service model to maximise the funding streams.

3.1.2 Provider access

All children and young people from birth to their eighteenth birthday, who have mental health and emotional health /psychological well-being, needs, should have access to timely, integrated, high quality services. Table 10 shows the hours and days that services across Universal, Targeted and Specialist CAMHS are available. The Out of Hours provision is identified either as an on-call/duty service or in settings such as Hospital environments or Residential units.

In order to develop access the Partnership has worked with the Regional Specialist Commissioning group and with all the other Eastern regions on a Crisis/ Intensive Home Treatment Service Specification. The rurality and large geographical area of Middleshire is a real challenge to developing services in general.

The Partnership believes that good financial, estates and logistics planning are key to keeping within resources and budget.

The Partnership has scoped out the impact of the Regional Service Specification and produced several scenarios, based on our Needs assessment, referral rates of demand, the available evidence base and NICE guidance and our skill mix.

The Partnership Integrated approach does not want to create another artificial layer between the 'Tiers' and although these services are commonly referred to as 'Tier 3+' the Partnerships vision is that 'Tier 4' is not just in-patient beds and 'Tier 3' can be flexible to offer Crisis/ intensive interventions based around family need and delivered in Estates that have an existing critical mass of staff Out of Hours to support lone working policies, care pathways, clinical decision making, make best use of administration and support services and offer child and family centred environments when required.

Table 10: Access to service provision

On Call Duty

Open

Closed

		Mor	nday			Tues	sday			Wedn	esday			Thur	sday			Fric	day			Satu	ırday		Sunday			
	AM	PM	EVEN- ING	24H	AM	PM	EVEN- ING	24H	AM	PM	EVEN- ING	24H	AM	PM	EVEN- ING	24H	AM	PM	EVEN- ING	24H	AM	PM	EVEN- ING	24H	AM	PM	EVEN- ING	24H
GP																												
Community Health																												
Paediatrics Impatient																												
Paediatrics Community																												
A&E																												
Schools Workforce																												
TaMHS																												
Malot																												
CAMHS LD.LAC/YOS																												
AMHS Crisis Team																												
Early Int Psychosis																												
Specialist CAMHS																												
In Patient CAMHS																												
SecureUnit																												
Juliet Centre																												
Headspace																												
New Direction																												
Childrens SW																												
Childrens Residential																												

3.1.3 Age range served

Table 11: Age ranges

Service Name	Service Type	Age Range																			
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19+
GP	Universal																				
Schools	Universal																				
Early Years	Universal																				
Social Work	Universal																				
Sports and Leisure	Universal																				
Paediatrics	Universal																				
Health Visitor	Universal																				
School Nurse	Universal																				
Juliet Centre	Targeted																				
New Directions	Targeted																				
Headspace	Targeted																				
Youth Offending Service	Targeted																				
MALOTs	Targeted																				
CAMHS (dedicated) targeted LAC, LD	Targeted																				
Multi-disciplinary Specialist CAMHS	Specialist																				
Tier 4 in patient	Specialist																				
Secure Unit	Specialist																				
AMHS Crisis & Intensive Home Treatment Service	Adult																				
Early Intervention in Psychosis	Other																				

3.2 Current Comprehensive CAMHS Service staffing

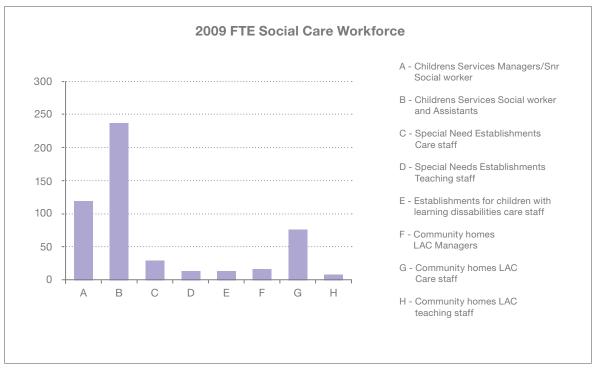
The wider Children's workforce within Middleshire has workforce plans within their own organisations. This plan does not replace those plans as Universal services have a wider remit than promoting and supporting mental health and emotional well-being.

Within Middleshire, Integrated and co-ordinated services are being delivered through the use of the Team Around the Child model. For the purposes of this plan the mapping of Universal service staffing focuses on those agencies involved in the Partnerships vision to build the core capacity and capability to meet Children and Young Peoples Mental Health and Psychological well being needs in the children's social care workforce , in the education workforce and in the Community health workforce.

All of this workforce being key in the integrated pathway design through Children's Centres, schools, social care and paediatrics. This workforce is being prioritised for Universal services education, training and consultation programme being offered by the Multi-agency Training programme.

3.2.1 Children's Social Care Workforce

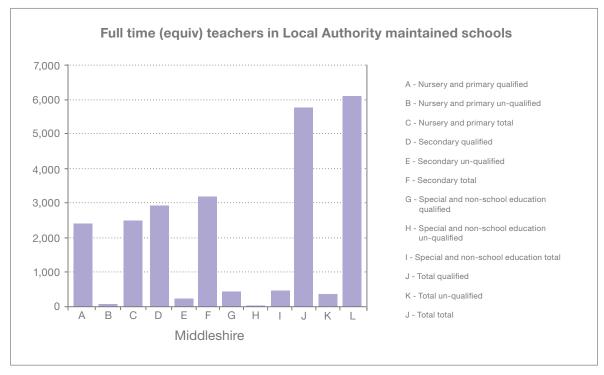
Figure 8: Middleshire Children's social care workforce



Source: Local Government Association. Social Care staff data:

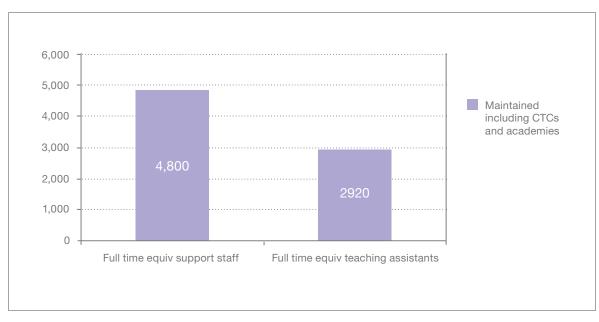
3.2.2. Schools Workforce

Figure 9: Schools workforce - teachers



Source DfE: School Workforce in England, January 2010

Figure 10: Schools workforce - assistant and support staff



Source DfE: School Workforce in England January 2010

3.2.3. Community Health Workforce

120 Managerial roles fte in post 100 Nursing staff fte in post 80 Allied Health Professionals fte in post Administrative and secretarial fte in post 60 Health, care and support fte in post 40 20 <u>0 0 0 0 0</u> 12 12 Early years School health Children's and health therapy visiting service

Figure 11: Middleshire Community Health Services

Source: Children's Services Mapping Child Health 2009/10

Allied Health Professionals include Occupational therapist, Physiotherapist, Speech and language therapist, Hospital play specialists.

There are 9 WTE Consultant paediatricians and a range of supporting medical and nursing staff.

3.2.4. Targeted CAMHS and Specialist CAMHS workforce

There have been numerous attempts to calculate the workforce required for a Specialist CAMHS. Numbers and recognizing that no amount of system reform, tool or techniques can compensate for a fundamental lack of numbers in the workforce; it is more than just numbers that have to be considered. The Partnership continues to examine how many staff are required within the service and how best to staff the overall service, paying particular attention to key interfaces and ensuring a balanced distribution of staff and skill mix.

The National Service Framework (NSF) Standard 9 suggested that in order to populate viable multidisciplinary teams and services at Tier 3 with teaching responsibilities, providing evidence-based interventions for 0-17 year olds to be a minimum of 20 whole time equivalents (WTEs) per 100,000 total population, and a non-teaching service, a minimum of 15 WTEs. This was based on a nominal population of 20,000 children and young people age 0-17th birthday, or 20% of a local all age population of 100,000.

In the NSF this recommendation relates to core CAMHS that is those delivering clinical services, administrative and management staff is in addition. Further work by Kelvin (2008) has recognised that additional workforce is required to provide full services up to the 18th birthday (19 whole time equivalent in non teaching centres or 24 whole time equivalents in teaching centres for a 0-18th birthday service, based on a nominal 21,100 children and young people age 0-18th birthday in the local population. Professional bodies such as the British Psychological Society and Royal College of Psychiatrists provide some guidance for the number of each type of professional per 100 000 total population; (Wallace et al, 1997).

Calculating the numbers required in the Middleshire workforce is not straight forward. The Partnership has made use of tools from the National CAMHS Workforce Programme to provide practical and logical support to local service development rather than to prescribe to a 'one size fits all' approach. We have re-designed our service in Middleshire over the past 5 years to take into account our local population profile recognising the significant variations in levels of deprivation, whilst on the one hand elevating many risk factors and markers for ill health, deprivation is also associated with poor uptake/utilisation of health services, our ethnic mix of the population, health profiles and the rurality of our County.

We have developed local solutions to the development of our service delivery.

By adopting a Comprehensive Integrated CAMHS we no longer have an isolated, discrete Tier 2 and Tier 3 service. We have developed Multi-Agency Locality Operating Teams (MALOT'S), Dedicated and Targeted services to specific vulnerable groups as we know prevalence of Mental Disorder is higher in those Children and Young people Looked After, those in YOS, in Secure Settings and Children with LD.

- Specialist CAMHS services are now developing a Crisis/Intensive home support function with investment and capacity released from the workforce in the Multidisciplinary team and the reduction in beds in the Tier 4 In-patient service and reinvestment from reducing Out of County placements.
- The Partnership has commissioned pilot projects increasing Third Sector counselling in and through schools, BME counselling through the schools project, Infant Mental Health in and through Children's Centres delivered through partnerships and integrated care pathways.
- The Partnership will be using part of current Grant funding and exploring new sources of funding to develop a Multi Systemic Therapeutic Team.
- The CAMHS Partnership supported the use of Choice and Partnership Approach (CAPA) as a way of calculating demand and capacity of all the Targeted and Specialist services. Care pathway and care bundles projects have enabled us to use the best available evidence and make the best use of our resources across Universal, Targeted and Specialist CAMHS.

 We have invested in workforce planning methodologies and tools such as the Capable Teams for Children and Young People (CTCYP), New Ways of Working Supplementary Prescribing role for ADHD and New Roles of Assistant Practitioners to achieve practical and sustainable change.

http://www.chimat.org.uk/camhs/workforce/working

We recognise as a Partnership that we need to have sufficient numbers in the workforce. Figure 12 shows that for our 697,000 total population, Middleshire has 115 clinical WTE staff. (If Dedicated, Targeted CAMHS, MALOTs and In-patient were not included it would be 85 clinical WTE - NSF recommendations would equate to 105 WTE required for Non teaching service equivalent to around 19% under the NSF recommendations).

Figure 12: Total clinical WTE

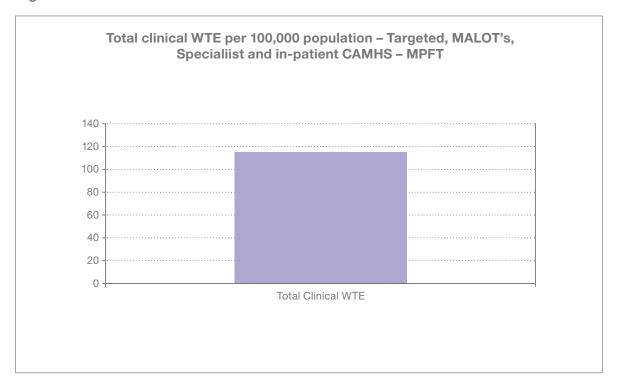


Figure 13: Disciplinary mix

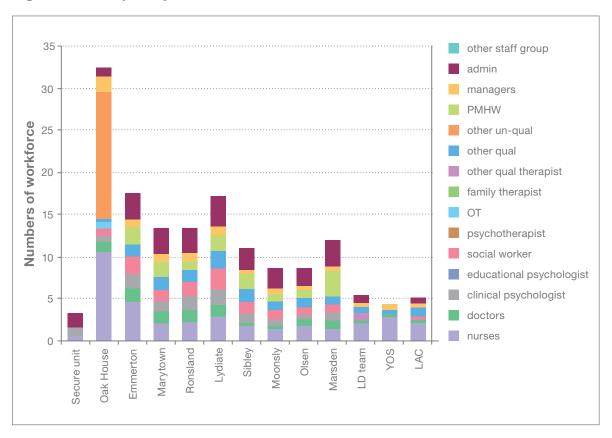
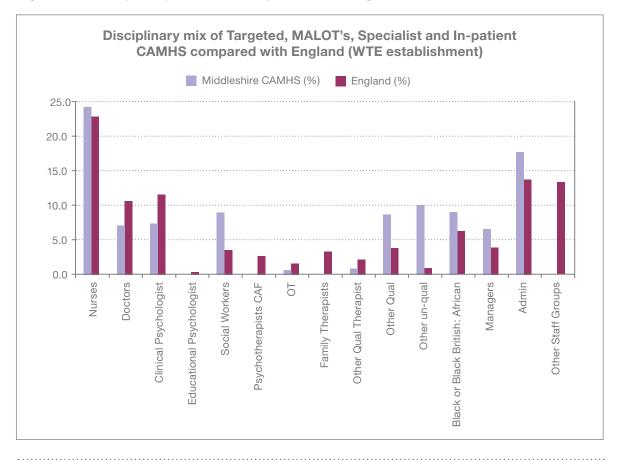


Figure 14: Disciplinary mix - % compared with England



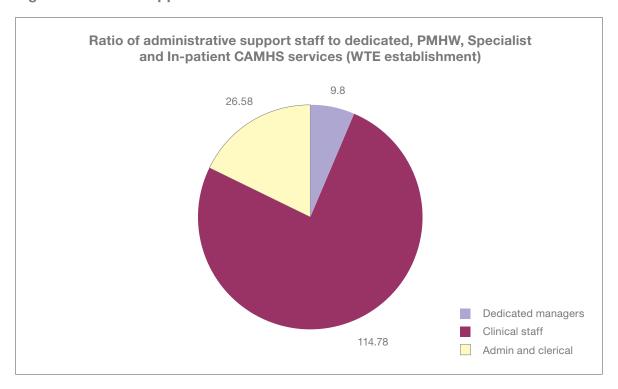
The disciplinary mix shows that the Doctors and Clinical Psychology is below the England average. There are no Psychotherapist or Family therapist disciplines in Targeted and Specialist CAMHS. The SASAT identified family therapy and Psychodynamic Psychotherapy interventions were not available in the Targeted and Specialist service. Admin and Managerial staff groups are higher than the England average.

Table 12: Ration of admin support

Dedicated managers	9.8	Ratio of admin to clinical 1:4.32				
Clinical staff	114.78	Ratio of admin to all staff				
Admin and clerical	26.58	1:4.69				

The ration of administrative support staff to clinicians. The recommended ratio is 0.3, or one admin support staff to 3 clinicians. This ratio does not include unqualified practitioners.

Figure 15: Admin Support



The MPFT 'Management, Administration and Clerical review' has already reported back to the MPFT and a process of Organisational Change has commenced.

Age of Workforce

Workforce ageing presents a growing challenge to most employers. Birth rates have been falling for many years, and in the next few years the numbers retiring will outnumber young people entering the labour market. The resulting skills gaps and labour shortages in many industries can be reduced if employers can find ways of making better use of older workers, and encourage people to stay in work longer. (Centre for Research into the Older Workforce, 2006, page 2.)

Figure 16: Age of workforce

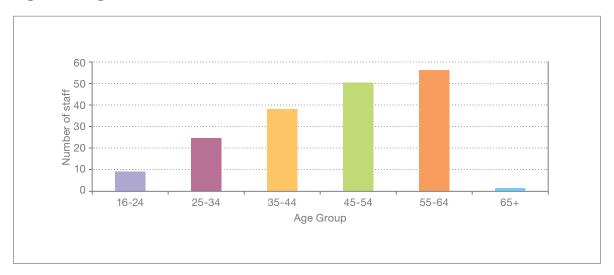


Figure 17: Age by profession

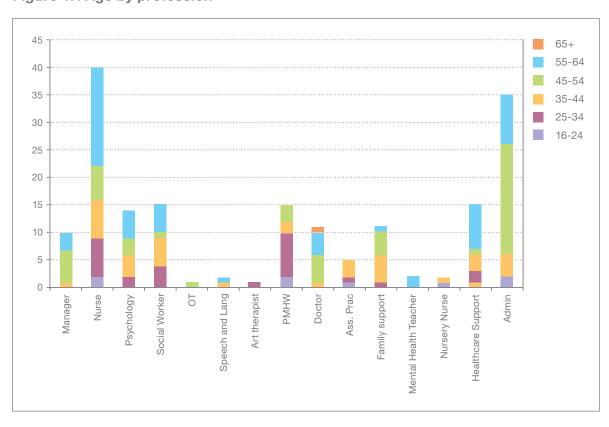


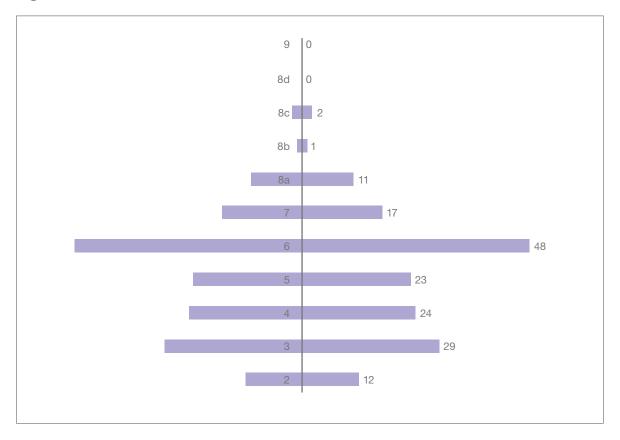
Figure 17 shows that the targeted and specialist workforce is ageing. Over 90% of the Administration and Managerial staff are over 45 years of age. 50% of Medical, Nursing and Healthcare support are 55 years and above. Whilst we recognise and value the skills and experience of all of our staff, the Partnership is aware of the need to encourage younger people into the workforce, both from a practical perspective in terms of a sustainable workforce, but also to have a workforce which reflects the community we serve.

The Providers actively support staff who wish to remain in employment beyond 65 and their Retirement Policy goes above and beyond that which is required by law as evidence of the value on which they place the skills and experience of their workforce. Our Action Plan needs to look at growing our own workforce and actively recruiting across the age range and to positively promote the younger workforce, and to eradicate stereotypes based on age.

Grow-your-own workforce strategies are characterised by two important features. First, they look to local labour markets as a key source of workforce supply. Second, they encourage organisations to use the skills and talents of their existing unregistered – or not formally qualified – workforce more effectively. Developing and extending staff roles, especially to meet new service requirements and expectations, can achieve this. In addition, home-grown workforce approaches in the NHS may be more likely to recruit and produce staff with greater commitment and loyalty to their organisation. By offering improved development opportunities, and more interesting and varied roles, the NHS can become the employer of choice locally, which may also reduce staff turnover rates. Crucially, successful grow-your-own approaches do not exist in isolation from an organisation's overall workforce plan and strategy.

Agenda for Change banding

Figure 19: Career framework levels

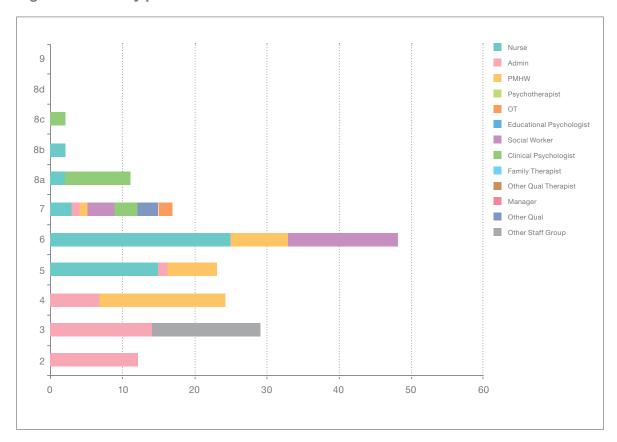


The term 'Christmas tree' itself is used to describe the visual representation of the workforce numbers at each level of the NHS career framework because of its similarity to the traditional shape of a Christmas tree i.e. wider around the base and narrower further up the branches (Skills for Health, 2007).

The representation of the A4C bandings in Figure 19 shows that the largest group is Band 6. The Partnership has encouraged New Roles such as the Family Support Worker and the Assistant Practitioner both requiring supervision from the qualified workforce. The Voluntary sector and the wider Children's Workforce also require opportunities for Consultation by skilled practitioners.

The provider will monitor the capacity to continue these vital elements of service delivered through the Band 6 workforce following the Organisational Change process responding to the Band 7 to 8C review currently underway.

Figure 20: A4C by profession



3.3 Productivity

Closely linked with the physical numbers employed is the productivity of the service, which should be evidence based. York and Lamb give a recommendation for an average caseload of 40.

York, A., & Lamb, C., (2005) Building And Sustaining Specialist CAMHS Workforce, capacity and functions of tiers 2, 3 and 4 specialist Child and Adolescent Mental Health Services Capacity calculations based on providing an epidemiologically needs based service for 0 to 16 year olds suggest that current specialist CAMH services are overburdened. Team capacity should be set at 40 new referrals per whole time equivalent (WTE) per year. This will enable specialist CAMHS to respond quickly, flexibly and offer evidenced based treatments for long enough for them to be effective. However, commissioners may prefer to choose to use existing capacity in specific ways such as setting the number of new cases that are seen a year as higher than 40 per WTE but limiting the number of treatment sessions available. If this is done it needs to be recognised that some effective treatments could not be provided.

- Matching demand and capacity is essential to ensure efficient service provision.
 Much can be done to ensure the patient journey is smooth and that delays are kept to a minimum. A service that has streamlined operations has a team capacity of 40 new referrals per WTE per year.
- Middleshire Specialist CAMHS have been using CAPA for 4 years. Waiting time for assessment and interventions is less than 6 weeks. Average caseloads match 40 new referrals per WTE per annum.
- MALOT have a new Service Specification that places more emphasis on Early Intervention and delivering training and support consultation networks in order to strengthen, support, build capacity and capability within the Universal workforce. Productivity in terms of face to face direct clinical contacts will reduce to increase capacity to support the workforce in and around Children's Centres to develop infant mental health knowledge, attachment and brain development, nurturing, relationship and parenting education.

The Investment from the Area based grant into the Voluntary Sector counselling in schools pilot has increased capacity to intervene early. The Partnership is committed to funding the Voluntary sector provision. The grant allocation for the schools counselling will be halved from April 2012, the Partnership is working with Middleshire schools to match fund the Grant to ensure current capacity and activity will continue.

3.4 Sickness

The CAMHS Partnership have been able to begin collecting data as a result of a specific project undertaken by the staff health and Wellbeing work stream focussing on productivity improved reporting, audit and staff engagement. The work stream has been led by a HR Manager from MPFT. All partners, through the Annual CAMHS Partnership Service Provider Evaluation process have been reporting on the sickness audit tool developed by the work steam. The annual audit for 2010 has enabled the Partnership to begin to gain an overall picture of staff sickness from all the Partnership Commissioned Services and from our colleagues in NHS Middleshire.

Staff absenteeism due to coughs, colds and flu-like symptoms is 66% higher than for the same period last year. The last week in November 2010 had one in every 50 employees calling in sick with a cough, cold or flu-like symptoms. This is a significant increase from the annual average for the same period last year. In relation to ill health prevention, an extensive programme of swine flu vaccinations has been delivered with clinics running up until April 2011. This is in addition to the annual flu vaccination programme.

The CAMHS Partnerships Staff health and wellbeing work stream have a focus on sickness prevention looking at early intervention and potential links with the Condition Management Programme.

Table 13 Sickness rates

	April - June 2010	July - Sept 2010	Oct - Dec 2010	April - Dec 2010
Children's services (social work) (MCC)	6.19%	3.52%	4.94%	4.88%
Youth Offending Service	2.80%	3.74%	3.36%	3.30%
Secure Unit (MCC)	6.94%	1.18%	6.20%	4.78%
Health Visitors (M-NHS)	3.39%	4.45%	3.76%	3.87%
School Nurses (M-NHS)	5.15%	5.94%	5.88%	5.65%
Paediatricians (Community) M-NHS	1.31%	2.30%	1.38%	1.67%
MALOTs (PMHW, FSW, Children's workforce LA and Education Staff	3.48%	6.54%	2.52%	4.18%
TaMHS (Educational Psych, TaMHS practitioners)	1.79%	3.63%	3.39%	2.93%
New Dircetion Counselling service 9 (5-11 years) Vol. Sector	6.70%	5.71%	6.53%	6.31%
Headspace Counselling service (11-19 years) Vol. Sector	4.07%	3.56%	3.67%	3.77%
Managers (MPFT CAMHS)	0.00%	0.59%	0.00%	0.20%
In-Patient (MPFT CAMHS)	4.77%	5.41%	5.13%	5.10%
Specialist CAMHS (MPFT)	0.75%	4.03%	12.36%	5.82%
Targeted CAMHS (MPFT)	3.16%	0.69%	1.33%	1.72%

Admin (MPFT CAMHS)	7.02%	7.00%	7.47%	7.16%
Overall Percentage	4.97%	5.61%	5.48%	5.35%

Figure 21: Sickness rates by service

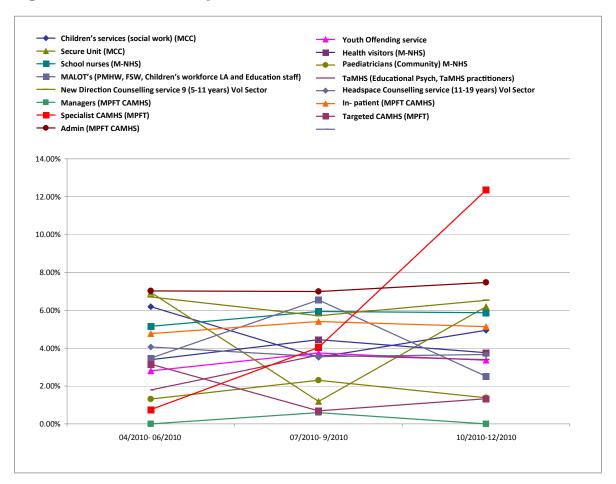


Figure 21 shows that the staff groups with higher than average sickness levels are Nursing-Registered, Admin, Children's services social work and New Direction Voluntary sector. The NHS National sickness level has been identified to be 4.50%, the NHS CAMHS services overall are higher for 2010. Historically they have fluctuated around this National figure for the past 3 years. In terms of cost, the most expensive groups overall have been Nursing Registered and Administrative and Clerical, this is an ongoing trend. The most frequent reasons for sickness absence for the quarter were as follows:-Stress/Anxiety, Muscular-skeletal- Other Joint, Lower Limb, Back, Not known, Surgery, Infections. Pregnancy related and Other.

3.5 Turnover

The turnover for MPFT Targeted, MALOTs, Specialist and In- patient services has been calculated for April 2010 – December 2010. The tables shows that there is a significant reduction in the rate of leavers within this time period, the staff groups leaving were from Professional, Scientific and Technical staff groups and Nursing and Midwifery Registered groups. The data collected showed that MPFT are less able to retain male staff than female 18% starters but 26% leavers. The proportion of male/female is already low. Work must be carried out to see what the reasons are for leaving amongst male staff.

No disabled staff left in 2009-10; however numbers of disabled staff in the MPFT are very low (only 1%) so this is unsurprising.

Bearing in mind our ageing workforce as seen on the profile of staff in post, it would seem likely that the largest age group for leavers would be those going into retirement.

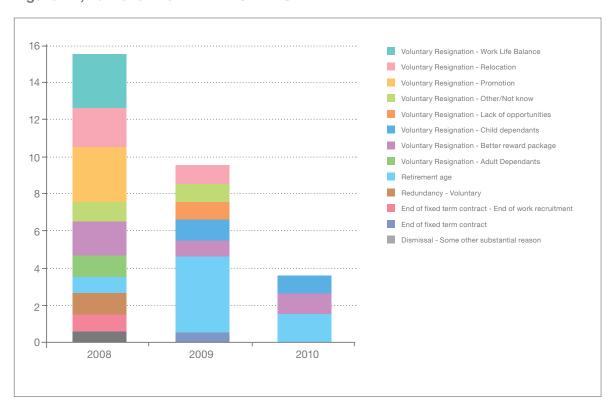


Figure 22; Turnover from MPFT CAMHS

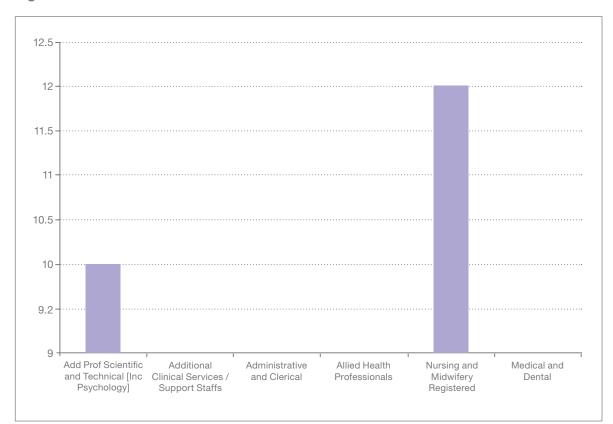


Figure 23: Exit % of workforce from MPFT CAMHS

The Partnership is anticipating that the rate of turnover will significantly increase during the period January 2011 to January 2012. The impact of Mental Health Officer status for the nursing workforce needs to be understood as this is the largest discipline group and form over 60% of the 45 years+ age group.

MPFT have been committed to using Secondments and backfilling with fixed term contracts. All external secondments will be returning to the Trust in April 2011.

Both Middleshire County Council and MPFT have recently offered Early Retirement Schemes and Voluntary redundancy to their workforce. At the time of writing this plan, HR departments are processing applications and Expressions of Interest. The re-fresh of this plan will need to map the impact on service delivery and plan accordingly.

3.6 Current case mix and indicative skill mix

The case mix for each service is an approximate indicator of demand. Additionally, employing the best available evidence it is possible to use case mix as a proxy indicator of the skill mix needed in each service, in order to offer the most effective interventions.

Figure 25 below show the proportion of each presenting problem seen in each team. The skills required to deliver the most effective interventions have then been mapped on to these proportions, to indicate the relative amount of each skill that would be needed in the service. These are indicative charts showing a range of skills and do not specify which professions or disciplines may or may not be competent in those areas.

Figure 25: Case mix - MALOT

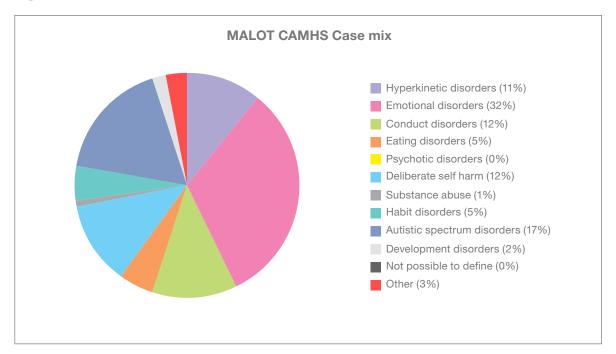


Figure 26: Indicative skill mix- MALOT

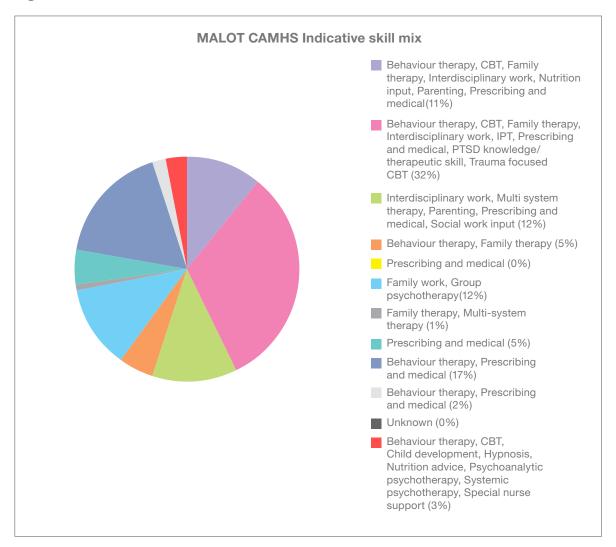


Figure 27: Case mix – Targeted, PMHW and Specialist CAMHS

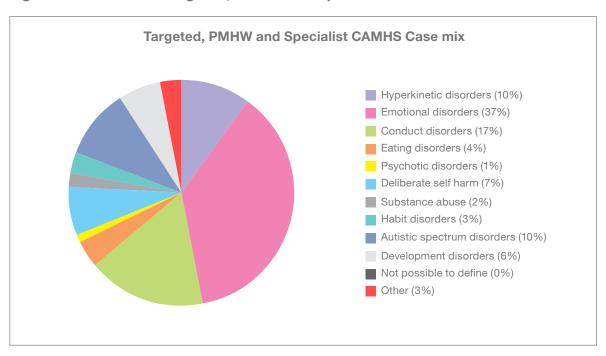


Figure 28: Indicative skill mix – Targeted, PMHW and Specialist CAMHS

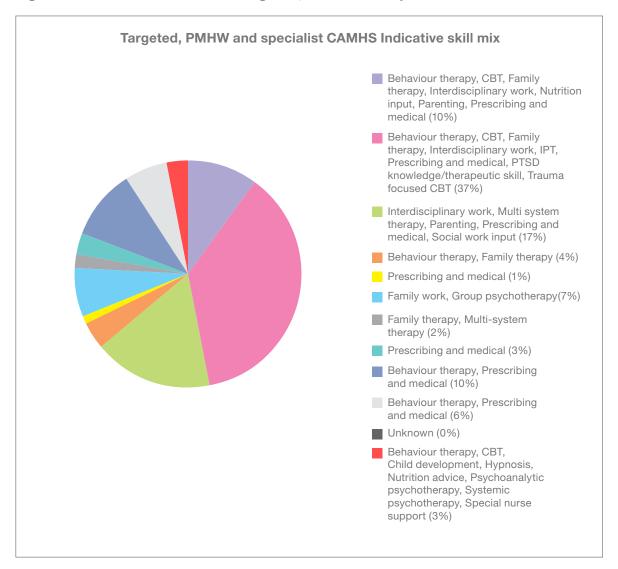


Figure 29: Case mix -Oak House In patient unit

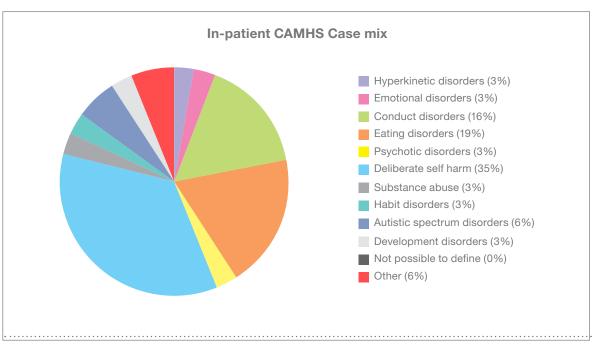
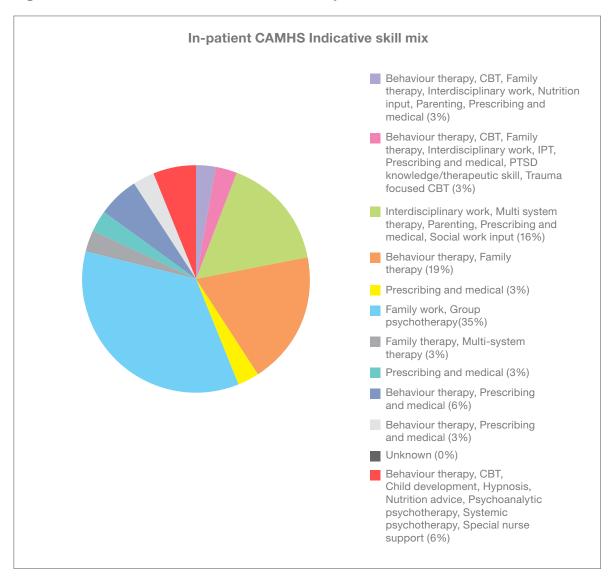


Figure 30: Indicative skill mix - Oak House In patient unit



Indicative skill mix has been calculated by taking evidence for effective interventions and isolating the skills required to deliver them (Wolpert, et al [2006]).

3.7 Core functions

All staff working in targeted and specialist CAMH services are required to be competent in the core functions (Skills for Health). The core functions include competencies in:

- Effective communication and engagement
- Assessment
- Safeguarding and welfare
- Care coordination
- Health promotion
- Supporting transitions
- Multi agency working
- Sharing information
- Professional development

Middleshire CAMHS were one of the National pilot sites to test Specialist CAMHS core functions. The service developed a Job description and KSF matrix which supported the recruitment of Band 4 Assistant Practitioners (AP) who now form part of the Specialist CAMHS Multi-disciplinary team. The AP's particularly support those young people on the re-focused Care Programme Approach, support admission and discharge in Tier 4 and transition to adult services.

http://www.chimat.org.uk/resource/view.aspx?QN=CAMHS_WORKFORCE_ DEVELOPMENT

3.8 Universal competence

Standard 3 of the NSF lists the competences required by all in children's services to enable them to promote the psychological well being of children and young people:

- Child and young person development (physical and psychological)
- Safeguarding and promoting the welfare of children, including risk and protection factors
- Effective communication and engagement (listening to and involving children and working with parents, carers and families)
- Supporting transitions (maximising children's achievements and opportunities and understanding their rights and responsibilities)
- Multi-agency working (working across professional and agency boundaries)
- Sharing information.

3.9 Skills audit

Skills audit is a process that can assist individuals, teams and organisations to map the current skills and knowledge that staff have, supporting the identification of the usage of the identified skills and highlighting any training gaps. Organisations can use the information gathered to respond effectively and flexibly to education and training needs as they emerge and to inform current and future education and learning commissioning and provision.

3.9.1 Universal workforce audit

A skills audit of staff was undertaken in January 2010, by the CAMHS partnership prior to the start of the Multi-agency training programme. The audit focused on three areas, knowledge, skills and experience. 382 of the children's workforce participated. The children's workforce were asked to respond to a number of questions by using a rating scale.

Staff knowledge: The first part of the audit focused on staff knowledge of the provision of local services, Common Assessment Framework, referral routes, concept of mental health, impact of mental illness, factors impacting on mental health and possible interventions.

The audit demonstrated Low levels of knowledge about services available to support the mental health of children and young people (90% of respondents), knowledge of the Common Assessment Framework processes (76%) knowledge of referral routes (81%). The audit showed that respondents assessed they had medium levels of understanding of mental and emotional health were (84%). Between 9%-26% of the workforce rated themselves as having good or excellent knowledge of all the audit questions.

Experience: The audit of experience focused on two key areas. The audit demonstrated a lack of experience amongst the vast majority of the workforce in identifying issues that impacted on mental health, and on delivering interventions. Less than 2% of the workforce felt very confident in this area.

Training Needs: The training needs part of the audit identified that the workforce indicated a greater confidence in working with partner agencies (60%) having effective communication skills (77%) ability to observe the needs of a child within the context of the school environment (69%) and 59% rating their ability to prioritise activities to meet need. There was less confidence in facilitating group work in addressing mental and emotional health with 57% rating themselves low.

3.9.2 Targeted and Specialist CAMHS Self Assessed Skills Audit Tool (SASAT)

Self Assessed Skills Audit Tool (SASAT) for Tier 2,3 and 4, Targeted and Specialist CAMHS was developed to be used as part of the Integrated Workforce Planning Tool, providing organisations (SASAT Service profile), teams (SASAT team profile) and individuals (SASAT individual profile) with a process and tool to support the initial, albeit significant step of gathering self-assessed information (not objectively measured) mapping the usage of the identified skills and highlighting any training gaps. Organisations can use the information gathered to respond effectively and flexibly to education and training needs as they emerge and to inform current and future education and learning commissioning and provision, gain key information to support long term workforce planning and development and embedding of a learning culture.

Intended Outcomes of the SASAT

- To determine whether the organisation can meet its indentified goals and provide a framework for organisational development
- To enable a targeted analysis of learning and development needs and allow for a more systematic and targeted approach to education and training
- To Identify self assessed skills and knowledge within the team and organisation and provide an understanding of existing skills and knowledge and their usage and any gaps in the necessary skills required
- To provide Information that supports dynamic succession planning and targeted recruitment
- To provide the basis for discussion within supervision to support professional development
- To support quality and productivity agenda

Click here to view the individual questionnaire workbook.

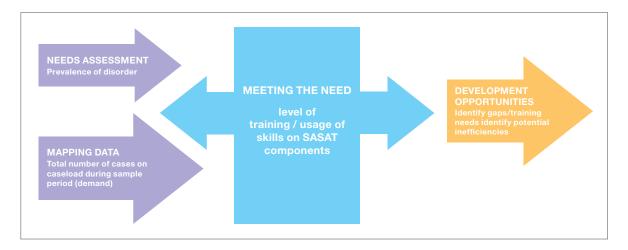
Click here to view the individual questionnaire user guidance.

Click here to view the team profile workbook.

Click here to view the service profile workbook.

Click here to view the team and service profile user guidance.

The Model

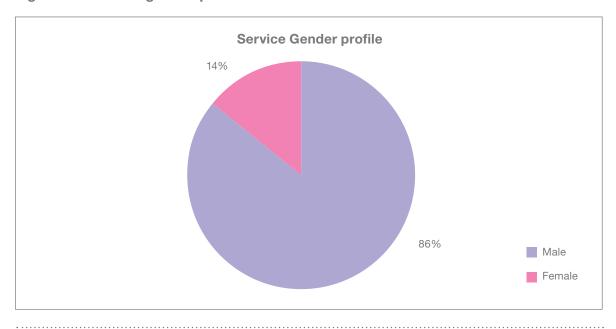


Targeted and Specialist CAMHS undertook the individual SASAT. The individual SASAT's were exported into team and a service profile. 98 respondents from a total service of 123 Headcount completed the SASAT. Of the 25 non responders 5 were on long term sickness leave, 3 were on Maternity leave, 5 were on secondment, 6 vacant posts, 6 non response. Those in a senior managerial role (3) and administration role did not take part in the skills audit as they do not undertake clinical work.

Service Gender profile

Figure 31 demonstrates that the majority of the workforce is female. The male workforce is mostly comprised of doctors and in-patient staff. The audit has shown that the service, HR and the media departments would benefit from working together to promote CAMHS as a place to work to succession plan to gain a workforce that is representative of the community and one that can offer more choice of therapist gender.

Figure 31: Service gender profile



Length of service

The respondents were asked to quantify how long they had worked in service. This allowed respondents to identify how long they had been in their team and also how long they had worked in other services and therefore capturing skills, experience and confidence they may have bought with them from other fields. Figure 32 demonstrates that there is a spread of respondents across all the categories with the peak being 16 to 20 years in service and the largest % being over 15 years.

Recent recruitment particularly the PMHW, nursing, social work accounts for both the younger workforce highlighted in figure 16 and figure 17 and also the under 5 years length of service highlighted in Figure 32. The workforce in the 20 years plus group will be the majority who are retiring over the next 5 years, mainly from the co-ordinator managerial/clinician (Band 7) Psychology, nursing (Band 6), Social work and Healthcare support workforce (Tier 4/ in-patient) roles.

The audit has enough detailed information to identify what skills will be depleted and where gaps in skills or new skills may be needed.

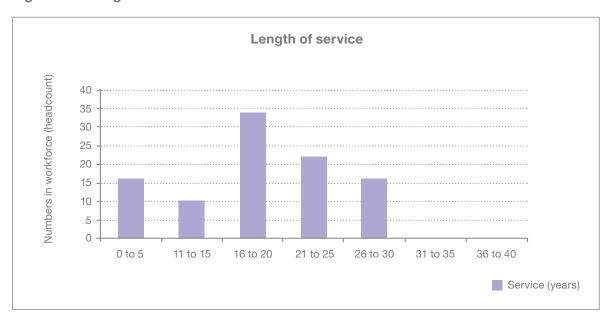


Figure 32: Length of service

Self Assessed Interest, Confidence and skill

The analysis tool provides 2 types of information relating to the 96 components on the SASAT questionnaire. The first being subjective and explores the respondents self assessment of their interest, confidence and skill in all the components. The second being a quantifiable self assessment of their level of training which can be supported by portfolio or certification evidence and usage of skill which can be supported by workload diary/appointments and caseload data.

Meeting the mental health and psychological well-being needs of children, young people and their families/carers is not a simple process and cannot be based purely on numbers; all the components of a Comprehensive CAMHS under Standard 9 of the NSF and the Every Child Matters agenda must also be in place.

Figure 33: Self Assessed Interest, Confidence and skill

I feel interested confident and skilled in the following	I feel confident and skilled in the following	I feel interested and skilled in the following	I feel skilled in the following	I feel interested and confident in the following	I feel confident in the following	I feel interested in the following	I have indicated none of the following	I have not entered anything	Data input error
45.16%	8.16%	0.11%	1.37%	1.05%	14.63%	20.84%	4.42%	1.21%	3.05

The service profile shows that on just under half of the components (45.16%) the clinicians self assessed as 'Interested, Confident and Skilled'.

The service profile showed that feeling 'confident' was identified against 15.68% of the components. This could be an opportunity to build up skill by targeting training in these components.

The service profile shows that the team members, although not skilled or confident stated they were interested in 20.84% of the components which were the second largest majority of components. The team can use this interest as an opportunity to develop confidence and skill through experience by possible shadowing opportunities within their team or within the organisation.

Self assessed level of training and use of skill

When analysing the audit it is important to remember that:

- everyone in the team does not need the same skills
- some skills are useful to have in several people, whereas others may need only one person to make them available
- skills can be gained through a qualification, experience or a combination of both
- the matrix can highlight missing or depleted skills in the team, and can be used to plan best use of the training budget available
- It is a starting point for discussion, not an end in itself

Figure 34: Self Assessed level of training and Use of skill matrix and key

		2	0	0	Level	of training	Use	of skill rating
	Low				Low	No training received		
ing						Self directed study	Low	Never / rarely
of training	Medium	1	0	0		In house training		
						Day course		
Level	I li ede	0	-1	-2	Medium	Certificate or equivalent level	Medium	Occasionally
	High					Diploma or equivalent level		
		High	Medium	Low	High	Degree	High	Frequency
		Use	of skill frequ	iency		Masters level or above		

Training gaps

The needs assessment tells us that Emotional disorders will be the highest prevalence in our community, then Conduct disorder, then hyperkinetic disorders, which matches with the demands (% case mix) in the service. Emotional disorders account for 37% of case mix, hyperkinetic disorders 10% and ASD and developmental disorders a combined 16% of case mix (Figure 27). The prevalence of mental health disorder and need is higher for those with a Learning disability (Table 6) and the case mix is showing an increase in demand for services by children and young people with an LD and for those on the Autistic Spectrum.

The service profile has identified that group therapy, Autism behavioural work and Awareness of syndromes relating to learning disability are the priority training gaps for the service. Figure 35 highlights the range of interventions that should be considered in the Action plan as a priority for training for the Specialist CAMHS workforce.

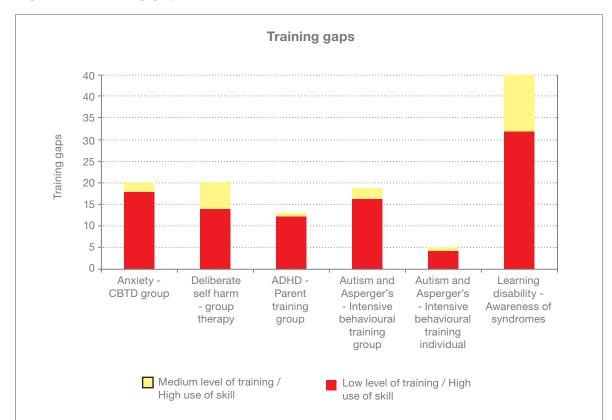


Figure 35: Training gaps

Potential inefficiencies

The service has invested in interventions to support children and young people and families with PTSD over the last 3 years. Middleshire is a County with 6 Armed Forces bases and our organisational knowledge of historic presenting need during periods of war and conflict that although low in demand and volume, our forces families have experienced high levels of parental PTSD which has often been mirrored in anxiety, depression and PTSD-like behaviours in their children.

We know from No Health without Mental Health (DH 2011) that The Government is committed to the health and welfare of people serving in the armed forces, both during and after their time in service. This is part of rebuilding the Military Covenant, which is the basis for government policy aimed at improving the support available for the armed forces community. Middleshire services have a key role to play in fulfilling this Covenant.

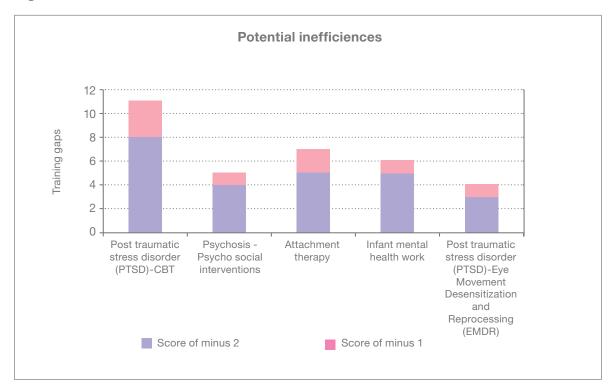
We will use the findings from the trial community based mental health services to fulfil the expectation of the NHS Operating Framework, which is that we will make special provisions for veterans during 2011/12. Training our front-line staff in military culture, we believe will help ensure Middleshire veterans' have access to Comprehensive CAMHS services and achieved comparable outcomes to those achieved with our civilian population.

Our children and young people attend base schools and also our local schools. We will be working with all schools in relation to the pupil premium for children of forces families to ensure we map and meet their mental health needs.

The SASAT has highlighted that although there is a high level of training and low use of skill in PTSD interventions in the workforce the potential inefficiency is not an actual inefficiency as the use of skill will increase over the next 2-3 years. (Figure 36)

The CAMHS Partnership commissioned training in preparation to support the Children's Centre pilot to increase capacity and capability around infant and parental mental health as part of our Early Intervention strategy. The pilot will commence April 2011. The SASAT has highlighted that we have a sufficient workforce now trained to a High level/ Medium level (Degree/diploma) in attachment therapy (Figure 36). We anticipate that the potential inefficiency captured by the SASAT will have changed to High/medium level of training/ High/medium use of skill (Figure 34) when the SASAT is repeated next year.

Figure 36: Potential inefficiencies



High level of Training / High use of skill

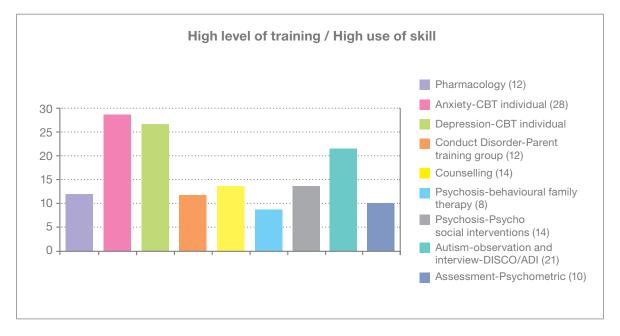
The service undertook the SASAT 3 years ago which highlighted the need to:

- Invest in CBT to respond to NICE guidance, prepare for CAMHS- IAPT
- Invest in assessment skills for Autistic Spectrum diagnosis due to the increasing numbers of children presenting to both Paediatrics and CAMHS for diagnostic skill.
 The increased numbers in diagnosticians for ASD will contribute to the ASD care pathway work stream currently underway with NHS Middleshire, GP's, Social care and Education

The SASAT has identified that the workforce is using the high level of training and using the skills frequently to offer evidence based assessment and interventions (Figure 37).

The service will be repeating the SASAT next year, we will be able to assess our readiness for the Department of Health model for CAMHS- IAPT and plan accordingly from our base line.

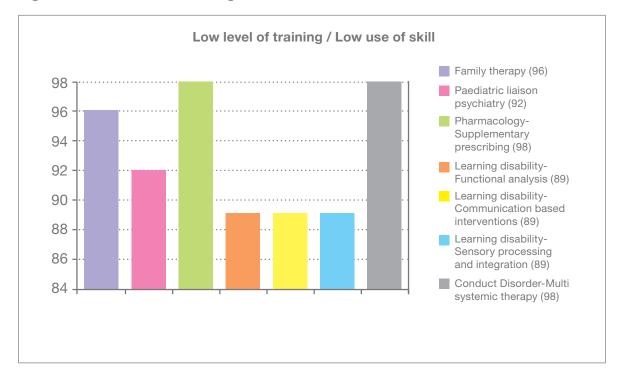
Figure 37: High level of training/High use of skill



Low level of training/low use of skill

The SASAT has confirmed that the Specialist services do not employ a Family Therapist, offer any Paediatric liaison service, or MST service. The Partnership is aware that in order to support our vision and new service commission, capacity will be needed to support the paediatric re-design and specific training will be needed in MST.

Figure 38: Low level of training/low use of skill



PART 4: The local labour market, regional, national and international labour markets

4.1 The local labour market.

Office for National Statistics NOMIS web site.

4.1.1 Middleshire is one of the largest and most sparsely populated counties in England. It has just under 700,000 residents, of whom 22% are under 18 years old, which is about the same as the national average. Around half the population live in the City of Lydiate and the main towns of Emmerton and Ronsland. The remainder are scattered throughout the county in small towns, villages or isolated communities.

Although 97% of the population is white British, there has been a significant increase in the number of people from other European countries, particularly from Poland and Portugal. Many have settled in the south and east of the county to work in the large agricultural sector, but many also work in seasonal employment in the rural areas and in the eastern coastal region, which has a high influx of tourists in the summer.

The birth rate is declining in Middleshire but the overall population has increased by 11% since 1995, due to inward migration, one of the largest increases in the country, and is set to rise by a further 10% by 2014. There has been a notable movement of people from the South of England to Middleshire over recent years, many of whom were attracted here by the perceived higher quality of life and lower than average UK property prices, rather than for new employment opportunities.

The movement of British people to South of Middleshire has involved an increasingly older population many of whom are over retirement age, and not looking for the temporary and non-qualified jobs which are currently filled by the migrant workforce. There is also a difference between the current local average working age of 41 years, against 25-34 years for migrant workers. Migrant workers are proving to be younger and more competitive in the labour market than the local population. 2001 Census data for Middleshire shows that there have been significant increases in the number of people in the 40-59 and 75+ age groups and a noticeable fall in the number of the 25-39 age group. This trend could have a negative impact on the county's economy should it continue.

The Census data also show that the largest 'out-migration' is by young people of the 16-24 age group (31.6%); and of the 25-44 age group (33.7%). It has been local knowledge for some time that Middleshire tends to lose young people, particularly of college age, when they move away for further education and job reasons but then do not return. The county is, however, starting to attract more people of the young to middle age range, including families with children rather than just new older residents.

Unemployment is below the national average but wage levels are also low. Almost one third of adults have no qualifications; in the east of the county this rises to 40%. Middleshire has a high proportion of low skilled industries and jobs, with a relatively low proportion of residents employed in upper tier occupational groups (professionals, associate professionals and managers), 37% compared to a regional average of 39.5%. This is compounded by the fact that a number of these employees reside in the county but commute to higher skilled level jobs outside of the county.

Middleshire has a low percentage of its working age population qualified to NVQ Level 4 equivalent or above, 21% compared to the National average of 28%. These figures suggest that an issue for Middleshire is not only the quantity of employment, but also the quality. Nevertheless, whilst a high proportion of employment in Middleshire is in low skilled jobs, the County has previously maintained a stable, and above average, rate of employment.

4.2 The regional, national and international labour markets

4.2.1 Regional labour markets

Within the Eastern Midlands, Middleshire has the highest number of self employed people (13.1%) and the region as a whole has slightly more than the national average. Hubbelshire also has a relatively high percentage of people who are self-employed, whilst Magellanshire has the lowest percentage.

Middleshire and Magellanshire have the highest percentages of people in parttime work (25.8% Middleshire, 25.6% Magellanshire).

Middleshire has the highest percentage of young people aged 16-19 in employment working part-time (65.7%), whereas Magellanshire has the highest percentage of young people in the 20-24 year old age band working part-time (22.6%).

Marinershire has the highest proportion of people aged 25-49 working part time (24%). Middleshire (36.6%), Cassinishire (35.3%) and Magellanshire (35.1%) have the highest proportions of employed people aged 50+ working part time.

For females aged 50 and over Middleshire (67.4%) and Magellanshire (67.8%) have the lowest economic activity rates.

Cassinishire and Middleshire have the lowest percentages of people with higher level qualifications (Cassinishire 14.6% NVQ3, 20.9% NVQ4; Middleshire 15% NVQ3, 21.2% NVQ4).

Middleshire has the lowest proportion of 30-39 year olds qualified to NVQ4+ (18.7%) and the lowest percentage of those aged 20-24 (23.9%) with NVQ3.

4.3 National and international labour markets

The difficulty in gaining a University place and the recent raising of English University fees against the much lower cost of University tuition fees in European Universities (approximately £1,500 per annum in Maastricht) has been attracting UK students to study abroad. A third of some schools students are also choosing to study in North American Universities. Future recruitment of a graduate workforce might consider a strategy of how to attract these International students back to the UK Health and Social care workforce.

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses

4.3.1 Psychiatrists

Pidd (2003) offers key messages from senior house officers (SHO) about their training, reporting that they want to:

- receive good, regular supervision
- work in safe, pleasant environments
- have exposure to varied posts in training schemes, including more specialities
- work with enthusiastic, positive consultants
- see a future in do-able jobs at the end of training (page 408)

Pidd also suggests various strategies to attract students and SHOs into psychiatry:

- Getting enthusiastic young psychiatrists to promote the speciality at career fairs
- Developing promotional material targeted at graduate entrants
- Developing recruitment initiatives for those already in mental health
- Ensuring that undergraduate experiences are positive
- Identifying and nurturing interested students through to SHO posts
- Developing special study modules in psychiatry and promoting them to students
- Encouraging more pre-registration house officer posts in psychiatry (page 405)

The Middleshire % disciplinary mix of doctors is below the England average. Both the medical and nursing workforce are ageing and over 50% of both disciplines are over 55 years of age. Middleshire has had great difficulty recruiting into the medical positions, historically it has needed to use Locum cover and it is only in the past 10 years that the service has managed to retain its Medical staff.

4.3.2 Nurses

In the 1990s one in ten new nurse registrations were from overseas; by 2000-2001 this had risen to over half of all new registrants. The Royal College of Nursing (2005) has responded to this upsurge by producing good practice guidance for recruiting and employing nurses from overseas. The guidance covers recruitment, retention, continuing professional development and culturally competent practice.

The Royal College of Nursing (2004) has also produced The Future Nurse Project, in which it is made clear that the shortage of registered nurses is not just about increasing numbers entering nursing but also about understanding the exit routes out of the profession. If the number leaving, either early by retiring, exceeds the number joining, then an increase in the workforce cannot be achieved. Retention may therefore be seen as critical to future workforce levels.

The document reports there are relatively few nurses in the NHS at the end of their nursing career and that the challenge for the NHS to retain nurses comes early on in nurse careers, when the vast majority of nurses are NHS employed and form opinions about the suitability of the NHS as a workplace for later in their careers.

Sixty-four percent of nurses employed in the NHS work full-time (around 44 hours per week) and most (51%) of these work internal rotation shift patterns. In contrast 20% of nurses in general practice work full-time. The level of choice and control over working hours also varies between employment sectors. Nurses working in NHS hospitals or independent care homes are less positive about the choice they have over their hours and those who work internal rotation shift patterns particularly dissatisfied. Control over working hours and achievement of a work-life balance will be an important determinant to their choice of employment.

The age profile of the Middleshire service shows that the older nursing staff have also been in the NHS for over 25 years, the impact of Mental Health Officer status needs to be urgently explored as many of this professional group may wish to retire which could present imminent succession planning issues to the provider service.

The implications for Middleshire Comprehensive CAMHS:

- The areas of most need are likely to be where we will need to recruit to, but potential staff are not liable to be living in those areas.
- Inducements will need to include good career pathways and training/development prospects.
- Managers across all services may consider joining up together in recruitment drives, graduate fairs and in making Middleshire Integrated CAMHS an attractive career choice for young adults who may otherwise move away.
- As the workforce ages, in agreement with employers, CAMHS may consider more flexible arrangements for those staff approaching retirement and incentives to keep them longer, to allow for succession planning and smooth transition.

4.4 Role of social workers

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses

Services for children and young people with learning disabilities (Lindsey, 2005)

There has been a dearth of services for children with learning disabilities, despite the fact that 40% of them have a mental health disorder and that the rate is higher amongst those with a severe learning disability. The CAMHS Standard, together with Standard 8 — Disabled Children and Young People and Those with Complex Care Needs, made recommendations that all disabled children, including the learning disabled, should be able to access the range of mental health services they require. This is one of the greatest challenges that the implementation of the NSF creates, since it requires the creation of a workforce that is capable of working with children and their families, who also have the skills and understanding to work with complex, severe and multiple disabilities. In the short term, this is going to need a high level of cooperation between existing specialist services and CAMHS, with services developing in partnership with them, by using consultation, joint working and training. A key recommendation of the Disability Standard is the need for the children and families to receive coordinated, high quality services which promote social inclusion. Here is another example where children and families will benefit.

4.4.1 Role of social workers in highly specialist services (Lindsey, 2005)

Highly specialist CAMHS (Tier 4) should consist of a network of out- and day-patient, assertive outreach and in-patient services for young people requiring highly specialised provision. The needs of children and young people with severe, challenging and complex problems are best met in each locality by a network of care. This recognises that all agencies but particularly health, social care, youth justice and education, face situations with young people that require collaborative working of a highly specialised nature. This may be provided in residential care and education settings; in secure units and young offenders' institutions; in intensive community settings, for example therapeutic fostering. In these settings, social workers require a sophisticated level of mental health expertise and CAMHS need to be in a position to offer consultation and advice from health, social care and education services working together, since what is often the case for these families is that they have to relate to a myriad of uncoordinated services.

The expertise of our social work and social care partners will greatly assist the development and delivery of the Multi Systemic Therapy provision.

4.5 New ways of working

The entire national labour market is changing from a professions base to a skills base, which is encapsulated by New Ways of Working (NWW). Workforce planning has to reflect the changing nature of the health and social care workforce, as reflected in the box below.

New Ways of Working (NWW)

In essence, NWW is about promoting a model where responsibility is distributed amongst team members rather than delegated by a single professional, such as the consultant. The aim is to achieve a cultural shift in services that enables those with the most experience and skills to work face to face with those with the most complex needs, and to supervise and support other staff to undertake less complex or more routine work. This enables qualified staff to extend their practice, e.g. non-medical prescribing, and provides opportunities for new people to come into the workforce at various levels within the career framework, e.g. Support, Time and Recovery workers, Primary Care Mental Health Workers, and Assistant Practitioners. NWW is about making the best use of the current workforce, providing job satisfaction and career development for staff, providing services that meet the needs of service users and their carers and make efficient use of resources.

This 'distributed responsibility' model, across and between teams, represents a challenge – not just about how members of the workforce operate as a team, but also to those individual members of staff who are currently not working to their full potential or capabilities. It may mean some of them having to 'up their game' if they are to take their proper place in a more fully functioning team. The CTCYP provides a valuable tool to help both teams and individuals focus their approach on the needs of service users. It may mean changes in the expectations of their practice to help improve the functioning of the team they work in.

NWW is not about undermining the role of professionals, nor about 'dumbing down' the workforce. It does recognise, though, that with an ageing workforce and population, we need to concentrate on how we develop all our staff, in order to ensure we provide the mix of capabilities required to meet the needs of service users and carers. The solutions will differ across localities, depending on local circumstances, such as vacancies, workforce supply, etc. It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce offering a high-quality service.

4.6 Attracting people to work in the NHS

Arnold et al (2003) researched the reasons why people join, stay and leave the NHS. They conclude that:

- The best aspects of working in the NHS are working with patients, job security and availability, a good pension, task variety, team working and learning were also mentioned.
- Understaffing and associated pressures at work were the strongest barriers to working for the NHS. Issues to do with the convenience, flexibility, length of work hours and low pay were also mentioned.
- Working for the NHS as a nurse or associated health professional (AHP) was thought to be a rewarding career.
- The starting pay levels for nursing, physiotherapy and radiography are often underestimated.
- Qualified staff currently working outside the NHS were unlikely to return.
 Agency staff are slightly more likely to do so, but are still not enthusiastic.
- Unqualified people (students, school pupils, general public) were positive about the NHS.

The report recommends the following:

- Use realistic job previews.
- Emphasise job security and availability, pension provision and career progression prospects in recruitment publicity.
- Further publicise the starting pay levels for qualified staff.
- Further opportunities for senior staff to retain direct patient contact should be made available and publicised.
- Offer all staff (not just those with children) some control over their work hours.

Effort should be concentrated on attracting new recruits, more than existing qualified staff working outside the NHS.

PART 5: Strategic vision for future integrated services

5.1 Strategic vision for future Integrated Comprehensive CAMHS services

Equality and Equity

There should be consistent County-wide services available to all who need them.

The Comprehensive CAMHS Integrated workforce should be sufficient in number to serve all geographical areas and competent to deliver a comprehensive service as outlined in the NSF.

Improving Quality of Life for Children, young people and their families/carers

All our interventions should improve outcomes.

Interventions should be based upon evidence of effectiveness, including NICE guidelines. Outcomes should be collected routinely and reported to commissioners as part of monitoring the service level agreement (SLA).

Improving Efficiency and Productivity

Streamlining processes to remove internal barriers and duplication, increase capacity and reduce unit costs.

There needs to be a clear understanding of need and demand and plans implemented to strengthen capacity.

Enhancing Service Users' Experience

- access and waiting
- safe, high quality, coordinated care;
- better information, more choice
- building relationships

Service models will be developed in partnership with service users. Young people and their families should have choice about the timing and location of their appointments. Staff may need training and support in effective participation and addressing stigma.

Social Inclusion

Children, young people and their families are supported to break the cycle of social exclusion – NEET, unemployment, debt, homelessness and worsening health.

Fulfilling aspirations through education/ work and social networks.

The Integrated CAMHS workforce needs to be competent in partnership working and managing/participating in the network of services around a child and family.

5.1.1 This plan addresses the local issues identified from the 7 stakeholder events held with Universal, targeted and Specialist CAMHS within the seven principles of Comprehensive CAMHS workforce planning, under the headings below:

Table 14: Stakeholder key priorities

Seven principles of workforce planning		Stakeholder key priorities		
Improve workforce design and planning	•	Workforce planning should be based upon the CAMHS needs assessment – targeting the most appropriate groups with the right workforce		
	•	There should be free communication between service providers and commissioners, in which the plan is commissioner-led but professional-informed		
	•	Providers need knowledge of commissioners' expectations		
	•	The workforce plan should provide a structure and timeframe		
	•	Primacy should be given to skill mix		
Identify and use creative means to	•	The skill mix should reflect the community being served, around ethnicity, culture and religious diversity		
recruit and retain	•	Create new roles based on skill mix and recruit creatively based on this within appropriate financial levels		
	•	Develop clinical supervision frameworks.		
Facilitate new	•	Promote collaborative working across the tiers in an integrated way		
ways of working across professional	•	Well-defined and integrated working		
boundaries	•	Facilitation of working across the tiers		
Develop leadership and change	•	Create a baseline to identify training required and match against service needs (specific evidence based/ mapped)		
management skills	•	Create a support network to facilitate change		

Seven principles of workforce planning	Stakeholder key priorities
Develop the workforce through revised education, training and development	 Develop competency-based training, including cultural competence Relate to new ways of working and evidence based practice Aim for consistency across all partner agencies Develop appropriate levels of supervision
New roles	 Adopt a skills-based approach Developed within clear limits of clinical accountability to manage risk Identify distinct areas of clinical expertise – New roles could include interface staff who can do both
Develop the skill mix, capability and competences	Recruitment - Incentives, effective HR support, new markets Retention - Opportunity, development, career pathways, training, flexible working Education and training - Linked to competence/ effective practice New ways of working - Change management, leadership, new roles if appropriate Education and training throughout Comprehensive CAMHS - Tier 1 Mental Health Awareness Training, Specific Post Qualifying Therapy, Linked To Evidence, e.g. CBT, Leadership and Management, CAMHS Training For New Roles

5.2 Implementing this plan

5.2.1 Links with other strategies and/or plans

This plan is a sub-set of the Children and Young Peoples plan.

5.2.2 Action plan – derived from analysis of the information from the stages in the workforce planning process and from stakeholder events

Table 15: Action Plan

	Outcome	Task	Resources / Information Needed	Responsible Person Deadline for completion
1	Comprehensive CAMHS providers, Commissioners and the Children's Trust will be able to implement, continually update and monitor the plan	Share plan with Children's Trust, CAMHS and AMHS Commissioners, all staff, partners and service users and Middleshire community	Health and Social care, ChiMat websites Local media	Gareth Gerard May 2011
2	The workforce will be planned and developed on the basis of the Needs assessment and reflect the population it serves	Build a recruitment and retention plan to address access and equity issues raised in Needs assessment by ethnic minority communities key demographic themes for our area such as isolation (virtual, or perceived and real) and deprivation Equity of service – counselling provision in the East Ageing workforce and difficulties recruiting medical workforce into rural and coastal parts of County Development of a more integrated approach to terms and conditions of service for staff working within multi agency teams HR and providers to agree core Job descriptions and recruitment process for FSW as a transferable role	Recruitment literature and opportunities to target Middleshire communities, explore local labour markets to see if we can 'grow our own' CDW-BME audit has shown we have a migrant workforce of nurses, physiotherapists and doctors working in our local 'pack houses' CAMHS cultural competency-BME CDW and CSIP project. Train the trainers to cascade training to newly recruited (past 3 years) workforce Up to date knowledge of Market outside of the County and Region Geographical boundaries • for more providers of counselling services who can provide into the East of the County • for medical and nursing workforce Electronic staff record problems need resolving	HR MPFT and LA June 2011
3	Strong inter-agency commitment will be demonstrated through the Partnership to consult with and act on children's and families' views	Utilise the expertise and contributions already given and provide opportunities and mediums for further participation by young people and carers groups	Use available resources stigma toolkit Capable teams for Children and young people (CTCYP) Tellus Text talk	Gillian Hay June 2011

	Outcome	Task	Resources / Information Needed	Responsible Person Deadline for completion
4	All multi-agency workforce will be planned and developed using the best available evidence to ensure sustainable and effective services.	Use service improvement methodologies and National Workforce Programme tools to plan and develop the workforce Send out Annual CAMHS evaluation audit tool to continue to measure quality of current ABG and the Early Intervention Grant –pilots: Increase access to Voluntary sector counselling in schools Children's Centres to develop infant mental health knowledge, attachment and brain development, nurturing, relationship and parenting education Targeted counselling for BME groups and Domestic violence counselling through Voluntary sector provision TaMHS rollout through EP and MALOTs	Audit and evaluation reports from Children's Centre pilot, BME pilot, Domestic violence counselling, TaMHS rollout Agreement and SLA with Middleshire schools to match fund to ensure capacity and activity continues beyond April 2012	Gareth Gerard Alison Tomley Marie Walker March 2012
5	Increase volume and capacity of services in line with the Integrated workforce plan	Develop CAMHS intensive home treatment service MST Work-stream in CAMHS partnership dedicated to the development of a care pathway to demonstrate network of care required in each locality for children and young people with severe, challenging and complex problems. Pathway will promote collaborative working between services such as therapeutic fostering, pupil referral units, secure units, adolescent in-patient units and children's homes.	Findings from Regional Specialized Commissioning group on Tier 3 / 4 services An updated map of our current estates to ensure existing and new service developments are appropriate, safe, child- centred surroundings with the necessary facilities to ensure optimum professional practice. Our programme for development of facilities is to take account of the Built Environment report.	Gareth Gerard March 2012

	Outcome	Task	Resources / Information Needed	Responsible Person Deadline for completion
6	Comprehensive CAMHS workforce will be planned using best available evidence for skill mix, offering evidence and outcome based care	Treatment interventions are guided by the best available evidence and which take account of individual needs and circumstances. • Continue to develop care bundles to compliment care clusters, care pathways. The care bundles will use the Evidence base. Evidence will comprise three levels, in keeping with CAMHS Outcomes Research Consortium (CORC) principles. • Research based evidence, such as summarised in Drawing on the Evidence • Values based evidence, usually contained within policy and guidance • Practice based evidence – collected by practitioners using robust audit tools and/or service user feedback • Implement Assessment and Outcome measures across Comprehensive CAMHS	Task focussed group from providers, commissioners, CORC link worker from MPFT and IT input Information and support from National Care Clusters, CORC evidence base http://www.corc.uk.net/ IT system and training: • Universal services in SDQ • Targeted services in SDQ, GBO and CHI-ESQ • Specialist CAMHS in SDQ, HoNOSCA, CHI-ESQ Tier 4 Quality guidelines QNIC	Dr Knox September 2011

	Outcome	Task	Resources / Information Needed	Responsible Person Deadline for completion
7	The continuing education and training needs for the Integrated CAMHS workforce will be planned over a five year cycle.	A variety of therapeutic skills are needed, including behavioural, cognitive, interpersonal/psychodynamic, pharmacological and systemic approaches. These skills are not necessarily all vested in particular disciplines so that a combination of a skills-based and professional-based approach to team development is appropriate Build on the skills audit by devising a training programme and recruitment plan: • Develop links with HEI's and use NCQIF to commission training and education • Plan and implement a series of PR/recruitment events for the service, linking in with HEIs and piggybacking on other local activities	Multi agency training programme – Everybody's Business/e-learning Common core Essential capabilities CAMHS induction CAMHS core functions PMHW competencies Modality specific competencies In patient e-learning Task focussed group to agree communication strategy and action plan involving all organisations media departments	Marie Walker Stewart Booth July 2011
8	DSH Care pathway is implemented across all services. Reduction in inappropriate and crisis admissions to Tier 4 and Paediatric wards	Cascade Self harm care pathway, ensure all workforce in all level of service have knowledge, skills and competencies appropriate to their role and function to assess DSH and safeguarding issues. DSH training will form part of the general Multi-agency training programme	Development of bespoke training package on DSH for • those providing first on-call to children presenting with acute psychiatric illness in hours, in emergency and out-of-hours services • those working in A&E departments who may carry out initial social and medical assessment of children with mental health problems • those working in Specialist CAMHS who are on the duty rota	Annelize Timpson Dr Nixon December 2011

	Outcome	Task	Resources / Information Needed	Responsible Person Deadline for completion
9	Clear clinical and supervisory arrangements and structures in place for all staff, to ensure accountable and safe service delivery .All staff have CPD arrangements in place with professional development plans	Develop workforce and leadership through: • Mentors • Shadowing • Cross boundary/ professional working to increase understanding • Links between in-house and external/accredited training • Secondments • Placements e.g. voluntary sector • Leadership course • Awards programmes e.g. positive practice awards	Set up small pilots, to evaluate the potential for shadowing, mentoring and secondment as CPD opportunities. Staff health and well-being CAMHS Partnership work stream to undertake an audit of supervision arrangements and structures across all levels of service and all providers	Alison Tomley March 2012
10	Staff sickness reduced to National average %	Further improve staff support and absence management	The CAMHS Partnerships Staff health and wellbeing work stream have a focus on sickness prevention looking at early intervention and potential links with the Condition Management Programme and the Mindful Employer Initiative.	HR MPFT and LA co opt

5.2.3 Goals

- Plan accessible to all children's workforce and users of services
- Services planned and developed on the basis of needs assessments and the capacity of local services to meet those needs
- Consult with and act on children's and families' view
- Recruitment and retention plan
- Crisis and Intensive home treatment and MST service developed using best available evidence
- Multi-agency Universal training programme delivering across Comprehensive CAMHS. Targeted and Specialist CAMHS training programme developed to ensure children and young people receive treatment interventions which are guided by the best available evidence and which take account of their individual needs and circumstances
- DSH Care pathway is implemented across all services. Inappropriate and crisis admissions to Tier 4 and Paediatric wards reduced
- Evaluation of TaMHS roll-out, BME pilot, Domestic violence counselling, Infant Mental Health and Attachment capacity and capability through Children's centres
- Clear clinical and supervisory arrangements and structures are in place for all staff, to ensure accountable and safe service delivery. Services ensure that all staff have CPD arrangements in place with professional development plans.
- Staff sickness reduced to National average %

Impact of MARS, MHO, Voluntary redundancy and other budget related savings across all services mapped and incorporated into this workforce plan.

5.2.4 Monitoring and review

- Progress against action plans
- Progress against organisational plans
- Project Plans
- Variance monitoring
- Service delivery plans
- Financial budgets
- Star ratings annual healthcare check review
- Productive time monitoring Turnover / sickness & absence / locum and agency spends

Evaluation and review date: October 2011

References

Arnold, J., Loan-Clarke, J., Coombs, C., Park, J., Wilkinson, A., and Preston, D.,(2003) Looking Good? The Attractiveness of the NHS as an Employer to Potential Nursing and Allied Health Profession Staff. Loughborough University https://dspace.lboro.ac.uk/dspace-jspui/handle/2134/2100

Department for Education: School Workforce in England (including pupil: teacher ratios and pupil: adult ratios), January 2010 http://www.lga.gov.uk/lga/core/page.do?pageld=15145727

Department for Children, Schools and Families (2008) 2020 children's workforce strategy.

http://www.education.gov.uk/search/results?q=2020+childrens+workfroce+strategy

Department for Education. Every Child Matters: Change for Children (2004) http://www.education.gov.uk/search/results?q=every+child+matters+change+for+children

Department of Health (2011) No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 123766

Department of Health (2011) No health without mental health: Delivering better mental health outcomes for people of all ages.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

Department of Health (2011) Talking therapies: a four year plan of action http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=talking+therapies+a+four+year+plan+of+action

Department of Health (2011) Health visitor implementation plan 2011-15: a call to action.

http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=health+visitor+implementation+plan

Department of Health (2008). Children and young people in mind: the final report of the CAMHS review

 $http://www.dh.gov.uk/en/Publications and statistics/Publications/PublicationsPolicyAndGuidance/DH_090399$

Department of Health (2008) Valuing People Now. From progress to transformation http://www.dh.gov.uk/en/Consultations/LiveConsultations/DH_081014

Department of Health (2007) New Ways of Working for Everyone - A best practice implementation guide.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 079102

Department of Health (2004) National Service Framework for Children, Young people and Families

http://www.dh.gov.uk/en/Healthcare/Children/DH_4089111

Local Government Association. Social Care staff data:

http://www.lga.gov.uk/lga/search/system-search.do?k=social+care+staff+data&x=12&y=6

NICE (2004) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE Clinical Guideline 9, available at:

http://guidance.nice.org.uk/CG9

Social Work Practice With Regard to Child Mental Health. Journal of Social Work Practice, vol.19, 2005, p.225-234

Walker, S., (2005) Releasing Potential — The Future of Social Work and CAMHS. Journal of Social Work Practice, vol.19, 2005, p.235-250

Wallace et al (1997) Appendix 1 – Research evidence and theory underpinning the 2003 NHS staff survey model

http://www.cqc.org.uk/_db/_documents/04007753.pdf

Wolpert, M., et al, (2006) Drawing on the Evidence http://www.annafreud.org/dote_booklet_2006.pdf

York, A., & Lamb, C., (2005) Building And Sustaining Specialist CAMHS Workforce, capacity and functions of tiers 2, 3 and 4 specialist Child and Adolescent Mental Health Services. Royal College of Psychiatrists

National CAMHS Support Service

National Workforce Programme

Integrated Workforce Planning for Comprehensive CAMHS: A Model Plan http://www.chimat.org.uk/default.aspx?QN=CAMHSTOOL

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Published: March 2011

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