

New Ways of Working in CAMHS

Evaluation of the Early Implementer Programme

***Developing and sustaining a capable and
flexible workforce: what can we learn from
New Ways of Working in CAMHS?***

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Artwork by young people from Merseyside Youth Association

Foreword

New Ways of Working (NWW) has supported incremental changes in the ways that the mental health workforce relates to patients and its own members. Diverse elements of the workforce, across a range of service configurations, have used the principles of NWW in different ways. Whilst the national programme has now been completed the principles and practice examples across all services provide a template for dealing with the challenges of the future. Economic change and the heavy staff resource needs of mental health services mean that workforce challenge will be significant. There remains a need to innovate and design services that will deliver effective, patient focused, evidenced based services. NWW represents an efficient methodology for delivering high quality future services.

Within CAMHS there has been a long tradition of team based multidisciplinary working and decision making and some have questioned whether CAMHS needed NWW. Yet NWW has presented an opportunity to foster a broad spectrum of child mental health practice and the early implementer projects demonstrate the value of challenging assumptions about how current services are being delivered and incorporating new ideas and system developments to produce better services for patients. Despite considerable investment in CAMHS the changes in service delivery have been varied. Without innovation in service delivery the aspirations for a comprehensive CAMHS will not be realised. NWW represents one method of developing innovative services to best match the needs of young people with mental health problems.

The projects evaluated in this report highlight a diverse range of challenges and responses to enhance services, using the framework of NWW. An essential factor in implementing change is a cultural shift for professional staff. Inherent in those involved in the projects was a commitment to evaluation and learning from others. The qualitative nature of the evaluation attempts to capture the diverse impact of NWW within a CAMHS context. Understanding these contextual factors is essential if complex systems are to be understood and improved. The contextual factors also enable findings to be appropriately generalised to other settings.

Within the current economic climate it is more important than ever for services to be responsive, efficient and effective.

Tim Morris
October 2009

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EXECUTIVE SUMMARY

To launch New Ways of Working in CAMHS an early implementer programme was introduced in 2006. Ten sites were selected addressing a broad range of issues deriving from PSA targets and other workforce strategies.

This formative evaluation has been carried out independently and provides information about:

- What the outcomes were and whether the funders of the early implementer programme gained value for money
- What other similar services and settings can learn from the findings
- What the wider learning is
- How the findings can be used to add to the knowledge base

The evaluation methods were largely qualitative and comprised documentary analysis of all written material associated with the projects, alongside selected telephone interviews with key informants.

Documentary analysis showed:

- All reports demonstrated fidelity to the NWW principles
- In addition to the variety of local issues addressed, there were 6 key aspects common to all the site projects
- Service users were the main intended beneficiaries
- 26 different outcome measures were used
- 32 separate issues were addressed
- Some sites had been unable to disseminate the findings
- 14 discrete products are available for use by others in the field

Interview data revealed:

- NWW provided the impetus to address significant identified workforce issues It is unlikely these issues would have been acted upon without NWW as the incentive
- All the projects achieved a range of sustainable outcomes, particularly around effectiveness and efficiency
- There was some confusion about the relationship between various tools (such as CAPA and CCTA) and how they fit into the framework of NWW
- NWW is not seen as a “must do”

Issues specific to NWW in CAMHS include the relatively small size of services, differences in service configuration compared with adult services and that some new ways of working are not new, whereas others such as service user involvement need more emphasis.

- **The programme gave value for money to the funders**
- **There is a great deal of helpful information and learning for other CAMH services implementing change programmes**
- **There is also transferable learning for a wider audience that would include children’s services and adult mental health services**
- **The evaluation findings can contribute to, revise and adapt the broader knowledge base for NWW**

Developing and sustaining a capable and flexible workforce - what can we learn from New Ways of Working in CAMHS?

Formative evaluation of the early implementer programme

1. Introduction

The Royal College of Psychiatrists (RCP) published the final report of *New Ways of Working for Psychiatrists* in October 2005. The initiative had been guided by the National Steering Group (NSG), jointly chaired by RCP and the National Institute for Mental Health in England (NIMHE), which had been established in response to “a groundswell of opinion that there was a need for new and changing roles for psychiatrists”. In 2007 *New Ways of Working for Everyone* was published.ⁱ

During 2006 child and adolescent mental health services (CAMHS) were invited to submit proposals for local projects that would demonstrate outcomes consistent with the principles of NWW, but with a specific focus that made sense within the local context. Expressions of interest were sought using CAMHS regional development workers and the FOCUS mail base¹. Forty-six written applications were received and ten early implementer sites were selected. The selection aimed to cover a geographic spread of services across England where Regional Development Worker support was available. Projects also provided coverage across a number of key issues identified as public service agreement (PSA) targets. Two projects focusing on children with learning disabilities did not complete so there were eight final reports. Following publication and dissemination of the final reports an evaluation was commissioned by the national CAMHS workforce programme from Cernis, an independent organisation specialising in service improvement and change in children’s services, with an emphasis both on CAMHS and workforce development. A commitment to evaluation and learning is a key cultural value within the national CAMHS workforce programme and a multifaceted evaluation in addition to each individual project evaluation was considered a key developmental task within the overall workplan.ⁱⁱ

Summary 1

To implement NWW in CAMHS an early implementer programme was introduced in 2006. 46 applications were received and 10 were selected to give geographical spread as well as covering a range of issues, including PSA targets. 8 early implementer sites completed to final report stage.

2. Purpose of the evaluation

The purpose of evaluating any programme is to assess and describe its value – does it have worth, excellence, utility and/or importance?

¹ The FOCUS discussion group was set up in 1998 to encourage communication between professionals in child and adolescent mental health services. It allows all staff working in child and adolescent mental health to seek advice and share information and experiences. For example, on developing a particular type of service, approaches to clinical management, or examples of evidence based practice. The group currently has over 750 members from a variety of disciplines.

In order to answer these questions the evaluation must address the goals and objectives of the programme, some of which will be stated explicitly and others that are implicit, derived from different sources and need to be illuminated. Thus the evaluator asks what is the difference between *what is* and *what should be*, then describes the gap.

The evaluation purpose is achieved by the evaluation functions. There are four “ideal” functions of evaluation:

- The accounting function
- The feedback function
- The dissemination function
- The theory building function

In this instance the four functions have the following applications:

- Accounting: provide information on the benefits of the programme, including in relation to costs; in short to answer the question “Did the CAMHS NWW early implementer programme achieve its goals and provide value for money?”
- Feedback: use the evaluation results for other, similar (ie CAMHS/children’s) services to draw upon.
- Dissemination: produce knowledge in a more generalised form that can be used by a wider audience.
- Theory building: contribute in a broader way to the theory base from which the original tenets of NWW were derived, by challenging and/or supporting the underlying assumptions and underpinning principles.

The accounting function can be elaborated further by reference to benefits realisation, a process that is geared to integrated change programmes such as NWW. Benefits realisation states the benefits being targeted by a programme and the necessary and sufficient steps that will be taken by the programme to realise them. Benefits underpin integrated and transformational change that is both successful and sustainable.ⁱⁱⁱ

Any programme being evaluated involves change and in many cases is predicated upon a belief in the *need* for change; New Ways of Working is such a case. Sociologically the concept of *need for change* can be seen as ideological and it is inevitable that there will be conflicting ideologies and beliefs throughout the programme that will affect the evaluation. This leads to an acknowledgement and appreciation of *who* the interested parties are, *what* their vested interests are likely to be and *how* to use any information provided by these parties.

This evaluation has sought to provide cautious answers to questions of value and value for money.

It offers a succinct overview of the major findings that other services will be able to draw upon when designing their own change programmes, as well as more abstracted knowledge that could be used by a wider audience than CAMHS. Finally it questions some of the inherent assumptions, both implied and explicitly stated, of NWW and the national CAMHS early implementer programme.

Generally evaluations that occur soon after the event are said to measure impact and those that use pre and post measures with longer term follow up are known as summative evaluation.

An often overlooked feature of evaluation is that in addition to measuring change that has happened, it can create a framework for change in the future – in order to do so the evaluation needs to examine process as well as outcomes and views the outcomes themselves as part of a bigger process. This is known as formative evaluation and may be seen as educational and informing future programmes. This formative evaluation ends by examining the implications of the findings in light of recent policy and makes proposals for the future NWW CAMHS programme.

Summary 2

This formative evaluation has been carried out independently and provides information about:

- **What the outcomes were and whether the funders of the early implementer programme gained value for money**
- **What other similar services and settings can learn from the findings**
- **What the wider learning is**
- **How the findings can be used to add to the knowledge base**

3. Methods

A weakness of many evaluations that do not have pre and post programme measures integral from the start is that there is an over-reliance on people’s testimony, which necessarily is retrospective and therefore liable to error. There may also be different ideologies and value systems; conflicting or at least disparate perspectives on the need for change and various interpretations of how change is and could be manifested. This evaluation has used a combination of approaches, within the two main methods below, geared to achieving multiple perspectives in which no one ideology or set of values can dominate the discourse. This gives a more balanced result than relying on one method alone.

3.1 Documentary analysis

Within an evaluation documentary analysis has the potential to provide “thick description”, enabling the processes and outcomes of each constituent part (in this case each site) to be understood within context so the findings are meaningful, even to an outsider.^{iv}

Implementation of NWW in CAMHS through the national early implementers programme was well documented, by a range of producers, for various audiences and provided a wealth of material. The advantage of analysing documents is that, unlike interviews with and surveys of people, they were not produced with the intention of informing the evaluation and are therefore free of the kind of bias that occurs in retrospective accounts.

Another positive feature of using the documents accumulated during the programme is that the degree of programme consistency can be assessed over time.

In complex initiatives such as this the programme goals can be difficult to articulate in ways that make them specific and measurable, so having different “lenses” through which to view the data can help to crystallise programme intent. Additionally the goals of the site projects are likely to be more local and process orientated than the programme goals, which will be more global and focused on outcomes. One task of the evaluation is not just to assess the extent to which sites achieved their own objectives, but also the level to which those achievements in turn contributed to the attainment of the programme goals.

The programme documents were analysed to ascertain the full range of aims and objectives, explicit and implied, of the key stakeholders; then to identify consistency and inconsistency. The approach used for this analysis derived broadly from grounded theory, in which the texts were approached with an open (but not empty) mind and the data allowed to speak for itself.

It was possible to analyse the site reports partly by content analysis, as the sites had been provided with a template for final reports, containing essential headings that determined content and created a certain amount of standardisation. There were also however large sections of the reports that were not standardised and these were analysed using thematic analysis.

Even within a qualitative framework it is common practice to quantify findings in some way. The strength of a theme is usually gauged by looking at the *number* of times it occurs across the items or subjects in the sample. When we say that subjects or documents *consistently* stated *x*, we are actually saying this statement was made a number of times. Counting instances can also be done more explicitly, an approach adopted in this report, where the information has lent itself to being displayed graphically. The intention is always to illuminate and to offer different lenses through which to view the findings and understand their meaning.

3.2 Stakeholder interviews

The stakeholder sample included the national programme leads, the local project leads and strategic leads (local or regional development workers, national CAMHS lead).

The national CAMHS workforce lead and the CAMHS NWW project lead participated in individual face to face interviews using a semi structured approach that became more open ended towards the end. These findings provided the background to the project, the underpinning principles and information about planning and implementation.

Other stakeholders were invited to participate in a structured telephone interview lasting approximately 50 minutes. In addition local leads were asked to complete a brief rating scale.

All local project leads were interviewed. The local and regional development workers comprised a target list of eighteen, all of whom were invited to participate. Six people from this group had a telephone interview and one opportunistic informal interview was conducted with an additional two. Of those who did not participate, one was new in post and was therefore ineligible, two who made appointments were subsequently unavailable and the remainder did not respond. The number of individuals interviewed in total was seventeen and the interviews yielded information of significant quality and depth. The site leads comprised a 100% sample, whilst the strategic leads sample was approximately 30%.

This is disappointing, not so much in terms of numbers, but because the regional picture is incomplete. The strategic perspective is the essential counter balance to the necessarily local view from the sites.

3.3 Additional

Attendance and presentations at workforce meetings and conferences also provided an opportunity to gather information on how the findings could be best used to inform future developments and what other professionals would find helpful in terms of evaluation format, presentation of findings and dissemination.

Summary 3

The evaluation methods were largely qualitative and comprised

- **Documentary analysis of all the site reports and a range of documents produced by the national team**
- **Telephone interviews with key informants**

4. Context and thick description

4.1 Background²

The final report of New Ways of Working for Psychiatrists was subtitled “The final report, but not the end of the story”. “It was indeed not the end of the story and in 2007 New Ways of Working for Everyone was published.

Throughout the original documents references were made explicitly to the whole mental health workforce, including services to children, adults of working age and older people. Within child and adolescent mental health services (CAMHS), however, it was seen largely as a document that related specifically to adult services. Closer inspection reveals why this was the case. A list of “major policy initiatives and publications that will drive change” included the Mental Health and Social Exclusion Report (2004) but omitted Every Child Matters (2004), arguably the most influential policy of recent times for children’s services. Later reference was made to the significance of Louis Appleby’s report, The NSF for Mental Health – Five Years On, but no mention was made of the National Service Framework for Children, Young People and Maternity Services (2004). It is not the intention to present a negative critique of NWW and its antecedents, but to highlight that omission of the particular considerations that influence and affect children’s (mental health) services meant that many in the CAMHS world allowed the initiative to pass them by, as another idea presented as applicable to all, but firmly rooted within adult services (others had included Creating Capable Teams Approach, or CCTA and Increasing Access to Psychological Therapies, or IAPT). Equally it meant that ideas already prevalent in CAMHS were left to be rediscovered by adult orientated services using the principles of NWW.

²This section is based on an article co authored by, Barry Nixon, Tim Morris and Yvonne Anderson, in The Journal of Mental Health Training, Education and Practice Volume 4, Number 3 / September 2009

The foregoing does beg the question of what makes CAMHS different and there is an inherent danger that such difference implies that those working in children's services feel they are special and that they act in a way that is "precious". There are however many similarities and commonalities between mental health services, whether for children, adults or older people. These common threads are vital as they are the values and principles that are shared by all and which should provide the continuity and consistency for service users throughout the lifespan. The ten essential shared capabilities (10 ESC) proposed by NIMHE are designed to apply to all those working in mental health and espouse those shared principles and values.^{vi}

There are valid differences between services, however, related both to the age and developmental needs of the clients and to the varied service configurations that have evolved over time and in response to disparate policies.

CAMHS have operated as multidisciplinary teams (MDT) for many years, as shown when they were described and mapped by the Audit Commission (1999).^{vii} Although CAMHS psychiatrists often have a leadership role, it is also common for the leadership of the MDT to reside with another discipline and/or to be quite diffuse. The disciplinary mix usually comprises a wider range of professional groups than would be found in adult services, though as in adult services, the proportions vary according to whether the service offers inpatient or community based care.

The publication of the Children's NSF in 2004 introduced formally the concept of comprehensive CAMHS, in which children's mental health should be seen as everybody's business. CAMHS practitioners working in secondary and tertiary care are now known as "Specialist CAMHS", to distinguish them from the wider children's workforce across universal services such as schools, nurseries, youth centres and primary health care settings. The integration of all these services and practitioners to provide collectively a comprehensive CAMHS is qualitatively different from the configuration of services in adult mental health.

In brief these legitimate variations mean that New Ways of Working in CAMHS involves the same core principles as in adult services, but the tasks and the contexts in which they are carried out are different. Additionally it is reasonable to assume a slower adoption of NWW across CAMHS, where it may be viewed as more applicable to adult services.

4.2 New Ways of Working in CAMHS

4.2.1 The National Early Implementer Programme

Given that CAMHS already had a tradition of diffused leadership and multidisciplinary working, it would be reasonable to ask why new ways of working would be needed. Were new ways of working already established ways of working for CAMHS? Following extensive qualitative and quantitative investigations during 2005-6, Barry Nixon, National CAMHS workforce lead, gave the following rationale for NWW in CAMHS:

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.

The core principles of NWW were translated for CAMHS in the early documentation for the early implementer programme, as:

- *A sharpened focus on outcomes.*
- *Greater involvement of children, young people & families.*
- *Coherent targets and performance management.*
- *Increased local flexibility to deliver results.*
- *Funding decisions taken nearer to the frontline.*
- *Investing in skills and motivation with support for improvement and culture change.*
- *Greater emphasis on spreading best practice.*
- *Minimum standards and intervention if performance falls below these.*

The CAMHS project was the first to include inter-professional as well as intra-professional issues, within a particular context. The aim was to include projects that were sustainable and applicable to the majority, not just to highly specialist or highly resourced services.

During 2006 services were invited to submit proposals for local projects that would demonstrate outcomes consistent with the principles of NWW, but with a specific focus that made sense within the local context. The selection of the final ten sites aimed to cover a geographic spread of services across England where regional development worker support was available. Projects also provided coverage across a number of key issues identified as public service agreement (PSA) targets. Each site received funding of £10,000 from the national programme. The programme also contracted a national lead to run the project and the national programme lead oversaw the whole process.

Two projects did not complete and the remaining eight, for which final reports are available, have been used for the documentary analysis in the findings section. The two projects that did not reach completion were both in the area of learning disability, which is the proxy indicator within PSA targets that has been the most difficult for services to achieve. One of these project sites did bring about a significant service change by recruiting a consultant psychiatrist as part of developing New Ways of Working. This was a positive outcome for the service but not unique to a NWW programme.

Figure 1 below shows where the eight pilot sites were located. The information about each site's outcomes can be found on pages 32-40 at the end of this document.³

³ The final site reports can be downloaded from the New Ways of Working website, following this link: <http://www.newwaysofworking.org.uk/content/view/26/437/>

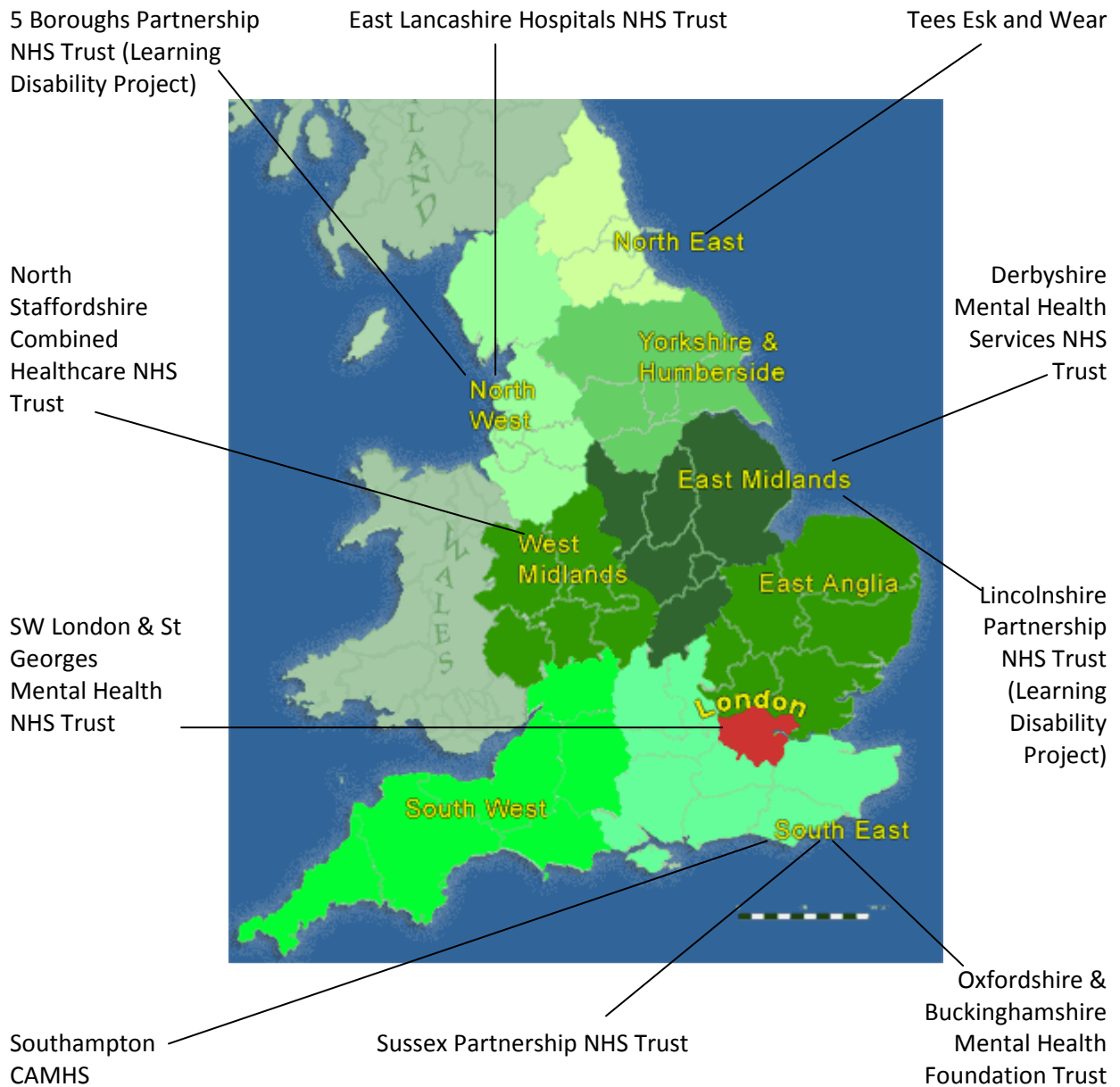
Summary 4

The original NWW framework may be seen as deriving from adult services and whilst the principles are clearly applicable across all settings and age groups, there are legitimate differences between adult services and CAMHS in service configuration and practice.

However a clear rationale has been produced for the implementation of NWW in CAMHS and this underpins the early implementer programme.

The CAMHS project was the first to include inter-professional as well as intra-professional issues, within a particular context. The aim was to include projects that were sustainable and applicable to the majority, not just to highly specialist or highly resourced services.

Figure 1 Selected early implementers



5. Findings

5.1 Documentary analysis (site reports)

The first finding is the diverse nature of the projects, which addressed very different issues, ranging from ADHD services to a focus on the role of consultant psychiatrists. This was inherent in the selection of sites to ensure as broad a range of understanding of NWW in CAMHS. However all the sites used a common framework and analysis of all the project documents from the early planning stages through to the final site reports suggests the following key aspects were integral to the early implementers:

- cultural shift
- person centred value based approaches
- responsiveness and flexibility
- new and enhanced roles for staff
- systems and processes that support staff in the delivery of care
- organisational and financial sustainability

The following are direct quotes from the project reports, which epitomise the fidelity to the core principles of NWW, regardless of the specific local focus of any project. The quotes have been selected as a typical sample of the reports as a whole.

- *a whole team approach to delivery of services*
- *make the best use of the available resources*
- *introduction of streamlined methods of team working (such as CAPA)*
- *extend the roles of a multidisciplinary staff group (patients can benefit from staff working in extended role)*
- *unexpected positive benefits to being involved in the change programme*
- *greater distribution of responsibilities*
- *enhanced the experience of young people using the services*
- *staff group working together to bring about change*
- *involving those that use the services to provide not only feedback on services but also an input into how those services are designed*
- *people that use services have the most expertise in their thoughts and feelings about services, it is therefore central to the successful delivery of services that they are central to the design process*
- *responsive to the needs of young people and their families at times of need*

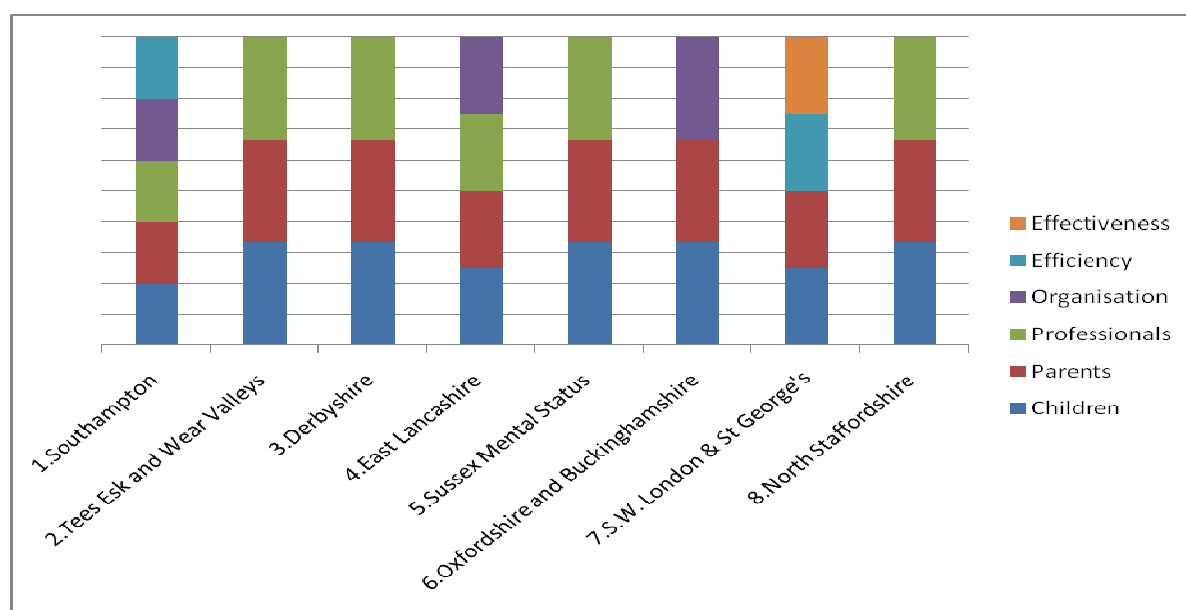
- *effective use of clinical resources can enhance services available to young people and their families*
- *Involving service users and carers in reviewing pathways of care and the delivery of specialist services: redesign of services has kept a clear focus on the needs of young people and their families*
- *important that the skills and competencies of psychiatrists are used to maximum effect*
- *interrelationships of different groups in providing integrated care and how one role is dependent upon other*
- *ongoing evaluation and response to changing demands*
- *flexibility of response is a key competency for all involved in delivering services.*
- *comprehensive review and service redesign of CAMHS*
- *key aim has been to offer a needs led flexible accessible service particularly for those groups such as Looked After Children and refugees who have traditionally been poorly served by these services*

The following tables and figures give an overview of the range and scope of the early implementer projects. The information was extracted from the final reports of each site. It is acknowledged that the charts are based on small numbers and for that reason percentages have not been calculated, since these could be over-interpreted.

Content analysis of the anticipated outcomes expressed in the reports revealed categories of intended benefits and/or beneficiaries across the projects. Whilst it might be reasonable to infer that all sites were aiming for, say, improved effectiveness, this was only counted in the analysis if it was specified explicitly. The analysis showed that all benefits/beneficiaries could be contained within six categories, including children, young people, parents and professionals as named beneficiaries, organisations as a whole as beneficiaries and efficiency and effectiveness as more general benefits.

The figure below shows how these were distributed across the sites, as proportions of each site's total intended benefits/beneficiaries. All sites stated explicitly that service users, including children and parents, would benefit. Only one site stated effectiveness as a benefit. One site stated five benefits/beneficiaries.

Figure 2 Intended benefits/beneficiaries



The table below shows that the number of measures used, as reported by each site, ranges from 0 to 6. The measures include validated tools as well as locally devised techniques and embrace both quantitative and qualitative methods.

Table 1 Range of measures used

Measures used		TOTAL
Validated tools:	General Health Questionnaire	1
	Strengths and Difficulties Q	3
	HoNOSCA	2
	C-GAS	2
	CHI ESQ	1
	Parenting sense of competency questionnaire	1
Self complete evaluation/ questionnaire:	Children and young people	1
	Parents/carers	2
	Professionals	2
Semi-structured questionnaire (telephone interview):	Children and young people	0
	Parents/carers	0
	Professionals	2
Focus group:	Children and young people	1
	Parents/carers	0
Individual interview:	Children and young people	1
	Parents/carers	1
	Pre and post knowledge/skill questionnaire	1
Costs analysis:	Patient information / activity data	3
	Verbal feedback	2
	TOTAL	26

As the Table below shows, the number of discrete issues addressed by each site ranged from 1 to 7. Five sites addressed new and extended roles and four addressed improving access.

Table 2 Range of issues addressed

Issues addressed	TOTAL
New/extended role	5
Existing role definition/development	3
New method/approach	3
Service user / carer involvement	3
Collaborative/multi agency working	2
Care pathway approach	3
Costs/efficiency	3
Waiting times	2
Improve access	4
Skills mix	2
Structural change	1
Information management	1
TOTAL	32

The next Table shows the ways in which sites were able to disseminate their findings.

Table 3 Extent to which sites were able to disseminate findings

Dissemination	TOTAL
Conference paper:	
National	1
Local	1
Journal article	1
Share with other teams (local)	1
Internal	3
TOTAL	7

All sites were able to publicise and disseminate through the national events organised within the programme, but further dissemination was challenging. Three sites were not able to disseminate further by the time of compiling their final report. There were seven different instances of dissemination, of which three were internal and one local, leaving three that could have had a national impact (beyond the availability of conference papers and the final reports on the NWW website).

Part of the value of early implementers is what they can offer to future implementers. The number of products available at completion of the projects was also counted and the results are given below.

Table 4 Range of products resulting from the projects

Products		TOTAL
Care pathway		2
Screening tool		1
Assessment process		1
Risk assessment process		1
Client information:	Children and young people	1
	Parents/carers	1
Model of care		1
Training manual		1
Literature review		1
Feedback form:	Children and young people	1
	Parents/carers	1
Job description		1
Job plan		1
TOTAL		14

There are fourteen products available from the early implementers, with two sites providing four each and three sites providing none.

Summary 5.1

Documentary analysis showed

- All reports demonstrated fidelity to the NWW principles
- In addition to the variety of local issues addressed, there were 6 key aspects common to all the site projects
- Service users were the main intended beneficiaries
- 26 different outcome measures were used
- 32 separate issues were addressed
- Some sites had been unable to disseminate the findings
- 14 discrete products are available for use by others

5.2 Interview findings

5.2.1 Site (project) leads/representatives

i) How the topics were selected for the projects.

All the sites had previously identified pre-existing problems or issues for which they were thinking about solutions. On hearing about NWW they had taken the opportunity to bid for funding. The funding in itself, at £10,000 per site, was simply pump priming, so it would seem the NWW programme itself, with its structure and profile, provided the impetus for action, whereby people who were already keen were provided with a catalyst for change. Pre-existing problems included long waiting times, high workloads, scarce psychiatry time, recommendations for service change following a needs assessment and the need to comply with commissioner requirements. NWW may be useful in thinking about these common service difficulties.

In one case the CAMHS targets within the NSF had triggered thinking about the problems around CAMHS, dating back to 2004.

The advent of the early implementer programme was therefore advantageous in providing a focal point for initiatives and changes that were already planned or desired. When NWW “came along” it was seen by one site as “flavour of the month”. In other areas the information about NWW came through psychiatry and links to the Royal College of Psychiatrists (RCP). In one case child and adolescent psychiatrists had known about their colleagues in adult mental health participating in NWW and were ready to respond when they heard about implementation in CAMHS.

ii) Engagement and motivation of colleagues in the site teams

Site leads reported generally that the engagement of colleagues was easy to secure, largely because NWW offered a solution to an existing problem, or a way forward. In some cases colleagues were already undertaking the work, so the project raised their profile and maintained interest in what they were doing. Where problems or issues had been around for a long time, NWW was seen as an answer. In one case the site lead had joined with other senior colleagues to “provide a united front” in encouraging other team members by stressing benefits such as enhanced CVs, especially important when new roles were not to be rewarded by increases to salary. In some cases team members were direct beneficiaries of the changes brought about by the project, so in the case of workloads being reduced, motivation remained high.

Motivation levels wavered in some cases when large amounts of data had to be recorded and audits conducted as part of the project. Staff found it difficult to make time for documenting and auditing and could not always see a direct benefit to themselves. One site however sought to overcome this by awarding a prize for the most audit forms completed.

Anxiety was created in some cases where staff worried that their workload and responsibilities might increase. Although the direct funding for the projects was modest, one site used the £10,000 to buy an assistant psychologist’s time, which relieved the burden of data collection. A measure of continuing motivation and engagement was that one site formed a steering group, which continued to meet even when the project took a new direction. One site lead mentioned that the team had felt threatened by changing roles, some fearing that they would lose areas of responsibility and others worried that they would have to take on new work for which they felt unqualified. One team within a site had struggled throughout the entire project.

iii) Involving service users and carers

Generally site leads acknowledge the time and effort required to do service user participation well. Meeting the deadline for submission of the bid had been a barrier for some, as it had not allowed sufficient time to think about and plan the service user involvement properly. Not all sites managed to involve service users and this was attributed to lack of time, the need for a dedicated role and, in one case, an admission that the focus on waiting times had eclipsed an additional emphasis on service users.

Where service users had been involved it was stated they are not interested in being token members of meetings, but want to be engaged in a meaningful way, for example by providing advice.

In one area a young people's panel was designing a satisfaction questionnaire to be used in place of Experience of Service Questionnaire (ESQ), which they had not found useful.

Some site leads interpreted involvement as the use of satisfaction questionnaires. One site reported that the main purpose was a professionals helpline, rather than a patient service.

iv) Senior management support

For some sites senior management support was a feature from the start, as NWW was seen as exciting and the projects contributed to wider Trust goals. One lead stated "The Trust management embraced NWW". One site's senior management were "tremendously supportive", establishing a project team and electronic record system that kept the project on track.

Some risk was perceived by senior managers in situations where roles were changed, for example where nurses took on some of the medical role. The nature of senior management support did vary however and, whilst the projects may have received senior (in one case Board level) approval, generally it was reported that senior managers were not proactive in their support. One lead stated that senior managers had never asked for feedback and did not respond to any of the draft reports sent to them.

In one setting the senior management allowed the project team to "get on with it", as they did not really understand the service.

v) Support from other agencies

In every case the project had arisen out of internal concerns and was developed mostly within the service. Some site leads reported there had been no need to involve other agencies, one stating it was an internal process "around tighter governance".

Some sites made their multi agency colleagues aware of the project, one attracting CAMHS grant as a result and one securing Partnership Board funding for an aspect of the project. In two cases partner organisations were on board and interested and in one the commissioners "signed up for it" and undertook a review resulting in recommendations to implement NWW. This had met with a little suspicion, of whether the commissioner had seen cost, rather than health benefits. One site ensured the commitment of partner agencies by involving them in care pathways development and multi agency away days. Where the project had arisen out of recommendations from a needs assessment, there had been a multi agency launch of the wider redesign project.

One site lead commented that although the project had been flagged up in local forums, it seemed no one had ever read the papers and neither other agencies nor the commissioner had shown any interest.

vi) Evidence used

Most of the evidence used was a mixture of local knowledge, service audits and national policy. Local evidence included needs assessment, experiential information (including service user feedback), workforce analysis, caseload data, complaints, waiting list audits, DNA rates and case discussions. Policy included NWW documents, the National Service Framework for children, young people and maternity services. One site lead reported that a literature search had been conducted.

vii) Dissemination of findings and sharing good practice

Most of the dissemination had been local and much of it within the host organisation. Broadening out, two projects had been presented to QNIC members, one at a network meeting and one at a conference, the latter attracting around thirty enquiries and fifteen requests for project documents.

One project was due to be presented at a conference in Berlin and another had been presented at a conference in Florence, resulting in several email enquiries. A reference to one project was placed on the FOCUS mailbase, resulting in a few requests for information.

Site leads/staff had been supported by the national leads in attending NWW conferences and were able to disseminate informally through networking, whilst one had presented at a NWW conference and subsequently supplied information to “a large number of people”.

viii) Has there been enduring change?

There was a mixed response to this question. Some site leads reported sustained but modest change, stating that after the initial surge of enthusiasm, further improvements would require resourcing over the longer term. Most however described changes that have become embedded in policy and/or practice and felt this to be a positive outcome. Embedded practice included continued reduction of waiting lists, greater access to consultants, improved recruitment and retention, new procedures (eg CAPA) becoming routine and continuation of service user involvement. One stated, “Partner agencies are delighted, as there is much better access”. At one site, where the changes had become routine, there had been a lessening of enthusiasm as perhaps the new ways of working had become established ways of working and lost their novelty. This contributor was in the process of introducing the changes to a second team and was becoming “re-energised”.

One lead stated that there had not been any lasting change as the Trust had re-structured and application for Foundation Trust status had also had an effect. Some leads mentioned the impact of staff changes on sustainability.

ix) What were the most successful aspects of the projects?

The responses of site leads to this question have been collated and synthesised to form the list below. It was evident that all sites had shown clear benefits.

- Cost effectiveness⁴
- Raised levels of confidence in the workforce
- Consultants working together and making joint decisions
- Happy teams
- Useful lessons about choice from service user feedback

⁴ All sites provided a brief budget statement, but one site performed detailed cost analyses showing significant savings. Across other sites, where cost effectiveness was felt to be an achievement, it was that staff time was being used more effectively, though this was not quantified (and had not been a requirement of the programme).

- Improved care pathways – so children get to the right place at the right time
- More planned and organised role development and skill mix
- Transparency and equity in case allocation by skill mix
- Full staff involvement and collaboration in planning and implementing change
- Reduction in waiting lists
- Evidence for effective practice

x) What were the least successful aspects of the projects and why?

- Little recognition locally of the work that went into the project. A 'well done' would have been motivating.
- An envisaged publication in a peer reviewed journal did not happen, which was disappointing.
- Not involving the stake holders/users more.
- Lack of managerial support.
- Inability of being able to sustain the work once the funding and support ceased.
- Insufficient resources (people and time) to be able to do it rigorously.
- Lack of commissioner support.
- Inability to move forward with the implementation because of bureaucracy and changes within the Trust.
- Not enough funding to implement the complete framework.
- The project was conducted alongside another significant structural change so had to compete, which was demanding and frustrating.
- Having to use an adult focused tool which is not reflective of the needs of CAMHS.
- Lack of support with the necessary infra-structure, eg in one case mobile phone coverage.

xi) Benefits to service users

Most projects reported benefits around the ability of service users to give feedback and for the feedback to be acted upon. One project had made improvements to the waiting room facilities as a direct result of feedback from young people. Some projects had provided information for service users and in one case for GPs. One project had improved access and choice for young people, so they could be seen more quickly and have options about their appointment.

One project had used a young persons' participation panel and will report the evaluative feedback to CORC in their next return. One site lead commented that whilst there had been anxiety among staff at the outset, there had been no concerns expressed by service users, who were pleased about the changes that ensured they would receive a more accessible and streamlined service.

Site leads were also asked whether and if so how they had measured benefits to service users.

One site had been evaluated by an external body and received good feedback from service users and carers. Another reported indirect benefits, suggesting that the changes introduced by the project would inevitably benefit service users, but that measuring any improvements would be difficult.

xii) The challenges of culture change and how they were overcome

There was a general acknowledgement that culture change had been pivotal in implementing the projects and in most cases had posed a challenge.

The challenge for one site was to "maintain the pressure" throughout the project. Some sites had anticipated the need to address culture change from the outset and introduced training sessions or focus groups from the beginning of the project. The training had created an environment in which concerns could be aired and explored and its worth had been recognised by staff. Others stressed the need to engage and work collaboratively with all staff, particularly to foster effective relationships between clinicians and managers. One site lead commented that culture change had not been an issue within the team, as they are engaged in continuous review and redesign, but that the culture of the Partnership and the PCT required change and it was difficult to effect.

Some of the issues around team culture were concerned with resistance to change, difficulty in recognising transferable skills in others, worry about loss of responsibility and anxiety about the unknown. Leads reported that anxieties had to be taken seriously and reassurances offered, as well as being careful to feed all information back to the team, ensuring transparency. It was stated that addressing the fears and anxieties that create a culture that needs to change is time consuming and requires consistent effort. One site lead said, "By talking about it we brought people along with us and there was very little resistance".

xiii) One over-riding message from each project to the national programme

- Career pathways for nurses needs to be clarified - the current structure is difficult and we need recognition, clarity and pay related to the job/skills. (E.g there are modern matrons, consultant nurses and then Bands, all needs reviewing.)
- Psychiatrists cannot implement change on their own – others with enthusiasm are needed to push the project and maintain energy.
- The input and support from Tim Morris and Barry Nixon was appreciated and demonstrated to staff a genuine interest in the project.
- NWW is exciting and that is reflected here in one project, however it needs to take into account the whole environment and all staff not just consultants and should be looking at making the whole service more effective, not just one part.

- Engaging users needs time and therefore money. It is necessary to outline to the users the boundaries in terms of what can and cannot be done so they understand and do not feel let down. We have to ensure we listen to what they tell us and feedback what we can or have been able to do.
- Senior management is pre-occupied with the adult service: CAMHS is too small. We need senior management and the commissioners to take more of an interest and push for sustaining changes.
- There is a huge range of different initiatives and projects within NWW, which makes it a bit bewildering.
- For future projects: keep going and don't give up. Have a realistic timescale - restructuring cannot happen quickly – and involve the whole MDT fully. Be aware that other initiatives/ restructuring may coincide and compromise your project implementation and completion.
- It is imperative to have good support from senior management and to be given the space to do the work. Engagement is very difficult if the teams are not on board.

A quote from a project lead:

A less robust team would have given up.

5.2.2 Strategic leads

i) Awareness of NWW and the early implementer projects

None of the strategic leads interviewed had direct experience of involvement in the early implementers, although all were aware of NWW as a way of encouraging flexibility in roles and caseload management. Their understanding of NWW was of global, systemic change in service delivery, focused specifically around creating flexibility of roles within CAMHS teams and loosening clinical leadership of cases.

Principles identified underlying NWW included:

- New roles and new flexible styles of working
- Developing sustainability
- Working in whole systems, redesigning services
- Working in teams/shared responsibilities
- Competency based development rather than traditional or hierarchical teams
- Improving access

ii) Benefits and outcomes

The advantages strategic leads expected from NWW in CAMHS included general flexibility of staff, enabling greater access and acceptability to users, more evidence informed interventions for children and families, better team working and better career pathways.

One lead commented that NWW is important in having the potential to show that change in CAMHS is possible.

Another contribution stated that NWW could promote practical developments across the whole of the children's workforce to support emotional health and well-being, the majority of which is provided in the mainstream. This would require an integrated approach and robust governance so that specialist CAMHS is not seen in isolation.

Specific outcomes identified were

- Greater alignment of functions and competencies in teams (inc. link to Knowledge and Skills Framework)
- User and care involvement in service design
- Better accessibility and acceptability of services (reduce stigma)
- Shorter waiting times
- Extending Tier 3 to longer hours and more locations
- Improved recruitment in areas where there has been difficulty in recruiting the traditional workforce mix
- Better training and education

iii) The challenge of NWW in the CAMHS context

All contributors mentioned the overload of initiatives in CAMHS and children's services, one stating, "There are so many changes already – this is another hurdle to jump". There was also agreement among the strategic leads' responses that despite the plethora of initiatives, targets and guidance, CAMHS remains less policy *driven* than adult services – NWW is not a "must do" and therefore may be undertaken reluctantly.

The differences between adult and children's services were elaborated further by respondents' commentary on the wider range of organisations, structures, and workers involved, including Children's Trusts, schools, Early Years, health visitors, etc. There are wide networks of stakeholders, there is deference to 'health' and there is a strong agenda to promote emotional health and wellbeing through universal services and citizenship. The diversity of the children's sector makes it more difficult to define a team or service and redesign could be compromised by the number of agencies involved in delivering a service. One contributor questioned however whether NWW has been focused particularly on specialist CAMHS.

Another contribution was that specialist CAMHS is resistant to change and “precious” about roles, leading to anxiety about loss of professional identity. Allied to this is a dislike for Increasing Access to Psychological Therapies (IAPT), which is perceived as diluting specialist knowledge, or as some clinicians have termed it, “genericisation”. It was suggested that psychiatrists are especially ambivalent about the changes inherent within NWW, having concerns about who will be held responsible when a serious incident occurs, if the consultant has not had sole control.

Another issue raised that is specific to CAMHS was that of workforce complement – contributors stated that CAMHS is often short of workforce or operating in small teams, creating difficulties for introducing role flexibility or alternative ways of working, such as outreach from Tier 4.

The contribution of social workers was considered to be valuable in the CAMHS mix but one contributor stated that they are also an easy target for cuts, on the erroneous assumption that other professionals can also ‘do social care’. Cuts in social work within CAMHS potentially reduce the flexibility and comprehensiveness of the service.

Another view offered was that CAMHS cannot be considered as somehow special and therefore not amenable to approaches that work in adult mental health services, such as NWW. The core principles of NWW apply across all ages and interest groups.

iv) What are new ways of working in CAMHS?

The strategic leads were asked whether they were familiar with other, effective, new ways of working. The inclusion of this question had been prompted by an opportunistic informal interview with a strategic lead, in which it had been stated that the NWW programme is not the only vehicle for introducing change in CAMHS. Creating Capable Teams Approach (CCTA) was mentioned as a known methodology and thought to be useful, but the contributors referred to CCTA as something related to, rather than part of NWW. The national leads however had invited all the NWW sites to take part in CCTA and many attended some of the CAMHS specific training. The national leads were clear that the early implementer programme should be seen as complementary or integral to a change management program under the umbrella of CSIP

Confusion about NWW is not confined to CAMHS: it was reported that in adult services NWW has been used with change of consultant contracts as a mechanism to justify reduced cost, hence alienating some psychiatrists.

Where regions did not have a local early implementer site, attempts had been made to embrace the principles of NWW, but deliver them through other mechanisms, for instance CAPA. Where this had happened it was felt to have shown significant benefits, in particular the combination of NWW flexibilities with commissioners aiming to lever change through contestability. (An external evaluation of CAPA has been commissioned, for completion around September 2009).

Other specific approaches mentioned were Effective Leadership in Teams programme, ‘Lean’ thinking and, more generally, support from RDWs in identifying blocks to developments in local areas.

v) Issues for CAMHS in implementing NWW

The concerns expressed about NWW in CAMHS all related to the particular nature of the CAMHS infra-structure and included operational issues as well as more general points of strategy. Elaborating on an earlier point, one respondent stated that some services have so few staff there is no critical mass in which meaningful change can take place. Several people indicated that more support is needed from local managers and commissioners to implement NWW, which cannot be undertaken by local teams within their existing resources. One contributor expressed concern that changing from traditional roles into functional teams is spreading people's capacity too thinly, so that "some people are now doing five jobs, all in different functional teams". This raised issues of clarity around line management, time management and lines of accountability.

Another issue was that some managers had been asked to lead NWW without full control of the budget to enable it to happen.

It was felt more resources are needed in workforce development, including workforce planning, to promote a collaborative model of development and develop trust, particularly where local partnerships are not aware of who is or should be undertaking workforce planning or what it entails. One contributor stated that NWW in CAMHS is evolving and hence still developing a smooth flow of communication from national to regional then to local levels.

It was thought by one respondent that some of the early implementer objectives seemed highly specific to those local areas, and while these had dealt with those specific issues or ambitions they did not in any obvious way provide lessons that could be used more widely. Following from this view it was suggested that the best lessons to come from the experience so far would be to isolate more generic learning, by describing methods or approaches that can be applied to a range of areas.

The constraint upon information sharing was raised in relation to commercial confidentiality both where Trusts are applying for or have achieved Foundation status and where organisations are competing for tender.

vi) Suggestions for the future

Strategic leads made the following recommendations:

- Build strong publicity for NWW and use for continued promotion and dissemination of the national programme.
- Develop local and regional leadership both to implement NWW and to disseminate evidence about successes and ways of moving forward (could include more frequent updates on existing projects as well as future developments).
- Provide closer support for working at locality level, for instance using CCTA as a practical tool and promoting it widely for CAMHS.
- Use CAPA as a change tool.
- Extend the early implementer projects to include local authorities, emphasising joint learning and seamless transitions.

- Create greater change agent capacity to support local developments with hands-on support (agreed by all interviewees).

Summary 5.2

Interview data reveals (in brief)

- **NWW provided the impetus to address issues that had already been identified and explored**
- **It seems unlikely these issues would have been acted upon without NWW as the incentive**
- **All the projects achieved a range of sustainable outcomes, particularly around effectiveness and efficiency**
- **There was some confusion about the relationship between various tools (such as CAPA and CCTA) and how they fit into the framework of NWW**
- **NWW is not seen as a “must do”**
- **Issues specific to NWW in CAMHS include the relatively small size of services, differences in service configuration compared with adult services and that some new ways of working are not new, whereas others such as service user involvement need more emphasis**

6. Discussion

6.1 This report has used thick description and documentary analysis to enable understanding of how the core principles of NWW were adhered to despite a diverse range of local issues addressed by the projects. In addition a selection of key stakeholders has been interviewed to provide a retrospective view of the successes, challenges and limitations of the early implementer project. Naturally more description would have been possible, but there is a limit to how much detail can legitimately be provided in a report such as this, if key messages are not be lost or diluted. More germane perhaps is that a better sample of strategic leads would have been desirable and the fact that about 70% of the key informants were not available to be interviewed is a lesson in itself. Finally, a truly thorough evaluation would have included direct contact with some of the intended beneficiaries, including front line staff, but specifically service users and carers. This was beyond the budget and scope of the evaluation, but in any case would have required the evaluation to have started with or before the project implementation.

The findings do however provide some rich material and learning for the project funders, national leads and future implementers of NWW and other change programmes and these have been addressed within the four functions of evaluation below.

6.2 The accounting function addresses the question of whether the CAMHS NWW early implementer programme achieved its goals and provided value for money. The findings show clearly that the programme as a whole achieved the goals of NWW, described earlier as the core principles (page 6). Evidently some projects were more comprehensive and generalisable than others, but the legitimacy of allowing a range of specific local issues as the focal points is that the NWW programme became the vehicle by which existing issues and concerns could be addressed in a systematic way.

(Many of these issues were related to PSA targets and national indicators.) In this way the NWW programme provided the impetus for change, but allowed the change to happen organically.

Each site received £10,000 to contribute to costs and in addition to this funding the project lead was paid to plan, support and monitor the sites. The national programme lead also provided support time.

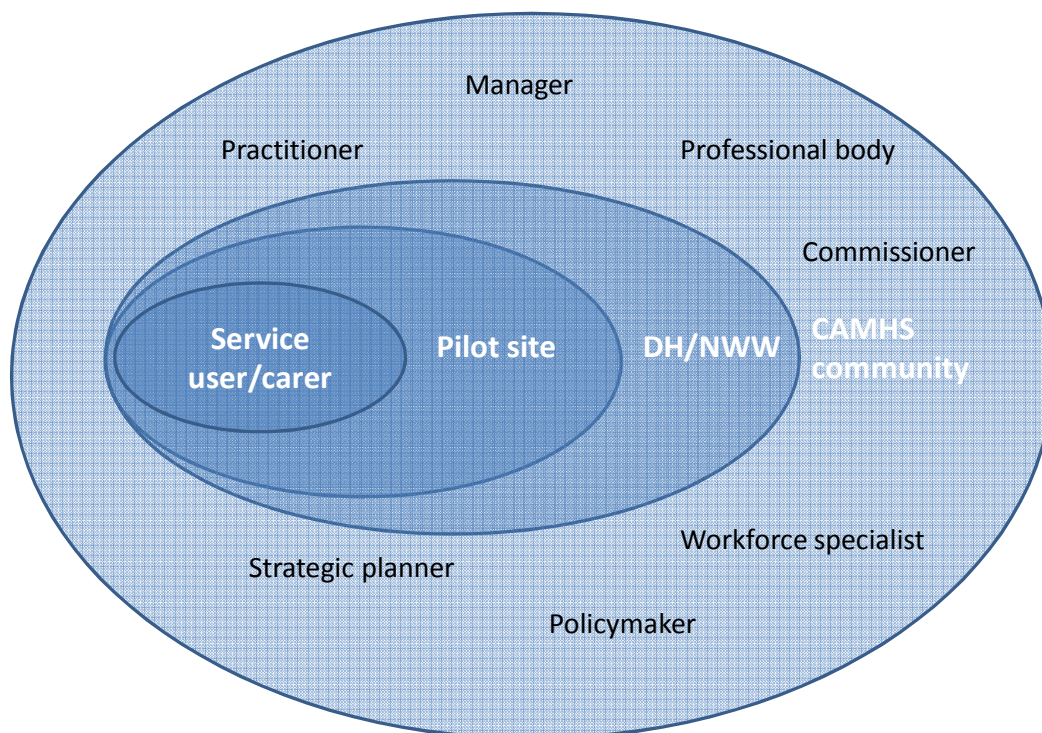
The direct costs could be estimated at less than £15,000 per site. However the indirect costs cannot be calculated readily, as they involved the time, commitment and energy of such a wide range of people on each site. If this unquantified resource is put into the equation as matched resourcing, the funders can be seen clearly to have received value for their investment. Each of the eight sites completing their projects reported tangible benefits and/or sustainable change. Since it is unlikely these changes would have occurred otherwise it appears that the projects offered value for money. Contributors did comment however that sustainability requires a longer time than that offered by the project and from this it can be inferred that some level of continued support from the national programme would be welcomed. An inevitable aspect of early implementer demonstration projects is that when the funding stops the sites often feel their work has been forgotten.

Some of the responses from strategic leads suggested that tools such as CAPA, CCTA and Lean thinking could offer equal if not greater benefits, when actually some of the sites were using CAPA as an integral part of their project and CCTA may be considered as one of the tools of NWW in any case. Lean thinking is based on a set of principles and criteria that offer a good fit with NWW, so any of these approaches should be seen as complementary or even integral to, rather than competing with NWW.

6.3 The feedback function uses the evaluation results for other, similar (ie CAMHS/children's) services to draw upon. This report is designed primarily for consideration by funders and policymakers, to judge whether their intended outcomes were achieved and to inform future programmes. There is potential however to present the findings in a more accessible and educative way, so that the key elements of the evaluation are made available to a wider audience in a more "digestible" form. It is proposed that a summary of the main learning points and recommendations for future implementers is produced in accessible formats following dissemination of this report.

The diagram in Figure 3 below shows the potential beneficiaries of the early implementer projects. The text in white running horizontally shows the core beneficiaries, starting with service users, through to others (largely staff) involved at the pilot site, to the national programme and the CAMHS community as a whole. The outer ellipse shows the constituents of the CAMHS community, demonstrating the disparity and highlighting the need for a variety of approaches to using and publicising the findings.

Figure 3 Beneficiaries



6.4 This leads to the dissemination function, which is to produce knowledge in a more generalised form that can be used by a wider audience. There is much in the findings that is transferable to other settings, including the challenges and processes involved in aligning functions and competencies, involving users and carers in service design, creating greater accessibility and acceptability, reducing waiting times and improving workforce mix.

Even in projects in which the focus appeared to be solely around a CAMHS issue, there is evident application to other settings. The work around services for ADHD has clear transferability to any condition or issue that, like ADHD, is resource intensive and poses a challenge to traditional service delivery.

6.5 The final evaluation function is to contribute in a broader way to the theory base from which the original tenets of NWW were derived, by challenging and/or supporting the underlying assumptions and underpinning principles. Some respondents expressed frustration at using a tool that had been designed for adult services and, as stated earlier in this report, whilst there are shared core principles in NWW that apply to all, there are also legitimate differences between services, one being that CAMHS has for many years been operating within some of the tenets of NWW and this perhaps should be more widely acknowledged. Some of the new ways of working for other services are in fact old and established ways of working in CAMHS.

The beginning of the process of contributing to the theory base has been to use some of this report within an article, co authored with the two national leads, due for publication in September 2009.

Summary 6

By addressing four functions of evaluation it has been found that

- The programme gave value for money to the funders
- There is a great deal of helpful information and learning for other CAMH services implementing change programmes
- There is transferable learning for a wider audience that would include children's services and adult mental health services
- The evaluation findings can contribute to, revise and adapt the broader knowledge base for NWW

7. Next steps

What are the lessons learned in thinking about future programmes? Strategic leads made it clear, both explicitly and by inference, that they experience some ambiguity about what NWW is, what it includes and how it should be implemented. Some of them were confused about the relationship of CCTA to NWW and some appeared to see CAPA as an alternative, rather than a complement to NWW. This may indicate a need to build in sustainable dissemination and publicity, as well as greater, or more visible integration of NWW with the national CAMHS workstream.

The findings from the sites showed there had been many tangible benefits resulting from the projects, although measurable outcomes for service users had not been demonstrated in every case. The biggest limitation for the sites was their inability to share findings and learning beyond the dissemination offered by the national conferences and NWW website. Perhaps in future programmes a separate dissemination budget could be allowed, as is the case for project evaluation. This could create a renewed impetus later in the process, when initial enthusiasm has waned. Where disappointment was expressed, it was around local issues. Some sites felt the lack of commissioner interest, yet without support from partner agencies and commissioners, long term sustainability will be compromised. Other local issues were even closer to home, with sites receiving varying levels of management support, yet all recognising it as vital. Wider organisational matters such as reorganisation and application for Foundation status were able to eclipse the relatively small CAMHS projects.

As one strategic lead commented, NWW is not a "must do", thus it will not necessarily be prioritised when there are other competing demands. This leads again to the ambiguity of understanding of NWW, which should be seen not as a thing to be done, but a framework to *enable* the things to be done.

Finally, although all sites anticipated benefits both direct and indirect to service users and carers, these were not evidenced in all the site reports. This perhaps reflects that, whilst some aspects of NWW (for example diffused leadership, multi disciplinary working) are well established in CAMHS, others are not (for example service user involvement). In making NWW more explicitly relevant to CAMHS it may be necessary to focus on those areas that particularly need development. This would also address the inescapable fact that children's services are not as well resourced as adults' and there may not be the critical mass in CAMHS to enact all the principles of NWW as it stands.

Following the first draft of this report further consultation took place with the national programme lead and the early implementer project lead, in which the implications of the findings were considered and debated. It was agreed that NWW had provided the ideal platform on which services could initiate changes that had already been contemplated, but here they had thus far lacked the momentum to implement. This led to further consideration about NWW as an innovation: by its nature innovation is the start of something new and new concepts take time to become accepted and embedded into everyday practice.

The acceptability of an innovation is partly a matter of timing: it is more readily accepted if it coincides with an existing desire for change. Conversely the innovation itself can create the publicity necessary to promote desire for change. Two change models that have been used widely to provide a framework for assessing and mapping readiness for change and the impact of innovation are summarised briefly in the boxes below.

Box 1. Diffusion of innovations – 5 stages

1. Knowledge

In this stage the individual is first exposed to an innovation but lacks information about the innovation. It should be noted that during this stage of the process the individual has not been inspired to find more information about the innovation.

2. Persuasion

In this stage the individual is interested in the innovation and actively seeks information/detail about the innovation.

3. Decision

In this stage the individual takes the concept of the innovation and weighs the advantages/disadvantages of using the innovation and decides whether to adopt or reject the innovation.

4. Implementation

In this stage the individual employs the innovation to a varying degree depending on the situation. During this stage the individual determines the usefulness of the innovation and may search for further information about it.

5. Confirmation

Although the name of this stage may be misleading, in this stage the individual finalises their decision to continue using the innovation and may use the innovation to its fullest potential.

Rogers, E.M. (1964). Diffusion of Innovations. ^{viii}

Box 2 Stages of change - progress through a series of 6 stages

1.Precontemplation

At this level people are not intending to take action in the foreseeable future.

2.Contemplation

In stage 2 people are intending to change in the near future.

3.Preparation

At this stage people are intending to take action immediately.

4.Action

People have made specific overt modifications or changes.

5.Maintenance

People are working to maintain the change and develop sustainability.

6.Termination

The change is embedded (ie stops being new ways of working).

Prochaska J.O, DiClemente C.C. (1982)

Trans-theoretical therapy - toward a more integrative model of change^{ix}.

It has been noted earlier that all the sites had identified pre-existing issues for which the innovation (NWW) became the catalyst for change. The findings indicate that using the *diffusion of innovations* framework summarised in Box 1, the early implementers moved through stages 1 to 4 or 5.

Moving from stage 1, *knowledge*, to 2, *persuasion*, involves a readiness to consider change. The concept of readiness to change is articulated in Box 2. This model shows that the sites were at stage 2, *contemplation*, before applying to be early implementers. By the end of the projects some of the sites had reached stage 5 and in the future may reach stage 6, in which the new ways of working will be so embedded as to cease to be new.

These frameworks could be used as a tool to formulate ideas around future implementation of innovations such as NWW, in which services that are at early stages of readiness to embrace change can be identified as early implementers or trailblazers. Introducing new ways of working to services not yet ready to change would arguably be setting them up to fail: the models could assist in planning for ways to move services from *pre-contemplation* to *contemplation* and *preparation*. The stages of change model could also be used as a tool with which to build sustainability into programmes, ensuring that more effective and efficient ways of working become part of normal practice and stop being “new ways of working”.

Finally the question of NWW as a “brand” was addressed, in the light of findings that had indicated some confusion or ambiguity. It was agreed that NWW would benefit from a new name and identity, which would re-launch the programme as a suite of integrated tools, customised for CAMHS and children’s services. The inherent danger of the programme being perceived as a panacea for all CAMHS problems was noted however.

Recent policy, notably the CAMHS Review^x and the 2020 Strategy^{xi}, places the workforce at the centre of improvement, change and reform for children’s services.

The CAMHS review (pages 64-5) concludes:

There are substantial opportunities for practitioners to work in new ways and across services so that what is achieved together is greater than the sum of the constituent parts. We welcome the focus on new ways of working, driven both by the CAMHS 'New Ways of Working' initiative, and by the Every Child Matters emphasis on integrated working more generally. This will involve developing new and enhanced roles for staff and redesigning systems and processes to support the delivery of child and family-centred care in a way that is personally, financially and organisationally sustainable. It seems clear that workforce initiatives need to be coordinated, cohered and tailored in order to have maximum impact.

Shortly after the publication of the CAMHS Review the impacts of the global economic recession began to be felt, making it more important than ever that the children's services workforce provides best value by being the most effective and efficient it can be. The recommendations that follow are based on the presumption of the need for continued workforce reform, with the principles of NWW as a central framework, forming the key mechanism for service improvement.

8. Recommendations

Recommendation	Rationale
1. Future implementation programmes should include baseline measurements of key variables relating to outcomes as well as requiring implementers to plan for dissemination.	More robust evaluation with pre and post measurement.
2. The findings from this evaluation should be tailored to different audiences and a manual of practical tips, lessons learned and pitfalls to avoid should be produced, in a variety of formats, for future implementation of NWW in CAMHS, within the broader context of children’s services.⁵	Maximise the value of the outcomes by sharing widely and making findings more accessible.
3. The range of frameworks, guidance and tools for workforce development in children’s services should be mapped to show services clearly what is available to them and how it is integrated. This should also involve the explicit tailoring of tools such as CCTA, IAPT and 10ESC for a CAMHS/children’s services audience.	Create greater clarity where there is currently some confusion, encourage take-up of products and promote effective use of appropriate tools.
4. The New Ways of Working “brand” should be reviewed and a re-branding/re-launch should be considered for the integrated package of workforce tools referred to in R3 above.	NWW is arguably no longer “new” and the re-brand is more likely to have applicability and appeal to children’s services.
5. In order to increase the opportunities for shared learning, future demonstration projects and early implementation programmes should consider having a cluster of local projects on a particular theme in a particular region, rather than aiming for national coverage.	This would support opportunities for sharing learning and support at a regional level which may lead to greater integration at both local and regional level and make future projects more attractive, replicable, sustainable and more likely to receive strategic support.
6. Service user participation in workforce programmes should be demonstrated and modelled from the top and the national CAMHS workforce programme would benefit from being linked into the national CAMHS participation programme.	Promote better participation: services struggle with user involvement, despite the main purpose of change being to benefit service users.

Yvonne Anderson, Cernis

⁵ There have been very few evaluations about service delivery configuration, which impacts on how effectively practitioners are able to inform their work with evidence of what works.

9. Site information – outcomes and achievements as outlined in the site reports. To read the full reports go to: <http://www.newwaysofworking.org.uk/content/view/26/437/>

East Lancashire Hospitals NHS Trust

Implementing an extended model of service delivery

Provide an adaptable service providing face to face contact beyond the hours of 9 to 5

Two groups have been run under the umbrella of the extended hours model:

- The pervasive developmental disorders group has run a parent and young persons' group, focused on the development of social skills - the group ran one day a week for six weeks 6-7 p.m. The staff group consisted of two extended scope practitioner's (one registered mental health nurse, one paediatric nurse) and one mental health support practitioner. Each session was structured in order to have a beginning (warm-up) followed by the main topic and a final "cool-down". The sessions focused on promoting interaction and communication through group activities whilst encouraging the participants to use their imagination and creativity. Participants were encouraged to make choices and to explore different ways of thinking.

Qualitative information in the form of participants responses was recorded. Responses were positive and a repeated theme was that the participants would have liked more and longer sessions.

The practitioners reported a good level of satisfaction with what the participant children derived from the groups. Practitioners felt that the consistent attendance confirmed this. There were some reported barriers e.g. the provision of childcare.

Parents were reported to have been struggling to come to the parents support group due to having to care for other children. Staff reported wishing to take the group into other venues in East Lancashire.

- The affective disorders group has run a young persons' group. This group focused on the development of anxiety management strategies. The staff group consisted of two extended scope practitioner's (one registered mental health nurse, one paediatric nurse). The participant group consisted of only two children and was aimed directly at the young people and no parents support group was offered in parallel.

Overall, this group feel that the participant benefited from the intervention but there are development issues in terms of preparation and group mix. Both clients who attended had a dual diagnosis of attention deficit hyperactivity disorder and anxiety disorder. This provided the practitioners with difficulties in differentiating the programme. In addition, one participant joined the group after a week and this caused some difficulties. However, participant satisfaction was consistently positive.

Overall, practitioners felt the programme needed to be six to eight weeks in duration with clients of a similar age and psychological difficulties. The barriers to uptake were reported to have been the venue. Several potential participants were unable to travel to the venue in Burnley.

In addition to the two groups that have been successfully run, there have been additional clinical appointments and family therapy sessions that have been conducted under the "safety" umbrella of the system.

The CAMHS service has provided a 24 hour telephone consultation service to A&E and paediatric services in East Lancashire. This service has been accessed on several occasions and the end user satisfaction is high.

North Staffordshire Combined Healthcare NHS Trust Implementing a Whole Systems Approach

The project has demonstrated ways in which, when implemented, service deficiencies can be partially remedied in a cost neutral fashion. It is anticipated that the project will continue even though it is now formally ended.

- 1) Consultant Job Plans have been negotiated, rewritten and agreed.
- 2) Preparatory work has taken place in that all existing Job Descriptions and KSF Outlines have been brought together and centralised.
- 3) Significant input into the working group producing the Consultation and Supervision Policy, which has now been endorsed by the Trust's Clinical Governance Committee.
- 4) The appointment of a Training Co-ordinator
- 5) A review of CAMHS establishing current levels of qualification and skills (both acquired through study and through experience), intended training plans of staff and further aspirations. This will assist in the formation of a clear Training Plan which will also be informed by duly agreed Job Plans.
- 6) A new Operational Policy for the service has been drafted, and to be agreed by the CAMHS Senior Management Group and Children's Services Board.
- 7) The review of clinical records processes within the service, this remains work in progress.
- 8) All staff groups have agreed the principle of transparency of Job Plans.

Tees Esk an Wear CAMHS

Capacity and Demand Modelling Implementation of Choice and Partnership Approach (CAPA)

Improved Patient Pathways

The service now operates with a clear central point of access for service users and agreed consistent pathways internally, which provide a more equitable service for young people.

Examine and challenge current working practices/develop constant, prompt, safe decision making processes.

The Team has questioned many of the approaches previously accepted in service. Decision making processes have been examined in detail and challenged. Historical systems dictated that Multi disciplinary teams were responsible for the decisions made regarding referrals made to the service. The multi disciplinary teams were usually made up from a number of key clinicians from within the team including psychiatry and psychology. A small in house audit suggested that one clinician was as accurate in decision making as the MDT.

Capacity and Demand Modelling

This information facilitated the demise of the MDT as the key decision making forum for new referrals to the service. This is now carried out by one clinician, Primary Mental Health Worker's predominantly. Initially there was a great deal of anxiety regarding this as the MDT was perceived as a 'safe' forum.

However implementation has proved to be far less anxiety provoking than first anticipated. Robust measures are in place should clinicians require additional support from the team for complex or difficult cases.

Define and develop roles within the team

- Working group established to help facilitate discussion in the team.
- Team members produced 'role definitions' highlighting their specific and core skills, areas of expertise and competence.
- Identification of skill gaps within the service. Identified nurse-prescribing skills needed.
- Member of team trained nurse prescriber.
- Nurse led ADHD clinic established.

Fed into service workforce development plan, increase in staff nurse posts and clinicians with CBT and systemic skill.

Ensure sustainability of capacity and demand work

- IT systems in place to capture relevant data.
- Evaluation incorporated into team business
- Recruitment and retention of staff increase the access to CAMHS looking at more effective skill mix.
- Included in the service workforce development plan

Develop and implement one consistent transparent waiting time management approach

The CAPA model has effectively achieved this; the team is currently seeing 70% of new clients within 4 weeks.

SW London & St Georges Mental Health NHS Trust

User and Carer Involvement in Service Redesign

Results

Service Redesign Proposal

This Work stream ran from May to October 2006 and the draft report describes the current service, considers the national guidance for CAMHS and the local needs assessment completed at the request of the PCT. In addition, internally the service has produced individual and a team job plans with activity targets and monitoring mechanisms, the results of which informed the redesign.

Key messages:

- 1) The current service is under funded in comparison to the national guidance (by 50%).
- 2) Services at Tier 2 are also understaffed and under co-ordinated.
- 3) Referrals received are appropriate and the balance of work matches what would be expected but the team does not have the capacity to manage the workload.
- 4) There are short waits for assessment but much longer ones for treatment.
- 5) There are some skills shortages within the team.

Given that there are unlikely to be more resources available to the service the recommendations are as follows.

- 1) Further work will be undertaken to review the referral and assessment process.
- 2) Reduce accepted referrals for intervention.
- 3) Hold Face2Face Choice (first appointments) at Children's Centres and other venues in the Borough.

- 4) Provide interventions in one Children's Centre or Extended School in addition to the Richmond Royal.
- 5) For cross-fertilisation of ideas and improvement in co-working, Educational Psychologists, Paediatricians and social workers to have sessions in the CFCC team and vice-versa.
- 6) Review efficacy of local services providing Paediatric Liaison Service to Richmond residents.
- 7) Address the skills gap by prioritising training in those areas identified.
- 8) Encourage the Borough to develop a Multi-Agency CAMHS strategy to address the gaps at Tier 2.

User and Referrer Feedback Report

This Work stream ran from December 2006 to May 2007. A literature review of national and local user feedback was undertaken to inform the process.

Users and Carers feedback

Views from children, young people and parents/carers were sought through a variety of mechanisms: a suggestions box in the waiting area, CHI Experience of Service Questionnaires (CHI ESQ), a 2-week sample period of those attending first appointments (Face2Face) and direct interviews. A young person's focus group was also held with a mix of users and non-users.

The Suggestions box was poorly used and did not reveal much new information. However, we have continued to keep it in the waiting area. Results of the CHI ESQ were extremely positive from children, young people and parent/carers. 9 forms were returned by service users attending a Face2Face appointment in the 2-week sample period. 8 reported that the Face2Face session was "very" or "extremely helpful". Direct Interviews with current service users showed that children (n=3) liked attending the person they saw and liked coming to the service.

Young people aged 11-18 (n= 13) generally had positive experiences prior to coming of:

- Access
- Information
- Choice

When they attended, most had positive experiences of:

- Choice
- Information
- Care Planning
- Venue
- Contact
- Waiting Times
- Confidentiality
- Waiting Area
- Key Working
- Knowledge of Professionals
- Qualities in Staff
- The Name of the Service
- Support from other Agencies

Oxfordshire & Buckinghamshire Mental Health Foundation Trust
Service Remodelling and New Ways of Working A Whole System Approach

Summary of the main findings and highlights of the evaluation

This project sits within a wider multiagency strategy, which includes:

- The commissioning and delivery of a Primary Care CAMHS Service (PCAMHS) in Oxfordshire to support front line workers of all agencies; to deliver Tier 2 interventions; to provide a single point of access for specialist CAMHS and to facilitate the introduction the Common Assessment Framework (CAF) as a single referral tool. The CAMHS Grant was used to fund the development of PCAMHS in Oxfordshire.
- Disinvestment in provision of inpatient services for children under 11 and reinvestment in enhanced specialist community services for both Oxfordshire and Buckinghamshire.
- Development of Assertive Outreach Services within CAMHS in Oxfordshire and Buckinghamshire.

As part of the overall Project, Service Specifications for the organisation and management of specialist Child and Adolescent Mental Health Services have been agreed for both Oxfordshire and Buckinghamshire.

This set out a number of key principles:

- Delivery of a community based model with Care Programme Approach (CPA) and care co-ordination as the clinical framework.
- Realignment of community team boundaries to shadow Children Young People & Families Directorates supporting locality working, Lead Professional and Team around the Child developments. Resources have been distributed on a percentage basis relating to the new 0 -19 population sizes, with appropriate weighting for deprivation levels.
- Development of a clinical and managerial structure to deliver sustainable change across the service.
- Agree and implement a skill mix review.

At the time of writing we have achieved:

- Review of specialist CAMHS services.
- Single point of access achieved and accepted in Oxfordshire – continue to test
- Clinical Team Managers, Service Development Manager, Associate Clinical Directors appointed.
- Realignment of Oxfordshire community team boundaries to reflect Local Authority Localities and agreement to shadow Buckinghamshire Localities once agreed.

- Development of former Park Hospital as Young People's Resource centre for Oxfordshire bringing CAMHS services together (completion October 2008).
- Eligibility criteria and thresholds agreed by Strategy Groups in both counties and implemented with review dates included.
- Sub-group to review specialist Learning Disability Team criteria in Oxfordshire with view to moving away from IQ based thresholds.
- Service remodelling

Sussex Partnership NHS Trust

The Development of Mental Status Examination Training for Professionals at the Sussex Centre for Children and Young People

The project proposed two pathways of training to account for the different needs of inpatient and outreach work. A protocol based system was developed to allow risk assessments and a modified mental state examination to be carried out by inpatient team and the outreach team. A training package was developed by the consultant psychiatrist and nurse consultant (project lead), which aimed to equip staff with further knowledge regarding the components of mental state examinations, terminology used and also to help increase their confidence. A training manual was provided for inpatient and outreach staff. Training was delivered separately for the inpatient and outreach teams due to the varying needs and differences between inpatient and community settings.

The in-patient team had two half day training days and an hour follow up session. The outreach team had one half day training session and an hour follow up session. An audit was carried out alongside the project to obtain measures of knowledge and confidence of staff before and after training. Knowledge was measured using a set of multiple choice questions regarding mental state examinations. The average pre and post training scores were compared. Confidence was measured in relation to carrying out risk assessments and making risk decisions. Staff were asked to rate their confidence on a scale of 1-10 (not very confident to very confident) and the average pre and post training scores were compared.

Inpatient results

The majority of staff members improved their mental state examination test score following training. The average pre-training quiz score was 89% and the average score post training was 93%. Confidence for risk assessments and decision making was rated pre and post training. On average confidence scores have increased.

The average pre training score for risk assessments was 62.7% and the average post training score was 79%. For decisions the average pre training score was 67.6% and the average post training score was 81.3%.

In the first three months of the project 12 risk assessment forms were completed by the inpatient staff. Life threatening mental state was present in five risk situations.

Within these life threatening mental state situations, three required immediate psychiatric assessment; one required a psychiatric opinion within the week and one as part of the next multidisciplinary review. All life threatening mental states were categorised as 'active suicidality/hopelessness'.

The majority of staff members improved their mental state examination test score following training. The average pre-training quiz score was 89% and the average score post training was 93%.

Confidence for risk assessment and risk decision-making was self-rated pre and post training. The average test score for confidence in risk assessment pre-training was 70% and in post training it increased to 80%. The average test score for confidence in decision making pre-training was 71% which post training increased to 77%.

Outreach results

22 risk assessment forms were completed by the outreach staff. None required immediate psychiatric opinion. Two (9%) required next working day discussion with another team member, three (14%) required discussion with a team member within the week and 17 (77%) could await discussion at the next outreach meeting.

Life threatening mental states were present in six (27%) risk assessments. One case (17%) required further discussion the next working day, two (33%) within the week and three (50%) at the outreach team meeting. The majority of life threatening mental states (83%) were 'active suicidality/hopelessness'. One was categorised as 'other' which was further explained as 'perceived concealment of overdose – aetiology unknown'.

Southampton CAMHS

Advanced Nurse Practitioners for Attention Deficit Hyperactivity Disorder (ADHD)

The main outcomes of the project were as follows:

A) Review of the care pathway, including an update of the literature resources for parents and children and the production of three time lines looking at the traditional way of working and the new nurse led approach.

B) Service User and Carer Involvement including drop in groups, systematic user feedback and the production of a manual for parents.

C) A review of Non Medical Prescribing including parental views, structure around supervision and development of a format for assessing costs.

D) Review of Education and Training and contact with schools:

E) The Role of the Consultant Nurse ADHD, the role of the Advanced Nurse Practitioner ADHD (prescribing) (ANP ADHD (prescribing)) and the Role of the Advanced Nurse Practitioner ADHD (ANP ADHD)

The specific objectives achieved were:

- The care pathway was reviewed re written and circulated to all team members.
- The literature for parents was updated and circulated ready for use.

- The NFPP- SH was finalised bound and the questionnaires for evaluation decided and a group evaluation form was developed
- Clinical Management Forms (CMP) were reviewed, the transfer of patients to the nurse formalised – letters to the parents, GP and local Pharmacist written.
- For new to nurse patients a system of discussion and medication recommendation with the CMP was developed
- Monitoring forms for medication were revised which included the reviewing of management and behaviour interventions.
- The ANP ADHD (prescribing) nurses were invited to attend the regular meetings with the Trust Pharmacists and participate in the review of the shared care guidelines locally.
- Reviewing the role of Advanced Nurse Practitioners in training SHO's has been clarified
- The project provided clarification on the ANP ADHD (prescribing) role. The project enabled evaluation the role of ANP ADHD (prescribing) and the supervision process from doctors required and set the agenda for working practice.
- Liaison/consultation work with schools

Derbyshire Mental Health Services NHS Trust

New Ways of Working for Consultant Child and Adolescent Psychiatrists from Geographical to Functional Teams

Consultant Child & Adolescent Psychiatrists moved from being exclusively locality based with large generic case loads to lead Specialist Teams and to have smaller highly specialised case loads.

To implement this change each Consultant remains part-time in their sector generic multidisciplinary team, while for the rest of the time they will lead a Specialist, sometimes functional, team across the whole of South Derbyshire.

The identified Teams were as follows:

- 16 - 17 year olds
- Substance Misuse
- Paediatric Liaison
- Autistic Spectrum Disorder
- Attention Deficit Hyperactivity Disorder
- Learning Disabilities

Project Outcomes

What can we learn from NWW in CAMHS

- A review of Consultant Caseloads.
- Establishment of Specialist Teams
- Skills Mix Review across the whole of the Service
- Improvement of Care pathways
- Evidence Based Care Bundles / Plans are developing
- In new Specialist Teams, Consultants have been able to implement the New Ways of Working focusing on complex cases only

Early Implementer Programme Team

Roslyn Hope, (then) Director NIMHE/CSIP National Workforce Programme

Directed and steered the programme

Barry Nixon, National CAMHS Workforce Lead

Led and managed the programme

Dr Tim Morris, Consultant Child and Adolescent Psychiatrist

Coordinated and supported the regional projects

Helen Warburton, PA to National CAMHS Workforce Programme

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REFERENCES

- ⁱ 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
- ⁱⁱ Morris T & Nixon B 2008 New Ways of Working in CAMHS. *Journal of Mental Health Training, Education and Practice* Vol3.
- ⁱⁱⁱ <http://www.isip.nhs.uk/roadmap/highlevel/PhaseII-Strategy/completeProgBRP>
- ^{iv} Geertz, Clifford. "*Thick Description: Toward an Interpretive Theory of Culture*". In *The Interpretation of Cultures: Selected Essays*. (New York: Basic Books, 1973) 3-30.
- ^v Royal College of Psychiatrists (2005) *new ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts. Final report 'but not the end of the story'*. National Institute for Mental Health in England Supported by the Changing Workforce Programme
- ^{vi} 10 ESC: <http://www.mhhe.heacademy.ac.uk/news-and-events/latest-news/free-cd-10-esc-learning-materials/>
- ^{vii} Audit Commission (1999) *Children in mind. Child and adolescent mental health services*
<http://www.audit-commission.gov.uk/nationalstudies/health/mentalhealth/Pages/childreninmind.aspx>
- ^{viii} Rogers, E.M. (1964). *Diffusion of Innovations*. Glencoe: Free Press
- ^{ix} Prochaska J.O, DiClemente C.C. (1982) Trans-theoretical therapy - toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice* 1982;19(3):276-288.
- ^x Department for Children Schools and Families (2008) *The CAMHS Review: children in mind*.
<http://www.dcsf.gov.uk/CAMHSreview/downloads/CAMHSReview-Bookmark.pdf>
- ^{xi} Department for Children, Schools and Families (2008) 2020 Children and Young People's Workforce Strategy.
<http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-01052-2008>