

North Staffordshire Combined Healthcare



NHS Trust

# Implementing a Whole Systems Approach



**NWW** **New Ways of Working**  
in child and adolescent mental health

*Developing and sustaining a capable and flexible workforce*

# Contents

Forward	1
Executive Summary	2
Introduction	3
Project Outcomes	4
Appendices	
I. Draft Operational Policy	10
II. Project Evaluation Plan	24
III. Clinical Team Managers Draft Job Description	26
IV. Consultant Psychiatrist Job Plans	30
Contact Details	39

---

# Forward

---

New Ways of Working represents a cultural shift in the way that mental health services are delivered. It emphasizes person centred value based approaches where services are responsive and flexible to the needs of those that use them.

New Ways of Working is about developing new and enhanced roles for staff. It is about designing systems and processes that support staff in the delivery of care in a way that is personally, organizationally and financially sustainable. New Ways of Working supports the development of a flexible workforce which is adaptable to changing needs. These changes need to be underpinned by the needs of children, young people and their families so that their emotional health and psychological well being can be enhanced.

The initial New Ways of Working projects in adult mental health had a focus on psychiatrists. This has gradually extended to other professional groups. This project highlights how this process can be used within a Specialist CAMHS. Psychiatrists are one of a number of professional groups that are core to the delivery of high quality child and adolescent services. There has been a significant increase in the numbers of psychiatrist but there remains an overall shortage of psychiatrists. It is therefore important that the skills and competencies of psychiatrists are used to maximum effect. This project illustrates some of the potential ways and difficulties in bringing about change. It demonstrates the interrelationships of different groups in providing integrated care and how one role is dependant upon other. This project also highlights the commitment and timescale needed to bring about changes that have the potential to improve care for young people and their families. This is not a static process but one of ongoing evaluation and response to changing demands. There are a number of other constraints and levers for change that impact on everyone so that flexibility of response is a key competency for all involved in delivering services.

New Ways of Working is about having the right people with the right skills in the right place in the right job at the right time.



Dr Tim Morris, *NWW CAMHS Project Lead*

e: [timmorri@liverpool.ac.uk](mailto:timmorri@liverpool.ac.uk)



Barry Nixon, *National Workforce Lead CAMHS*

e: [Barry.Nixon@wwl.nhs.uk](mailto:Barry.Nixon@wwl.nhs.uk)

# Executive Summary

This project initially aimed at a whole systems change by full implementation of New Ways of Working in CAMHS in four specialist Community CAMHS teams in North Staffordshire and Stoke. The very tight timescale set centrally for the national project dictated that it became a virtual project, which aimed at conducting all the necessary negotiations and writing the necessary documents so that full implementation could be effected at a later date. This revision of the project's aims led to an extension and refinement of some of the project's aims.

The project met various challenges. Some of these were intrinsic to the project, such as the sensitivity of staff to discussion about Job Descriptions and Job Plans in the context of the recent Agenda for Change process and the interface of the project with other systems, such as a rigid IT system and expectations of other professionals. Some of the challenges, however, were the results of quite extraneous external events, such as the Trust's application for Foundation Trust Status and systemic team difficulties, which significantly diminished the capacity of Steering Group members to work on the project. Nevertheless, as of the date of the report, substantial outcomes have been achieved and these are reported here.

Additionally, the project has had unexpected beneficial outcomes, such as rendering the management of the service more coherent and laying the groundwork for further innovation in the area of service line management and PBR contracting.

Additionally, 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.

---

# Introduction

---

At the time of writing the proposal, NSCHT provided four Community Specialist CAMHS teams. These teams worked according to a fairly traditional but progressive CAMHS model. This means that whilst there was some adoption of the principles of New Ways of Working by the teams, this was not comprehensive and was somewhat variable between each team and was not overt.

## Aims & Objectives

The aims stated in the application for the project was 'to fully implement New Ways of Working for Consultant Psychiatrists across a whole specialty Community CAMHS'. It was intended to do this by conducting the following activities:

- 1) Negotiating, agreeing and rewriting Consultant Job Plans (both old and new Contract, as our Consultant group has staff on both).
- 2) Formalising team management structures with defined Team Leaders and specific allocated tasks.
- 3) Negotiating, agreeing and writing team members' Job Descriptions to comply with New Ways of Working, but staying within the parameters of already agreed Agenda for Change gradings.
- 4) Establishing clear processes for consultation and supervision.
- 5) Training staff in new roles where required.
- 6) Evaluating the impact of these changes.

## Target Groups

- 1) Children & Families. It was anticipated that waiting times would be reduced and children and families would be responded to faster than previously. A better 'fit' between complexity of case and clinicians' skills was anticipated.
- 2) Consultant Psychiatrists. It was anticipated that these staff's workloads would be better controlled and their skills would be better used.
- 3) Other Multidisciplinary team staff. It was anticipated that these staff would have increased job satisfaction from an extended role and there would be better prospects of career progression for them.

# Project Outcomes

The first outcome was a significant amendment of the aims and objectives of the project. This arose consequent to a meeting with the Project Lead on 26 September 2006 at which it became apparent that the timescale for completion of the project was very tight. Therefore it was agreed that the aim of full implementation of NWW for Consultant Psychiatrists across a whole specialty Community CAMHS was unattainable. The new aim was identified as exploring the pragmatics of implementation through negotiation with staff so that the project became, as it were, virtual, and by the end of the project we would have a package of negotiated and agreed papers which would allow us to seek the agreement of commissioners to implement rapidly. This would, of course, also produce material that would assist in the development of a detailed service specification that would be helpful in the development of a better contract between commissioners and the Trust than had hitherto been the case. It has recently become apparent that this is additionally helpful in the development of service line management, which is a direction of travel required of the Trust by Monitor as part of its Foundation Trust Application.

The subsidiary Aims & Objectives identified in Section 3 above therefore remained, but they were refined and in some ways extended through the process of the project. These additional objectives are listed below:

- 1) It became apparent that the aspiration of rewriting Job Descriptions was fraught with difficulty, partly because of staff sensitivities that this might fundamentally challenge their banding under the recent and somewhat traumatic Agenda for Change process and partly because the Psychologists in the service advised that their Job Descriptions were nationally agreed and not amenable to local renegotiation. It was agreed that the way to deal with these two areas of difficulty was by pursuing the model of Job Plans, which Consultant Psychiatrists have been following for some years. It was accepted that Job Plans could be written to take account of local circumstances and could be reviewed annually as part of the clinical management system. No other discipline within the service had previously used the
- concept of Job Plans and this, I think, is therefore one of the immediate outcomes of the project; the recognition of the utility of Job Plans as a flexible and staff acceptable role in clinical management.
- 2) It was recognised that the service's existing Operational Policy needed rewriting to accommodate New Ways of Working.
- 3) It became apparent that the conduct of clinical work using New Ways of Working required a comprehensive review of clinical records processes in CAMHS and this allowed an opportunity to ensure the introduction of good practice by formalising the requirement for clinical notes to contain, as part of the assessment section, clear problem formulations and management/care plans. It then became apparent that this facilitated the development of clear care pathways and these themselves could form the basis of a contract currency for Payment By Results within CAMHS.

- 4) The Steering Group also realised that implementation of New Ways of Working would require a change in the service's methods of recording clinical activity, as it was realised that the current methods were anachronistic. The only centrally reported clinical activity that was recorded was the consequence of referrals to a named Consultant and the activities conducted by the Consultant and his/her junior medical staff. The work of the rest of the multidisciplinary team was either not recorded at all or recorded incorrectly as being directed by one of the medical staff. During the life of the project it was accepted that all referrals were to the Team. This resulted in no clinical activity data being centrally reported.
- 5) The process of open discussion of Job Plans led to a further aim, which was that all staff Job Plans would become available for scrutiny by all CAMHS staff and indeed, all others outside of the service. It was agreed in principle that such transparency could only be beneficial to multidisciplinary team working.
- 6) Our original application identified the process of our project as essentially within service. It became apparent to the Steering Group that this was too narrow a perspective, as part of the process of implementation would need to be the education of referrers and multiagency partners about New Ways of Working. We therefore set ourselves a new aim, which was to discuss within the Stoke and Staffordshire CAMHS Strategy Groups how best to disseminate information about this new model and with the help of our partner agencies, to develop and initiate a plan to do so.

Our original aims included the intent to evaluate the impact of implementation. Because we had decided to embark on a virtual rather than actual project, this aim clearly changed into writing a plan of evaluation. However, our evaluation plan proposed assessment before introduction and after introduction and also proposed an

evaluation of the impact, not only on service users, but also on CAMHS staff. Because of this latter and because we have a real expectation that we shall implement, we decided that it was both possible and necessary to commence evaluation by undertaking the 'before' assessment.

Having clarified that the first outcome of the project was its major revision and refinement, we now address outcomes in each of the several areas of activity identified above and in Section 3 above.

- 1) Consultant Job Plans have been negotiated, rewritten and agreed. See Appendix I for specimens of Job Plans for New Contract and Old Contract Consultants.
- 2) Team management structures have been formalised. Whereas there were previously four Team Leaders, there will shortly be two Team Leaders. The new Team Leaders' Job Descriptions and KSF Outlines have been agreed and have been approved by the local Agenda for Change Banding Committee. One new Team Leader has been appointed and will start work on 1 January 2008. The other Team Leader will take up post in April 2008. This process has been facilitated by retirement of existing staff. See Appendix for Team Leaders' Job Descriptions and KSF Outlines.
- 3) Team members' Job Plans have not yet been written. Preparatory work has taken place in that all existing Job Descriptions and KSF Outlines have been brought together and centralised. It is anticipated that the negotiation of new Job Plans will be a delicate task that will be undertaken by the two new Team Leaders.
- 4) It was fortunate that this project coincided with a move elsewhere in the Trust to formalise a Consultation and Supervision Policy. Consequently, CAMHS had significant input into the working group producing this Policy, which has now been endorsed by the Trust's Clinical Governance Committee. See Appendix 3 for the Consultation and Supervision Policy.

- 5) Staff have not been trained in new roles as this is dependent on the development of new Job Plans. However, the service has appointed a Training Co-ordinator and currently a Senior Nurse is conducting a CAMHS staff wide service 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. This, however, remains work yet to do.
- 6) A new Operational Policy for the service has been drafted, but still has to be agreed by the CAMHS Senior Management Group and Children's Services Board. The draft Operational Policy can be found in Appendix IV.
- 7) The review of clinical records processes within the service remains a work in progress. A new front sheet has been adopted (informed by the findings of the Laming Report), but there has not yet been full agreement on the form and structure that clinical records within CAMHS should take. This is a slightly difficult area, as there is a drive within the Trust as a whole to a single form of clinical record across all specialties within the Trust.
- 8) It has become apparent that radically amending the way that activity within the service is electronically recorded is beyond the capacity of the service to achieve. This aim, therefore, has not been fulfilled. However, through judicious manipulation of the existing system, it has been able to develop a working arrangement whereby the activity of other staff can be recognised. That this is inadequate is evidenced by the fact that the service is still unable to provide the data required for National CAMHS Mapping by electronic means.
- 9) All staff groups have agreed the principle of transparency of Job Plans.
- 10) The issue of dissemination of information about this new model of working has been discussed at both Staffordshire and Stoke Strategy Groups, but a formal plan has not been drawn up because it has not yet been agreed with commissioners that this is how CAMHS shall be provided in this area.
- 11) An evaluation protocol has been drawn up and can be found in Appendix V. The 'before' implementation evaluation has been carried out with two of the four teams. Data is not yet available.

## Challenges and Opportunities

Some of these have already been indicated above, but for clarity, they are listed in short here.

### Challenges

- 1) It soon became apparent that talk of rewriting Job Descriptions raised considerable anxiety for staff who had recently gone through, or indeed, were in the appeal stage of the Agenda for Change Process. Likewise, the difficulty around Psychologists' Job Descriptions has been mentioned.
- 2) The alteration of the way that activity was recorded electronically has proved too great a challenge to surmount. Although we have addressed the problem to some degree, the situation remains unsatisfactory.
- 3) It remains unclear whether implementation of New Ways of Working will be cost neutral. So far, it has been, but full clarity on this awaits the negotiation of Job Plans with individual team members by the new Team Leaders.

- 4) It is anticipated that dissemination to referrers and partner agencies might prove challenging, particularly with some referrers (eg General Practitioners) who have been used to referring to a named Consultant rather than a team. It is not clear how significant a challenge this is, as although initially it appeared potentially considerable, more recent experience shows greater willingness to accommodate to this change on the part of Primary Care than was expected.
- 5) The greatest challenge to the project has been that of events wholly unrelated to the project. During the life of the project, two developments took place which have seriously impacted upon delivery. The first development was a Trust wide financial crisis, which together with an application for Foundation Trust status and the need to negotiate new contracts for the Trust's Tier 4 CAMHS Service with the West Midlands Regional Commissioning Agency, took up a considerable amount of the time of members of the Steering Group. This adversely impacted on their capacity to deliver on tasks required relating to this project. The second event was a major systemic issue within one of the four Community CAMHS Teams resulting in grievance and disciplinary procedures, together with a large amount of staff sickness.

Managing this situation has taken a significant amount of capacity away from the Steering Group, as well as making it impossible to address the issues of New Ways of Working within that particular Community CAMHS Team.

- 6) It has become apparent that the implementation of this model of service will throw into high relief the tension between it and the choice agenda within the NHS. The principle of referral into a team rather than to a named clinician makes it very doubtful that referring General Practitioners within North Staffordshire will have a choice of CAMHS providers to refer to. This challenge remains unresolved.

## Opportunities

- 1) The process of participating in this project has led to greater clarity with regard to management processes within the service than it is thought would have occurred otherwise. The discussion that has inevitably taken place has had a very beneficial effect in opening up discussion and debate about staff members' roles and this has had the particularly beneficial consequence of acceptance of total transparency about Job Plans, which it is anticipated will be of considerable benefit to good multidisciplinary team working in the future.
- 2) The process of the project will make it easier for the service to accommodate to the requirement to develop service line management and service line reporting.
- 3) Greater clarification of the work of the service has opened up the prospect of greater clarification and delineation of care pathways, which itself appears to provide a way forward to the sensible implementation of Payment by Results.
- 4) It has become apparent that implementation of New Ways of Working will release Consultant Psychiatrists' time, which would then be able to address existing deficiencies in service, such as senior medical input into the Trust's Learning Disability Services for Children, the development of a neuropsychiatric and neurodevelopmental service (with particular reference to Autistic Spectrum Disorder), the improvement of psychiatric liaison with Acute Paediatrics and the development of an NHS Court Report Preparation Service. Partial implementation of New Ways of Working has already led to improvement in the medical input into the Learning Disability Service, but the remainder of these opportunities will not be realised unless and until New Ways of Working is fully implemented locally.

## Stakeholder Analysis

The project started with the support of both Stoke-on-Trent and Staffordshire Interagency Strategy Groups. That from Staffordshire has remained unchanged. However, the situation in Stoke has been complicated by a radical reorganisation of the Local Authority as a consequence of the tendering of Children's Services and the winning of that tender by SERCO, which is termed a Strategic Partner. It has been our impression that the Local Authority members of the Stoke CAMHS Strategy Group have been preoccupied by these matters.

Involving users and carers in the project has remained problematic. However, this has been addressed in some slight degree through the focus groups, which each community team runs with its users.

## Risk Analysis

The principal risks identified during the course of the project have been indicated above in Section 5 and 6. Although the national project has officially ended, this local project is not yet completed. There is, therefore, a risk that the local project will be abandoned because of the termination of the national project. The Steering Group does not think that this is a considerable risk because it is thought that the project now has a life of its own, which will continue to run despite the lack of central involvement in the future. This assessment may be wrong. Of course there is a very clear risk that the next stage of the project will identify considerable cost implications and the commissioners will therefore not wish to commission a service based on New Ways of Working. However, even if this was to happen, then some of the benefits already accrued will clearly stay with the service.

## Project Management

The Trust's CAMHS Senior Management Group identified a Steering Group to lead on this project. The members of the Steering Group are listed below.

Chair – Dr Jonathan Lovett, Consultant Child & Adolescent Psychiatrist, Children's Services Lead

Geoff Tomlinson, Children's Services General Manager

Dave Lear, Community CAMHS Modern Matron

Andy Reid, Moorlands, Staffordshire, CAMHS Team Leader

Chris Morgan, South Stoke CAMHS Team Leader

Julia Richardson, North Stoke CAMHS Team Leader

Rita Ghent, Newcastle, Staffordshire, CAMHS Team Leader

Dr Steve Dover, Consultant Child & Adolescent Psychiatrist

Dr Jo Barton, Consultant Child & Adolescent Psychiatrist

Geoff Tomlinson managed the finance arrangements.

The impact of events on the management of the project has been indicated in Section 6 above. Four of the Steering Group will retire within the next 4 – 6 months. This may well have an impact on the capacity of the group to manage the project.

## Programme Support

The Steering Group has met with the Project Lead on two occasions and the National Workforce Lead on one. There has been infrequent e-mail correspondence and discussion at the National Conference on New Ways of Working. This can best be described, as a light touch form of central direction and this has been perceived by the Steering Group as beneficial.

## Budget

Because of how this project has evolved, most of the cost so far has been in terms of staff time and this has been borne by North Staffordshire Combined Healthcare Trust. However we determined to bring in an outside facilitator (Keele University) for the project evaluation and the cost of this has been identified as £3,900. This covers 12 days of Focus Group work at £300 per day and preparation of papers for publication and peer reviewed journals at £300 in total. We have decided to spend part of the remainder of the budget on New Ways of Working Away Days for each of the four community CAMHS teams and the bulk of it on two skills courses for all secondary community CAMHS staff in 2008. These courses will seek to cover the training needs identified in the course of the project and whilst these are not yet formally identified, it is expected to encompass such matters as diagnostic formulation using different classificatory systems, assessment techniques and processing skills such as writing letters to referrers and personal time management. It is not anticipated that we shall exceed our budget of £10,000.

## Dissemination Plan

The project's Interim Report was sent to each CAMHS Interagency Strategy Group and was presented there by Dr Jonathan Lovett. The report was also presented at the West Midlands CAMHS Regional Network Meeting hosted by the Strategic Health Authority. This final report is available to each Strategy Group, to the Network Meeting and to the West Midlands Child & Adolescent Psychiatry Specialist Committee. Of course it, including all the Appendices, are available for dissemination by the National Workforce Programme as it sees fit. The Steering Group has decided that further dissemination, as originally planned at academic meetings of the Royal College of Psychiatrists and elsewhere, would await completion of the project.

## Impact and Sustainability

Clearly the project has had considerable influence on Specialty Community CAMHS in North Staffordshire. Its further impact is dependent on the matters discussed in Sections 6 and 8 above. In one year's time, it is hoped that we will have negotiated full implementation of the project with our commissioners, with a view to its detailed commencement in April 2009. We shall then be able to complete the evaluation of the project.

# Appendices

## Appendix I

### North Staffordshire Combined Healthcare NHS Trust

### Community Teams – Child & Adolescent Mental Health Service

### Operational Policy

#### Table of Contents:

- Introduction
- Philosophy
- Organisational Arrangements
- Management Arrangements
- Referrals
- Consultation
- Assessment
- Treatment/Therapy
- Interagency Working
- Discharge
- Staffing
- Staff Continuing Professional Development and Training
- Responsibility
  - 1) Professional Responsibility
  - 2) Keyworker Responsibility
  - 3) Medical Responsibility
  - 4) Line Management Responsibility
  - 5) Consultation Responsibility
- Professional Support and Supervision
- Supervision of Trainees
- Records/Case Notes
- Confidentiality and Consent
  - 1) Confidentiality
  - 2) Consent
- Observations, Video Links and Videotaping
- Monitoring, Audit and Quality Assurance
  - 1) Monitoring
  - 2) Audit
  - 3) Quality Assurance
- Complaints
- Working within a legal framework
  - 1) Children Act 1989
  - 2) Mental Health Act 1983
  - 3) Child Protection
- Medical Emergencies
- Accidents, Violent Incidents, Untoward Incidents, Health & Safety, Fire Procedures

This is a developing document and a number of matters are under review within the service. This is indicated in the text. Comments are welcomed.

#### Introduction

The Child & Adolescent Mental Health Service is a multidisciplinary service provided by North Staffordshire Combined Healthcare NHS Trust in partnership with Staffordshire and Stoke-on-Trent Social Services Departments. It is managed by North Staffordshire Combined Healthcare NHS Trust. It is a community focussed, locally based service, which utilises a team approach to service delivery, responding positively and flexibly to feedback from and discussions with service commissioners, referrers and service users. This Operational Policy seeks to outline the principles that govern the service but is itself to be subject to regular review. The service and its team members work in accordance with these policies and the policies of the Trust and its partner Social Service Departments.

## Philosophy

The primary aim of the service is to provide outpatient assessment and treatment to children and adolescents who may have mental health problems, giving due consideration to needs in relation to diversity and equality.

Difficulties are often complex and may involve other family members, in addition to the referred child or adolescent. As a result of this, other family members will frequently need to be involved in the planning and provision of treatment packages. In addition, the solution to some problems involves input from non-health agencies, (eg Social Services and Education & Voluntary Sector). The service endeavours to identify the need for appropriate input from other professional agencies on an individual case basis.

As an alternative to direct input by the service, the team also aims to provide advice and support to other agencies on a formal and informal consultative basis, in accordance with the preferred national tiered model of service delivery.

The team encompasses a number of therapeutic skills and aims to offer a comprehensive range of assessment and treatment techniques. The unifying principle behind all these techniques is the empowerment of children and families to enable them to manage the difficulties in their lives with the assistance of the skills provided by the professionals within the service.

## Organisational Arrangements

Currently, the service is based in four sites: The Ashlands Centre, North Street, Newcastle, Abbey Hulton Clinic, Leek Road, Abbey Hulton, the Blurton Health Centre, Ripon Road, Blurton and Eaton House, Buxton Road, Leek. The catchment populations of each service are based upon General Practitioner registration, with Ashlands and Eaton House taking referrals of patients registered with a General

Practitioner member of the North Staffordshire Primary Care Trust, and Abbey Hulton and Blurton taking referrals of children registered with General Practitioner members of Stoke-on-Trent Primary Care Trust. In the event of a child or young person not being registered with a General Practitioner, the referral should be made to the most geographically appropriate clinic base. The team secretaries may be contacted by telephone if there is uncertainty about which team should accept a particular referral. Historically, the service has taken a very few referrals from outside of the North Staffordshire area.

Arrangements regarding these are currently under review and any such referrals should be directed to the team in closest proximity. If a patient under the care of one CAMHS team changes GPs so that they 'should' be under the care of a different team, the case will not be transferred if any further work than initial assessment has been done. This can be varied by discussion between the teams.

The community CAMHS teams together operate a Priority Referral Team, which takes referrals from the Paediatric Wards (primarily of children and adolescents who have self-harmed) and from other referrers where an emergency referral is requested and thought appropriate by the relevant community CAMHS team. The Priority Referral Team's Operational Policy is appended to this policy.

The community CAMHS teams work in close liaison with the Trust's Child Psychology Department, some of whose members work as integral members of the community teams.

The community teams also liaise closely with the Regional adolescent inpatient unit at The Darwin Centre, Stoke-on-Trent, which is itself managed by the North Staffordshire Combined Healthcare Trust. However, that unit provides a service to a substantially larger geographical area than the Trust's community CAMHS service. The community CAMHS teams cannot arrange direct admission to the inpatient unit but may request assessment for admission in

accordance with the Regional Tier 4 CAMHS policy.

At present, the service is available Monday – Friday, 9.00 am – 5.00 pm (4.30 pm on Fridays). There is no out of hours service.

## Management Arrangements

The service is managed by a multiagency Senior Management Group, chaired by the Clinical Lead for Children's Services. That group is itself responsible to the Children's Services Board of the Trust, which is chaired by the Clinical Lead for Children's Services. The Clinical Lead reports to the Director of Operations. The service is supported by a General Manager within the Trust, who is also accountable to the Director of Operations. Members of the Senior Management Group from other agencies are accountable to appropriate senior managers in those agencies.

## Referrals

The age group of children and adolescents seen by the service is presently under review. However, at present, the service takes referrals of children and young people with mental health problems up to the age of 16 years and up to the age of 18 years if the young person is in full time education. Full time education means precisely that. It does not include young people who spend a significant part of their time in adult type work settings. The service recognises the importance of transitional arrangements between child and adolescent and adult mental health services and a transitional protocol defines those arrangements. The service does not have the expertise or resources necessary to take referrals of children with severe or moderate learning disabilities. Likewise, the service is not resourced to offer long-term or more intensive interventions to \*clients with problems related to mild learning disabilities.

When such children are seen by the service, there is liaison with the Learning Disabilities Service, to ensure that the most appropriate service is offered to the child and family. Children with severe learning disabilities have access to other services.

*Mental health problems in children and adolescents are relatively common, but most cases can be successfully managed at primary care level. Indications for referral to the specialist community CAMHS teams include evidence of formal psychiatric and psychological disturbance developmental difficulties and severe emotional, social and behavioural problems, particularly when they have failed to respond to previous interventions by primary care agencies.*

Cases are often complex in nature and decisions around appropriateness of referral will be made by the CAMHS team. Attention will be paid to the child's context and the special needs of 'looked after children' are acknowledged.

Problems which are confined to the school setting, such as learning difficulties and behavioural problems in the classroom, will not usually be seen by the service. The Special Educational Needs system in each school should assess and manage these difficulties in the first instance.

Referrals to the service can come from General Practitioners, School Nurses, Other Psychiatric Specialties, Social Services Departments, Educational Psychologists, Psychological Services, Educational Welfare Officers and Young Offenders Teams. Where a General Practitioner is not the referrer, they are informed that the referral has been made and any necessary clinical information is shared. Routine referrals should be made in writing and addressed to the team at the appropriate clinic base. A referral form is

available to provide the appropriate information to make decisions about priority/suitability of referrals to the service. This is not mandatory. A letter containing similar information is acceptable. A child or young person will not be seen until informed consent has been obtained from the child (if appropriate) and/or those holding parental responsibility. On occasions, referrals are received which are redirected by other parts of the Trust. These may be accepted at the Team Leader's discretion. However, usually the redirecting party will be advised to request the referrer to send the referral to CAMHS themselves directly. They will also be asked to explain that this is so that referred families understand who they have been referred to and consent to this.

New referrals are discussed at weekly multidisciplinary team meetings. At this time, a decision is taken as to whether further information is required through liaison with other agencies or whether the referral can be processed on the information received. The processing of referrals differs slightly in each of the three clinical teams. At Blurton, cases are allocated to a Keyworker for assessment whilst at the other three teams, cases are prioritised into two waiting lists, routine and urgent. Urgent referrals are then immediately allocated for assessment. Routine referrals are reviewed regularly within the allocations meeting and allocated when there is clinical space to do so. Referrers may request a reconsideration of this decision but this is usually only agreed to when there is new information which alters the clinical presentation of the case.

Occasionally, an appointment may not be offered if the team decide it is not appropriate to do so. If this occurs, the referrer will be made aware of the decision and reasons why the referral was not accepted. The process is co-ordinated by the Team Leader or their deputy.

Very urgent referrals will be accepted via letter, fax or telephone and given priority in the event of clear evidence of formal

psychiatric disorder such as life threatening depression or psychosis. In such an event, it may be that the referral will be passed to the Priority Referral Team. Children and adolescents whose behaviour is out of control rarely have formal psychiatric problems and the service does not provide crisis intervention in such cases. It may, however, be appropriate to refer such cases for routine assessment. Final decisions about the prioritisation of urgent referrals will be made by the team and not the referring agencies.

The Trust advises General Practitioners monthly on the maximum waiting times in each locality team. It is hoped to extend this to all referrers if practical means of doing so can be devised. Each team monitors its waiting lists weekly but more systematic ways of doing this are currently under consideration.

If a child is re-referred within 3 months of discharge, then that referral should go back to the original community CAMHS team under whose care the child had previously been. This over-rides the sectorisation of referrals by General Practice registration.

## Differing staff roles

Different staff within the team have different roles with regard to assessment and treatment. Some staff concentrate more on one than the other, but all staff can conduct generic assessments. Thus, as part of New Ways of Working the Consultant Psychiatrist in the service prioritises Neuropsychiatric assessments, whilst the Psychologist prioritises assessments, which appear from the referral letter as likely to require specifically psychological intervention. Similarly cognitive therapists, art and play therapists prioritise cases where their special expertise may seem pertinent. All staff who have space available following such prioritisation are available to conduct generic assessments. All staff are available to other team members for consultation and clinical advice.

## Consultation/Liaison

The service is willing to accept telephone enquiries about suitability of potential referrals to the teams from any referring agencies. In addition, the team can provide advice and support to primary care colleagues who are working with cases themselves.

## Second Opinions

- 1) The service has only limited capacity to provide second opinions. It is envisaged that each team would have the capacity to provide no more than a maximum of 5 second opinions per year, although this figure would be dependent on current re-sourcing within the team.
- 2) Current resources within the service do not allow for the development of specific areas of expertise within particular teams and the provision of second opinions would, therefore, be shared equally between the 4 community teams.
- 3) Second opinions will be exactly that and they will not provide for ongoing responsibility for the management of cases.

## Specific Situations

- 1) CAMHS worker wants second opinion re: case:  
In the first instance the team member will discuss the case within their own team, although in some cases they may seek the advice of a worker in another team on an informal consultation basis. If neither option meets the needs of the case then the worker will seek referral out of area, which may need the support of the GSM and/or commissioners if there are funding implications.
- 2) Client requests second opinion re: care they are receiving:-

In the first instance the situation will be discussed within the team and if the client is in agreement a second opinion will be provided by another worker within the team. If client not in agreement with this then the case will be returned to the referrer for them to organise a second opinion either via another local CAMHS team (subject to general principle 1) or externally.

- 3) Referrer requests second opinion:-  
The referrer will commission this themselves.

## Assessment

Referrals accepted by the team will usually be offered assessment appointments at the clinic. Assessment at home or elsewhere will be offered in exceptional circumstances. The time taken for assessment can vary, but families should be advised that it may be protracted. It may be performed by any member of the multidisciplinary team or by two members co-working. It is essential that the child or adolescent is accompanied by their parent(s)/carer(s) and in most cases, it is helpful for other family members to attend as well. This will be indicated in the appointment letter. Following an assessment, an opinion or formulation of the difficulties faced by the child is made, either at the time of the assessment or following further discussion within the CAMHS team and then, following collaboration with the child and the family, a plan of treatment is agreed, with arrangements for subsequent review if necessary, and a letter outlining the plan is sent to the referrer and to any other involved professional agencies (with the family's consent) as well as to the parents of the child and to the child, if over the age of 16 years. On occasion, if it is felt that sending such a letter to the family would be detrimental, this is not done but in that case, this decision and the reasons for it are recorded in the clinic records.

## Treatment/Therapy

It should be recognised that the boundary between assessment and intervention is not necessarily clear cut. Assessment forms the start of intervention and is itself ongoing and continuous throughout contact with the service. However, a variety of specific treatments are offered by the service. These include:

- 1) Family & systemic work
- 2) A variety of Individual therapies for children and adolescents
- 3) Parenting work
- 4) Medical treatment, including psychopharmacology
- 5) Specific behaviour therapies
- 6) Psychometric assessments for developmental difficulties and delay

Team members have their specific skill sets identified in their job plans (which are reviewed annually).

Some treatment modalities may not be available at any given time in each community team because of workload pressures, staff vacancies and lack of resourcing.

## Interagency Working

The complexity of many child and adolescent mental health problems means that other agencies may also have to provide input as part of a co-ordinated treatment package.

Whilst liaison and collaborative working is the responsibility of all team members some identified team members take on particular responsibility for liaison with other agencies. Referring professionals and others involved are encouraged to retain involvement in a case, particularly when long-term planning and continuing care is an issue. A child referred to CAMHS should not be discharged by the referring agency without prior discussion with CAMHS. Relevant

professionals are encouraged to play an active part in the design and implementation of interventions.

Collaboration may also occur with training and the development of procedures and as part of a continuing process of service development to meet the ongoing needs of the child and family.

## Discharge

In the majority of cases, service users will be discharged when the service is not actively offering an intervention. Discharge will be back to the care of the referring agency but some cases may require referral to other agencies or other parts of the Health Service for more specialised care. If clinically appropriate, service users will have a plan of care arranged and provided on discharge. This will take into account the appropriate legislative framework.

Following discharge, a family seeking help for similar difficulties as previously presented, may request self-referral to the service when the time lapse since the date of the discharge letter does not exceed three months. If the referral is accepted, the original referrer will be informed of the self-referral.

## Staffing

The present staffing of each clinic is as follows:

### Abbey Hulton Clinic

Consultant Psychiatrist – 1.00 WTE  
Team Leader – 1.00 WTE  
Mental Health Practitioner – 1.00 WTE  
Priority Team Worker – 1.00 WTE  
Art Therapist – 1.00 WTE  
Occupational Therapist – 1.00 WTE  
Mental Health Nurse – 0.90 WTE  
Modern Matron – 0.25 WTE  
Consultant Child Psychologist – 0.45 WTE  
Psychological Therapist – 0.4 WTE  
Social Workers – 1.83 WTE

### **Blurton Clinic**

Consultant Psychiatrist – 1.00 WTE  
Team Leader – 1.00 WTE  
Community Psychiatric Nurse – 0.70 WTE  
Child & Adolescent Therapist – 0.52 WTE  
Community Mental Health Practitioner – 2.00 WTE  
Senior Social Worker Practitioner – 1.50 WTE  
Senior Clinical Nurse/Modern Matron – 0.25 WTE  
Specialist Community Mental Health Nurse – 1.00 WTE  
A Grade Psychologist – 0.50 WTE  
Community Paediatrician – 0.20 WTE

### **Ashlands**

Consultant Psychiatrist – 1.00 WTE  
Specialist Registrar – 0.8 WTE  
Team Leader – 1.00 WTE  
Specialist Nurse – 0.60 WTE  
Art Therapist – 0.94 WTE  
Clinical Psychologist – 0.8 WTE  
Senior Practitioner/Social Worker – 0.5 WTE  
Community Mental Health Practitioner – 0.8 WTE  
Specialist Community Mental Health Nurse – 1.00 WTE  
Community Mental Health Nurse – 0.4 WTE

### **Eaton House**

Consultant Psychiatrist – 1.00 WTE  
Team Leader – 1.00 WTE  
Therapeutic Social Worker – 1.00 WTE  
Mental Health Nurse – 1.00 WTE  
Clinical Psychologist – 1.00 WTE  
Priority Team Nurse – 0.8 WTE  
Mental Health Practitioner – 1.00 WTE  
Senior Clinical Nurse/Modern Matron – 0.25 WTE

Trainees from all disciplines may be working with the teams at any time. They will take on responsibilities commensurate with their level of training. Medical students from Keele University may be attached to the teams from time to time.

## **Staff Continuing Professional Development and Training**

Taking into account the wide range of referral problems and complexity of cases, it is important that staff keep themselves informed of the latest research, therapies and models of practice. It is also important that staff have the opportunity to exchange information and to contribute to an increased knowledge base for the service.

It is intended that both funding and time for training will be included in all staff members' contracts of employment.

Staff training needs will be identified at their annual IPR when job plans are reviewed. Courses will be applied for and considered within the remit of service policy, taking recognition of personal/professional enhancement and service/team needs. CAMHS has appointed a Training Co-ordinator for the whole service and we have a comprehensive training strategy, which takes into account staff's needs under New Ways of Working.

## **Responsibility**

### **Professional Responsibility**

Each team member is a member of a professional group having its own areas of expertise, systems of training and professional and ethical standards. Therefore, all team members have a responsibility to act within the competence that derives from their particular professional group. Professional responsibility to use expertise within professional guidelines and competence for the benefit of clients is relevant to all professionals' activities and in this sense, is superimposed on all the other responsibilities, which are undertaken.

### **Team Leader Responsibility**

The Team Leader has responsibility for the overall operational management of their team. They ensure clinical cover is preserved and that

administrative support is available. They manage the referral and case allocation process and monitor workload ensuring appropriate workloads are held by each team member. They delegate responsibilities under the distributed leadership process, but ensure those responsibilities are fulfilled. They have a clinical workload and are available for consultation to other team members, particularly with regard to especially complex cases.

### **Caseholder Responsibility**

All cases referred to the service are, in due course, allocated a case holder from the range of professionals who comprise the multidisciplinary teams in each locality. The case holder then takes on full responsibility for the case and the co-ordination and assessment activity negotiating and communicating any plan of intervention and reviewing and reporting on progress. The identity of the case holder is clearly communicated to all relevant parties, as is any subsequent change that may be necessary. In some instances, a number of team members may be involved in providing therapeutic input. These individuals will provide verbal and written reports of their involvement. On occasions, these may appropriately go straight to the family, General Practitioner and referrer, and on others, the key worker draws these together. It is the caseholder's responsibility to ensure that information is appropriately communicated and in a co-ordinated manner. The case holder has a responsibility following consultation with the service user to refer on to colleagues or external agencies for further assessment or action.

### **Medical Responsibility**

Medical responsibility remains with the General Practitioner. In those circumstances when medical treatment such as psychotropic drugs are prescribed or advised by a medical member of the team, then this medical responsibility is shared with the General Practitioner.

### **Line Management Responsibility**

Different line management arrangements operate for the agencies and certain professions, which comprise the service. Line management of the Social Work staff lies within the Social Services Departments. The Team Leaders line manage all health staff except doctors and psychologists. Team Leaders account to the General Manager. Doctors are line managed by the Children's Services Clinical Lead and psychologists by the CAMHS Consultant Psychologist who accounts to the Head of Child Specialty (Psychology).

The goals and objectives of the service have primacy over individual or professional interests. Professional advice is sought regarding issues that affect a particular profession.

### **Consultation Responsibility**

Consultation is one of the range of interventions utilised by the teams in responding to cases referred to the service. This may be with a professional or professionals only or this may be to a therapeutic system which comprises of professional(s) and the patient(s). The consultation may occur in instances when the case under discussion has not been referred to the service at this stage.

In the situation of consultation, the consultant does not have formal clinical responsibility and what passes between the consultant and the consultee is advice. The consultee is under no obligation to heed it. The consulting professional's responsibility encompasses the duty to provide advice to the best of his/her ability and consistent with his/her level of training.

The consultant has responsibility to make it known to the consultee if the case raises matters, which are beyond the consultant's area or level of expertise and, if appropriate, direct the consultee to other professionals with the relevant expertise.

## Professional Support and Supervision:

Consultation & Supervision arrangements are dealt with by a separate Trust wide Policy. However some specific CAMHS issues are covered here.

In ensuring the highest quality of service and clinical intervention, there is a commitment to the professional support of team members and this occurs in a number of forms and at a variety of levels. It is accepted that co-working, professional consultation, ad-hoc discussions, and case presentations are valuable opportunities for team members to benefit from support with their clinical work. This form of professional support is available via the individual's immediate team colleagues. There are regular team group supervision sessions. These are non-hierarchical and operate outside of the line management structure.

Some therapeutic relationships require more detailed examination of the dynamics involved and it is accepted that support of this nature can be undertaken by a colleague acting as a professional support out of the individual's immediate team and indeed out of the CAMHS itself. Funding for this must be agreed with the Team Leader and Service Manager.

## Supervision of Trainees

When trainees from a range of disciplines appropriate to the work of the service are placed within teams, the responsibility for the work of the trainees lies with the identified supervisor. This arrangement is explicit prior to the commencement of a placement. The supervisor takes on an element of clinical responsibility because the supervisee can be made to comply with direction by the supervisor regarding assessment and therapeutic work in a case. The supervisor has a responsibility to ensure that the supervisee has training to conduct the work. The supervisor also has a

responsibility to make it known to the supervisee if the case raises matters that are outside the supervisor's area or level of expertise and to either direct the supervisee to other professionals with the appropriate expertise or to seek advice from those individuals themselves. If the supervisor considers the case is beyond the competence of the supervisee, he/she has responsibility to take on the case him/herself to ensure that the appropriate professional resources are brought to bear. The supervisee has a responsibility to carry out the supervisor's instructions and to keep the supervisor adequately informed about the progress of work with the case, in particular, bringing to notice matters, which they consider outside their competence. In the event that the supervisee is not prepared to carry out the supervisor's instruction, they can give up working with the case, in which case, full responsibility passes to the supervisor.

## Records/Case Notes

These are the property of Combined Healthcare NHS Trust. The Social Work module contained within them and letters signed by the Staffordshire Social Worker are the property of Staffordshire Social Services Department. Jointly signed letters are jointly owned. Stoke Social Workers record directly into the notes and these case notes are regarded as jointly owned.

Case notes are multidisciplinary and collaborative, documenting service involvement, therapy and information collected from other agencies.

The service fully complies with the legislation concerning the storage of notes/files and access to them, in accordance with Access to Health Records, Combined Healthcare and Data Protection, 1983.

Case notes are held within locked rooms and/or locked cabinets within areas covered by intruder alarm systems.

Art Therapy images are held in accordance

with the guidelines laid down by the British Association of Art Therapists.

Videotape recordings are stored under the same conditions as written case notes. Erasure of tapes takes place at a point agreed with the consenting families, or at least when a case is closed, unless consent was obtained for training or research usage. In that event, the decision of when to erase rests with the team member who obtained the consent. (See below, section on Observation, Video Links and Videotaping.)

## Confidentiality and Consent

### 1) Confidentiality

As a matter of routine, the service provides written report on its work to families, the referrer, General Practitioner and Community Child Health Service (when relevant). Families are informed of this. Where possible, objections to this are respected. If objections render professional work with the family impossible, this is explained to the family.

All team members are bound by strict rules regarding the confidentiality of the information they receive and have to use their professional judgement in deciding their actions in matters of confidentiality, using the following principles.

- a) All service users have the right to expect that information given in confidence will be used only for the purpose for which it was given.
- b) All service users have the right to expect that their confidentiality will be respected and breaches, other than with their consent, should be exceptional.
- c) Service users have the right to expect that information about them is held in secure and private storage.
- d) If it is seen as necessary and appropriate to share information about a service user with practitioners from another agency, then the team members should ensure that this is

being imparted in strict professional confidence and for a specific purpose.

- e) The responsibility to either disclose or withhold confidential information in the public interest, including Child Protection concerns, rests with the individual professional, who must have considered the matter sufficiently to justify the decision. This responsibility cannot be delegated. In this context the term 'public interest' relates to matters of Child Protection Reasons for decisions of this nature are recorded in the notes.
- f) Information concerning service users, when those service users are clients of agencies outside of the wider organisation, can only be divulged by a professional team member. Secretarial staff do not divulge this information. Generally, the enquirer is known, but when this is not the case, a contact number is requested and a team member will use this to contact the enquirer. Additional proof of identity may be required. The judgement on whether to disclose any information rests with the team member. Reasons for this decision will be given.
- g) Requests for access to notes/files by members of other agencies, including Adult Mental Health Services, can only be granted with the written consent of the family and professionals directly involved within the case. The only exception is when parental refusal is viewed as contrary to the best interests of the child.
- h) Service users have the right to access their medical records subject to Guidelines Under the Access to Health Records Act 1999.
- i) When a pre-appointment Professionals' Meeting has been requested in respect of a 'potential' service user, the referrer will be requested to obtain consent to such a meeting from the child/parent(s)/carer(s), unless held under Child Protection procedures as a Strategy Meeting.

## 2) Consent

The Department of Health and the Welsh Office (1990) proposed a definition of consent as 'The voluntary and continuing permission of the patient to receive a particular treatment based on adequate knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it.' Children under 16 years can give valid consent if they have 'sufficient maturity to understand what is involved. Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence.'

CAMHS staff have a responsibility to guide service users towards treatments and approaches that they believe are in the child's best interests. This is the key position providing clear information and communicating it in such a way as it can be adequately understood within the context of a supportive and trusting relationship.

Refusal to consent or a withdrawal of this may reflect knowledge and/or beliefs of the service users that conflict with the views of the CAMHS team members. It may also reflect anger, anxiety, and a limited capacity to understand the nature of the request or simply a misunderstanding about what is required.

In consenting, a service user should be able to understand the nature of the problem or disorder. The significance of any risks or benefits from interventions should also be understood, as should the likely effect of non-intervention. This needs to be in relation to the passage of time and the potential effects in the future of a particular intervention or of no intervention. Whatever the age or level of maturity, the views of children are sought, recorded and taken into account when decisions about service involvement and approaches are made.

Young people of 16 years and over may seek the involvement of the service without recourse to parent/carer. In this respect, consent given is viewed in the same way as

consent given by an adult. However, having heard and understood the reasoning behind parents, for example, being excluded, the service may guide the young person to involve and include significant others who may have a view on problems and solutions and may be affected by these. In these situations, any rights of those with parental responsibility are given consideration before decisions are made.

## Observations, Video links and Video Taping

The CAMHS team may use observation suites involving a one-way mirror and interconnecting system, or involving a video link to a TV monitor. The intention to use observation and the purpose of this is explained to service users in advance of the session. An opportunity to meet observing team members is provided. If families or individual family members object, then the method of observation is not used or is modified to suit the family's express wishes. If objections are made when a session is already under way, this would mean ceasing observing and switching off associated equipment.

In sessions where observers may interrupt, this and the method to be utilised is also explained and agreed with the family. During any break in which consultation with the observing team takes place, all means of observing the family cease to be used.

A video tape recording of work with a service user or family may be made on occasions. Written consent is obtained beforehand, based on a full explanation of the reason and use to be made of the tape and boundaries of confidentiality. Families and service users are informed that they may withhold consent without prejudice to the service they will receive from CAMHS. Service users can also withhold consent to a particular use to which a tape could be put and this is indicated in what is and what is not being consented to.

Service users can have an opportunity to view the tape in the format it is intended to be used and may subsequent to this, withdraw consent to its use. Families and service users can request that a tape is erased and this is acted upon, with the only exception occurring when a tape or tapes are required by a Court of Law. When a court has requested a videotape recording or identified the papers being of significance, the tape is retained by the Trust until the child concerned reaches the age of majority.

The purposes of videotaping are:

- 1) To facilitate assessment
- 2) To assist the design and implementation of therapeutic interventions or provide feedback for service users
- 3) To assist in the development and training of CAMHS teams' members, including students on placement with the service
- 4) To provide material for use by CAMHS team members in the training of professionals external to the service
- 5) To provide an audio-visual record for use in research

In deciding whether or not to make a video recording, team members balance the potential benefits of this, with any possible harmful or counter therapeutic consequences for the service users and families.

When using tapes for training purposes, it is the responsibility of the CAMHS team members to make it clear that the content of the tape is privileged information and this should not be revealed to anyone outside the audience. The team members should also check that no member of the audience has a relationship with a service user on the tape, other than a professional. If a member of the audience recognises a patient in this way, then the material should not be used or an opportunity created for the member of the audience to leave the session.

## Monitoring, Audit and Quality Assurance\*

### 1) Monitoring

Workload and activity is monitored through the CHIPS system. This system is currently under review as it is recognised as having limitations that impairs the utility of data produced by it.

### 2) Audit

Clinical audits will be regularly carried out with the assistance of the Trust's Audit Department.

### 3) Quality Assurance

Quality monitoring indicators will be used to assure high quality standards. These indicators and quality assurance activity will include:

- a) Indicators of responsiveness, such as time from receipt of referral to initial appointment
- b) Time taken to expedite communication to referrers and families and waiting times within the departments when patients attend appointments
- c) Consumer satisfaction: Regular assessments will be made of patient and referrer satisfaction and steps taken towards its enhancement.
- d) Outcome measures: Appropriately validated instruments, such as the Strength and Difficulties Questionnaire, self reported evaluation forms etc will be used routinely to provide an indication of clinical outcomes
- e) Information about the service will be provided for referrers and patients and the accessibility and value of this will be evaluated
- f) The service will examine ways in which user groups may provide feedback and influence services provided
- g) The service will examine ways to make itself more accessible to ethnic minority groups

\* This is currently under review and is likely to change following negotiation with commissioners

## Complaints

All complaints to the service should be received courteously and sympathetically. In the first instance, any complainant should be encouraged to discuss the matter with the relevant key worker and/or their line manager, as complaints are frequently a consequence of failed communication and can be thus resolved at an early stage. If the complaint cannot be resolved or if this way of acting is unacceptable to the complainant, then they should be encouraged to put their complaints in writing to the Trust Complaints Department. Complaints relating specifically to Social Workers, need to be directed to Social Services Management and leaflets are provided explaining the process required.

## Working Within a Legal Framework

### 1) Children Act 1989

At all times, due consideration and weight are given to the provisions of the Act.

### 2) Mental Health Act 2007

The Act is rarely used with children. It is this Service's policy\* to use the appropriate legislative route wherever permission to treat is sought. However, it remains a possibility if it is deemed necessary, after consultation with the parents/guardians and multidisciplinary team, that the Mental Health Act be implemented.

### 3) Safeguarding Children

The service is working towards all staff being fully conversant with Safeguarding Children Procedures by ensuring:

- 1) All staff, including trainees have access to the relevant Local Safeguarding Children Board Training Programme at the appropriate stage for their level of competence and the needs of the service.
- 2) Staff are familiar with the relevant Local Authority's Procedures.

Where Safeguarding Children concerns are identified the CAMHS Professional should share their concerns by following the Safeguarding Children procedures for the relevant Local Authority.

Where a child is on the Safeguarding Children Register

- 1) Communication with Social Services Department will be automatic and this will be explained to parents/carers at the outset
- 2) Any significant incident must be referred to Social Services and confirmed in writing by completing a multi agency form within 24 hours CAMHS addresses Safeguarding Children issues on a regular basis through team meetings.

The Senior Management Team address Safeguarding Children issues quarterly.

## Medical Emergencies

The service carries no emergency medical equipment. In the event of such emergencies, services will be utilised via the 999 procedure.

Until the arrival of Emergency Services, staff will use basic first aid/CPR techniques for which yearly refresher training will be provided.

## Health and Safety Procedures

Accidents at work are recorded using the appropriate form. Social Work staff complete an accident form for both the Trust and Social Services Department.

Procedures in respect of Staff safety follow Trust Policies and Social Services Department Policies for Social Workers.

Training in managing aggression and violence is offered to all staff.

All staff have a responsibility to follow Safety of Staff Policy and Procedures. Where a family member is known to be violent or aggressive, consideration is given to the best management of the case, consistent with staff safety.

## Priority Referral Team

### Operational Policy

The Priority Referral Team (PRT) comprises four staff. They form part of community CAMHS and are based within the four district teams. They have their own part-time secretary who is based at Abbey Hulton clinic and can be contacted on 01782 427920. The secretary will act as a point of referral from either paediatric/medical ward or the district CAMHS team. The PRT member will be on duty from 9-5pm Monday to Friday.

### Referrals from Paediatrics

Referrals regarding patients who have been admitted due to self harming behaviour or significant mental health difficulties must be phoned through before 10am in order to be seen on that day. Should the young person have current CAMHS involvement, the PRT worker will invite the case-holder to join them on the assessment in the promotion of good practice.

### Referrals from community CAMHS teams

Referrals must be submitted before 1pm to be prioritised for that day. If an immediate response to a situation is required and the priority team member is already committed to other Priority work, responsibility to see the case will lie with the district team. Should the young person have current CAMHS involvement, the PRT worker will discuss the appropriateness of who should respond in order to promote continuity of care.

### **For both paediatric referrals and community referrals, sufficient, detailed information must be available in order for the priority team to respond.**

The service provides assessment for young people up to the age of 18 (if in F/T education) within North Staffordshire. Clinical responsibility and authority for district referrals remains with the Team Leader for each team. Paediatric referrals remain the responsibility of the Consultant in paediatrics until discharged from the ward.

**Following assessment**, the PRT member may offer short term intervention, refer the case to the district team or close the case should no follow-up be required. Whichever management plan is decided upon, the district team leader will receive a copy of the assessment letter for reference.

The established PRT member can discuss assessments with the district Consultant. Should they be unavailable, the on-call Consultant can be contacted.

## Supervised training programme

The PRT members who are part of the ongoing supervised training programme **MUST** discuss all assessments with a Consultant in order that assessment outcomes and care pathways are clear and safe.

The PRT members who are part of the ongoing training programme will be closely supervised by their Team Leader and PRT colleagues. The outcomes of the objective setting will be monitored by the Team Leader, Modern Matron (community), General Manager and PRT colleagues. On completion of objectives, PRT member will work to agreed protocol/operational policy.

**Case notes** will be registered with the appropriate district consultant and stored at Abbey Hulton clinic or with the appropriate community team. Upon closure, the notes will be transferred to the relevant district team.

**Line management/supervision** for PRT members lies with the General Service Manager. The PRT members will meet on a monthly basis for peer supervision.

Continuing professional development and training, professional responsibility, key-worker responsibility, professional support and supervision, records/case-note, confidentiality and consent, complaints, health and safety, consultation and liaison, are all dealt with by North Staffordshire Combined Healthcare NHS Trust CAMHS Operational Policy.

# Appendix II

## New ways of working in CAMHS

### Project Evaluation Plan

#### Background

North Staffordshire Child and Adolescent Mental Health Service (CAMHS) has been selected as an early implementer site for New Ways of Working in Child and Adolescent Mental Health (NWW CAMHS). A project steering group led by Dr Jonathan Lovett (Clinical Lead for CAMHS) proposed a pilot project to examine the full implementation of NWW across a whole specialty community CAMHS. In this way the North Staffordshire project is unique, other pilot sites having chosen to address specific aspects of the delivery of CAMHS.

The underlying principle of NWW for Psychiatrists is to ensure that Consultant Psychiatrists focus on those clinical cases where their particular skills are most appropriately used and that they do not take work that other members of the multidisciplinary team (MDT) are equally competent to do. In practice in North Staffordshire this model of MDT working is already in operation. The NWW CAMHS Pilot project will therefore focus on formalising these working arrangements. This will involve the negotiation and rewriting of Consultant Job Plans which in turn will have implications for the activities and job plans of multidisciplinary team staff which will also be reviewed. The service operational policy will be rewritten to encompass the changing role of staff. There will be implications for consultation, supervision and training of staff. It is an essential component of the project that the impact of these changes on children their carers and staff is evaluated.

#### Aims

The overall aim of the proposed evaluation is to examine the impact of implementing NWW CAMHS on children, young people and their families, and staff working within CAMHS in North Staffordshire. The specific aims are to:

- 1) Examine the impact of NWW CAMHS on waiting times and clinical activity
- 2) Examine the impact of NWW CAMHS on child and carer satisfaction
- 3) Examine the impact of NWW CAMHS on clinical outcome
- 4) Describe the experience of children and carers of NWW CAMHS
- 5) Describe the experience of multidisciplinary team (MDT) CAMHS staff of NWW CAMHS

#### Methods

The evaluation will draw on both qualitative and quantitative methods in order to best address the objectives identified above. The study will be located in the North Staffordshire CAMHS and will include the four MDT's (Ashlands, Staffordshire Moorlands, North Stoke, Abbey Hulton).

#### Quantitative measures

Currently within CAMHS in North Staffordshire there are established mechanisms for routine data collection. Clinical activity is recorded by the Trust (CHIPS) and also by individual teams. Validated self-report measures are completed by families and clinicians at the point of first assessment and again at discharge. Measures are also administered at six monthly intervals to those families who are engaged with services for longer periods of time. At discharge, families are asked to complete a satisfaction measure. These measures (listed below) will be used to address the project objectives. Data for the 12 months preceding

the implementation for NWW CAMHS will be compared with that for the duration (12 months) of the NWW CAMHS pilot.

- Clinical activity data (CHIPS and team data) Objective 1
- CHI child/carer satisfaction measure Objective 2
- Strengths and Difficulties Questionnaires Objective 3
- CGAS/CGI Objective 3

### **Qualitative measures: Objectives 4 and 5**

Focus groups will be used to examine the experiences of families and staff of NWW CAMHS. Users and carers are actively involved in the Trust's Team 21 approach. A key component of this is the use of carer focus groups by each of the CAMHS teams to explore families experiences of attending CAMHS and to seek their views about how services might be improved. These groups will be used to explore families' experiences of NWW CAMHS.

Focus groups will also be convened to examine the experiences of MDT staff across the four CAMHS teams.

Stimulus material for both the carer and MDT staff focus groups will be developed by the project steering group.

### **Procedures**

The proposed project represents a service evaluation and therefore does not require the approval of the Local Research Ethics Committee (see COREC website).

### **Quantitative data collection**

As described above the administration of the quantitative measures to be employed in the evaluation is a routine part of day-to-day clinical practice across the four CAMHS teams. The project steering group will

oversee data collection by liaising with key members of the clinical teams. The Trust Audit Department have agreed to facilitate the scoring of measures.

### **Qualitative data collection**

All focus groups will be audio-taped and the tapes transcribed. The tapes will then be destroyed but transcripts will be kept for 10 years in keeping with the requirements of research governance.

User focus groups will be arranged by CAMHS teams according to their usual practice. An information sheet will be developed which will describe that in addition to the usual function of the focus group, information will be used to help examine the impact of NWW CAMHS. The information sheet will include details of the procedures for audio-taping groups.

MDT focus groups will be convened by the Team Leaders and will be facilitated by two members of the project steering group. Groups will be conducted during work time and participation will be voluntary. An information sheet will be developed describing the purpose of the groups and the details of the procedures for audio-taping.

All documentation relating to the project will be managed in keeping with the requirements of research governance and the Data Protection Act.

### **Data analysis**

Quantitative data will be subject to appropriate descriptive statistical procedures.

Focus groups and interviews will be audio-taped and transcribed. Transcripts will be subject to content analysis to identify key themes. The project steering group will work collaboratively to develop a comprehensive coding frame paying particular attention to differences in interpretation. Categories used will reflect both focus group questions/ stimulus material and any other issues raised by respondents.

## Outcome

The results of the evaluation will be used to consider the future implementation of NWW CAMHS in North Staffordshire. The results of the evaluation will be incorporated in the project final report which will be disseminated to:

- NWW CAMHS Programme
- North Staffordshire CAMHS MDT Staff
- North Staffordshire CAMHS Senior Management Group
- North Staffordshire Combined Healthcare NHS Trust Children's Board
- Staffordshire and Stoke CAMHS Strategic Commissioning Groups
- The West Midlands Specialist Advisory Committee for Child and Adolescent Psychiatry
- The Clint Audit Group

A summary of the report will be prepared for children and their carers. In addition the evaluation will be written up for presentation at local, national and international conferences and in peer reviewed journals.

# Appendix III

## Child and Adolescent Mental Health Services (CAMHS)

### Tier 3

### Draft Job Description

<b>Job title:</b>	Clinical Team Manager CAMHS Tier 3
<b>Grade:</b>	BAND 8A
<b>Hours:</b>	37.5 per week negotiable clinical/ management depending on size of team
<b>Accountable to:</b>	Children's Service Manager
<b>Reports to:</b>	Children's Service Manager
<b>Locality:</b>	Stoke and/or North Staffordshire
<b>Base:</b>	Abbey Hulton or Eaton House

### Job overview:

The primary functions of this post are:

- 1) To take overall management responsibility for all aspects of service delivery and operational matters, for one of the three locality CAMH Community teams.
- 2) To assist with the modernisation and redesign of the CAMHS tier 3 teams leading on agreed projects across the county.
- 3) To develop robust interagency relationships with PCAMHS Children, Young people and Families directorate, and other key agencies, supporting the development of integrated care pathways.

## Key Relationships

- Service Manager CAMHS
- CAMHS Management team
- Clinical teams
- PCAMHS
- Tier 4 services.

## Key Objectives

- To take operational responsibilities for the Locality Team. This includes monitoring and managing workloads, use of time, operational supervision, authorising leave and expenses.
- To take a lead role in the implementation of the tier 3 review, this will include leading on particular projects across the County these will include embedding CPA, case management, developing a community focussed model of service delivery.
- To work in partnership with key agencies to support, the roll out of Lead Professionals, team around the Child, the use of CAF and single point of access
- To support the development of integrated care pathways
- To manage the pay and non-pay budgets for the Locality team and to keep costs within these agreed budgets. Where appropriate, and with agreement, to apply these budgets flexibly to develop evidence based services in line with local needs and national drivers.
- Develop robust case management supervision structures.
- To ensure Young People and Carers are included in all the work we do and structures are developed to incorporate users at all levels
- To work closely and co-operatively with professional leads to recruit, retain, supervise and develop clinical staff. To jointly manage, as appropriate, appraisals and disciplinary processes.

- To oversee and improve the running and organisation of the CAMHS Teams and to ensure there is effective and efficient use made of multi-disciplinary working.
- To ensure that there are good operation procedures for all aspects of the Service
- To build strong strategic and operational relationships between CAMHS Locality Teams and services for children with PCAMHS, Children Young people and Families, in-patient services and with adult mental health services.
- To ensure that all sites and services have, and use, adequate and up to date policies including those for fire, health and safety and environmental risk.
- To contribute to the overall management, running and development of CAMHS at all Tiers
- To ensure that the Service is friendly and responsive and deals with complaints and suggestions in a timely and efficient manner.
- To co-ordinate and investigate complaints and SUI's
- To provide cover for the other Team Managers or the Service Manager as required

## Key success areas

- Embed CPA and Care Coordination within the
- Play a lead role in supporting and developing a new workforce to provide a flexible community based service.
- To be a key change agent modernising CAMHS within a multi agency context.
- To work in partnership with CYP and Families Locality Managers to roll out Common assessment Framework, team around the child and Lead Professional.
- Ensure ECM and NSF performance targets are met.

- Undertake Project work (for example implementation of the choice and partnership approach).
- Represent CAMHS at a range of multi agency forums Demonstrate understanding of Education, CYP and Families, DAAT, YOT.
- CAMHS mapping lead for locality team.

**This job description should be regarded only as a guideline and may be amended in the light of changing circumstances following consultation with the post holder.**

Education & Qualifications	Professional Mental Health qualification, e.g. RMN or DipSW	Educated to degree/diploma level ECDL	A A
<b>Skills, abilities</b>	<p>Ability to communicate to a wide range of people, senior managers, staff, children young people and Families, other agencies.</p> <p>Is able to communicate well verbally and in other writing, demonstrates an ability to negotiate, persuade and motivate.</p> <p>Able to prioritise work load and develop systems to aid efficiently. Capable of leading and managing the change process.</p> <p>Ability to use a range of leadership and facilitation skills.</p> <p>Well developed analytical and investigatory skills. Ability to interpret a complex range of information, clinical, financial, national and local and make sound plans and recommendations from this.</p> <p>Able to work across professional boundaries.</p> <p>Presentation skills.</p> <p>IT Skills</p>	<p>Understanding of Government policy and targets relating to Children's Services</p> <p>Experience of demand and capacity issues.</p>	<p>A,I</p> <p>I,P I,R I,P A,I A,I</p> <p>I,P,R A,R A,R</p>

<b>Education &amp; Qualifications</b>	<b>Professional Mental Health qualification, e.g. RMN or DipSW</b>	<b>Educated to degree/diploma level ECDL</b>	<b>A A</b>
<b>Experience</b>	<p>Be able to demonstrate a range of management experiences across a range of care groups or agencies.</p> <p>Experience of managing multi disciplinary teams.</p> <p>Demonstrate a good level of understanding of performance and budgetary management.</p> <p>Project management.</p> <p>Sound understanding of CPA systems.</p> <p>Experience of case management.</p>	<p>Demonstration of achievement in relation to service objectives.</p> <p>Management and development of staff.</p> <p>Implementation and management of successful change/ quality/practice development projects.</p> <p>Prince 2 training</p>	<p>A A,I,R A,I,R A,I A,I,P,R</p>
<b>Knowledge</b>	<p>A professional knowledge that is under pinned by a management training or equivalent experience</p>		<p>I,P A,I,P</p>
<b>Special Aptitude</b>	<p>Tenacious and resilient.</p> <p>Self motivated and dynamic.</p> <p>Organised and Assertive.</p> <p>Have a driving license.</p>		<p>I,R I A,I A,P,I,R</p>

# Appendix IV

## North Staffordshire Combined Healthcare NHS Trust Child & Adolescent Mental Health Service Consultant Job Plan (Old Contract)

Job Plan: .....

Base – North Stoke CAMHS, Abbey Hulton Clinic, Stoke-on-Trent

**This Job Plan is written as a part of the New Ways of Working Early Implementer Site Project. Its implementation, therefore, is dependent on wider systems change. Until those systems change, the alternate Job Plan applies.**

### 1) Job Content (Fixed Sessions)

Day	Time	Location	Work
Monday	PM	Abbey Hulton Clinic (AHC)	Outpatient Clinical Work
Tuesday	AM	AHC	Multidisciplinary Team Referrals Meeting
	PM	AHC	Outpatient Clinical Work
Wednesday			
Thursday	AM	AHC	Outpatient Clinical Work
	PM	AHC	Consultation work
Friday	AM	AHC	Outpatient Clinical Work

**Note:**

- 1) Outpatient Clinical Work is broadly defined to include Direct Clinical Work, Indirect Clinical Work, engaging in further specific training to allow role development under NWW, and teaching and training of others.
- 2) Non fixed sessions are devoted to administrative and management activities, other Continuing Professional Development activities, Audit, and activities identified in Section 2.5 and Section 5.

## 2) Objectives and how they will be met:

### 1) **Direct Clinical Work:**

To work directly with complex psychiatric cases requiring medical input. This is defined as those situations where the use of the Mental Health Act might be considered, together with those patients who appear to have neuropsychiatric and neurodevelopmental problems. This work will include both diagnostic and treatment work.

### 2) **Indirect Clinical Work:**

To offer consultation to other members of the multidisciplinary team relating to cases of the sort identified in Para 1 above. These consultation sessions will be delivered at a specific time or times each week. To supervise the work of a Nurse Prescriber when appointed. To offer consultation to Primary Care Staff in Health, Education and Social Services in cases of the sort defined in Para 1 above. To be available to the Team Leader or her Abbey Hulton Clinic Deputy to discuss complex cases on a consultative basis as and when required.

3) To undertake further specific training in Neuropsychiatry and Paediatric Neurodevelopmental Disorders.

4) To participate in CPD, Audit and Clinical Governance Activities within the Trust.

5) To participate in the CAMHS Senior Management Group and other relevant multiagency planning committees, particularly with regard to Stoke-on-Trent. To take on specific roles and tasks arising out of this work.

6) To undertake training to Primary Care Service Staff with regard to neuropsychiatry and neurodevelopmental disorders.

7) To take a lead role in the development of Undergraduate Nursing Teaching in Child & Adolescent Mental Health and to contribute to Medical Student Teaching.

8) To participate in a 1 in 5 On Call Rota for the Trust's Specialist Adolescent Psychiatric Inpatient Unit at The Darwin Centre. This is not a rota for responding to emergencies arising in the Community, but is a rota responding to emergencies arising involving inpatients of the unit. This work is currently not included in your contract and as such there is no formal commitment to such participation continuing should you wish to withdraw.

### 3) Supporting Facilities & Resources required for the delivery of Duties & Objectives in Section 2:

<p><b>1) Staffing support</b></p>	<p>1) An appropriately resourced Multidisciplinary Team in line with the NSF for Children. This will include non medical clinicians with a wide range of clinical skills. These skills should include assessment skills, both general and specifically related to risk, family therapy, cognitive behavioural therapy, creative therapy and behavioural management, including parental counselling, both group and individual.</p> <p>2) A Team Leader (and Deputy) who is competent to deal with consultation to team members dealing with the most systemically complex of cases.</p> <p>3) Medical Cover – An internal rota for absences due to external duties, study leave and annual leave.</p> <p>4) Adequate management support for the general running of the service and to find an inpatient bed when one is clinically required.</p> <p>5) Secretarial and administrative support for clinical, academic and management tasks.</p>
<p><b>2) Accommodation</b></p>	<p>1) Personal Office.</p> <p>2) Adequate and appropriate clinical space for the multidisciplinary team.</p>
<p><b>3) Equipment</b></p>	<p>1) Personal computer linked to Internet.</p> <p>2) Basic clinical equipment necessary to the monitoring of ADHD, Eating Disorders and Psychotropic medication, to include access to full clinical examination facilities.</p>
<p><b>4) Any other required resources</b></p>	<p>Access to inpatient services.</p>

#### 4) Additional NHS responsibilities and/or external duties:

It is accepted that the postholder may have, or may develop, other broader roles within the Trust and for external bodies in connection with the wider functioning of the NHS. The Trust supports such activities wherever possible and where the Trust Management agrees that the external bodies concerned are valid members of the wider NHS community which it is appropriate for you to be involved with. Therefore such developments should be discussed and planned at job plan reviews, although on occasion, retrospective approval might be given.

Such activities are, by nature, unpredictable and will typically simply replace the activity which would otherwise have occurred on any given day. However, reasonable notice should be given to administrative staff wherever possible.

At present the postholders additional NHS responsibilities/external duties are:

---

---

#### 5) Other Comments or Agreements:

- 1) The various agreements made between staff and management through the Local Negotiating Committee will apply unless specifically stated otherwise. This includes the Additional Contractual Entitlements Document.
- 2) It is agreed that medical audit, some administrative work and keeping up to date with the medical literature and journals may be done on a flexible basis in a setting which is most appropriate to the Consultant, which may include the Consultant's home. Of course this does not apply to the fixed clinical sessions.

#### Signed off and agreed

Consultant name \_\_\_\_\_

Signed (Consultant) \_\_\_\_\_ Date \_\_\_\_\_

Children's Services Clinical Lead \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

# North Staffordshire Combined Healthcare NHS Trust

## Child & Adolescent Mental Health Service

### Consultant Job Plan (New Contract)

Job Plan – (Reviewed December 2007)

South Stoke Child & Adolescent Mental Health Service, Blurton Health Centre, Stoke-on-Trent.

This Job Plan is written as a part of the New Ways of Working Early Implementer Site Project. Its implementation, therefore, is dependent on wider systems change. Until those systems change, the alternate Job Plan applies.

## 1) Job Content

Day	Time	Location	Work	Categorisation	No of PAs
<b>Monday</b>	9.00 am-5.00 pm	Blurton Health Centre (BHC)	am – Special Consultation Clinic pm – General Clinic	DCA	2
<b>Tuesday</b>	9.00-9.30	BHC	Patient Administration	DCA	1/8
	9.30-11.00	BHC	MDT Meeting (3 times per month specialty Community CAMHS, 1 time per month CAMHS Disability team)	DCA	3/8
	11.00-1.30	BHC	General Clinic	DCA	5/8
	1.30-5.00		Staff Consultation Clinic	DCA	7/8
<b>Wednesday</b>	9.00-9.30	BHC	General Administration	SPA	1/8
	9.30-1.00	Various	CPD	SPA	7/8
	1.30-5.00	BHC	New case clinic	DCA	7/8
<b>Thursday</b>	9.00-1.00	BHC	Follow Ups 2nd opinions for team staff Direct Patient Support Work	DCA	1
	1.30-5.30	BHC	Children's Learning Disability Joint Clinics & Follow up appts	DCA	7/8
<b>Friday</b>	9.30-1.30	BHC	General Clinic	DCA	1
	1.30-5.30	BHC	General & Learning Disability cases & patient administration	DCA	1
<b>Saturday</b>					
<b>Sunday</b>					

**Notes:**

- 1) Special Consultation Clinic. At this clinic, new work with Primary Care professionals with or without parent being present. Once a month, this clinic is a consultation group for Education Welfare Officers.
- 2) Staff Consultation Clinic. At this clinic you will be available for consultation to specialist Community CAMHS staff.
- 3) DCA stands for Direct Clinical Activity. SPA stands for Supporting Programme Activity.

**Additional agreed activity to be worked flexibly**

Day	Time	Location	Work	Categorisation	No of PAs
Various	Various	Various	Attendance at various Committees (Medical Advisory Group, CAMHS Senior Management Group, Medical Management Committee)  Other Audit Training & Teaching (Clint Audit Group, Regional Child & Adolescent Psychopharmacology Special Interest Group)  Regional Networking and Peer Support, West Midlands Child & Adolescent Psychiatry Specialist Group	SPA	2/8

Programmed activity	Number
Direct clinical care	8 3/4
Supporting professional activities	1 1/4
Other NHS responsibilities	0
External duties	0
<b>TOTAL PROGRAMMED ACTIVITIES</b>	10

## 2) On-call availability supplement

Agreed on-call rota eg 1 in 5	1 in 5
Agreed category	A
On-call supplement eg 5%	5%

The postholder also carries out on call work for the Learning Disability Service under a separate agreement. This on call work has a frequency of 1 in 6 and can be carried out at the same time as the postholder's on call work for The Darwin Centre.

## 3) Objectives and How they will be Met:

- 1) **Direct Clinical Work** To work directly with complex psychiatric cases, particularly those requiring medical input and specialist systemic expertise. This will include those situations where the use of the Mental Health Act might be considered, together with those patients who appear to have neuropsychiatric and neurodevelopmental problems, but also includes situations where the index child is adversely affected by complex systemic factors in the family and/or the wider community. This work will include both diagnostic and treatment work.
- 2) **Indirect Clinical Work** To offer consultation to other members of the multidisciplinary team relating to cases of the sort identified in Para 1 above. These consultation sessions will be delivered at a specific time each week. To give second opinions on such cases where the caseholder remains the multidisciplinary team member. To supervise the work of a Nurse Prescriber when appointed. To offer consultation to Primary Care Staff in Health, Education and Social Services. To be available to the Team Leader or her Blurton Health Centre Deputy to discuss complex cases on a consultative basis as and when required.
- 3) To provide psychiatric input to CAMHS Disability Team. This will involve attending their multidisciplinary team meetings, joint clinics and follow up of individual children.
- 4) To participate in CPD, Audit, Clinical Governance Activities within the Trust.
- 5) To participate in the CAMHS Senior Management Group and undertake specific roles and tasks that arise out of membership of that Group.
- 6) To participate in a 1 in 5 On Call Rota for the Trust's Specialist Adolescent Psychiatric Inpatient Unit at The Darwin Centre. This is not a rota for responding to emergencies arising in the community, but is a rota for responding to emergencies arising involving inpatients of the Unit.

#### 4) Supporting Facilities & Resources required for the Delivery of Duties & Objectives in Section 2:

<p><b>1) Staffing support</b></p>	<p>1) An appropriately resourced Multidisciplinary Team in line with the NSF for Children. This will include non medical clinicians with a wide range of clinical skills. These skills should include assessment skills, both general and specifically related to risk, family therapy, cognitive behavioural therapy, creative therapy and behavioural management, including parental counselling, both group and individual.</p> <p>2) A Team Leader (and Deputy) who is competent to deal with consultation to team members dealing with the most systemically complex of cases.</p> <p>3) Medical Cover – An internal rota for absences due to external duties, study leave and annual leave.</p> <p>4) Adequate management support for the general running of the service and to find an inpatient bed when one is clinically required.</p> <p>5) Secretarial and administrative support for clinical, academic and management tasks.</p>
<p><b>2) Accommodation</b></p>	<p>1) Personal Office.</p> <p>2) Adequate and appropriate clinical space for the multidisciplinary team.</p>
<p><b>3) Equipment</b></p>	<p>1) Personal computer linked to Internet.</p> <p>2) Basic clinical equipment necessary to the monitoring of ADHD, Eating Disorders and Psychotropic medication, to include access to full clinical examination facilities.</p>
<p><b>4) Any other required resources</b></p>	<p>Access to inpatient services.</p>

**5) Additional NHS responsibilities and/or external duties:**

It is accepted that the postholder may have, or may develop, other broader roles within the Trust and for external bodies in connection with the wider functioning of the NHS. The Trust supports such activities wherever possible and where the Trust Management agrees that the external bodies concerned are valid members of the wider NHS community which it is appropriate for you to be involved with. Therefore such developments should be discussed and planned at job plan reviews, although on occasion, retrospective approval might be given. Such activities are, by nature, unpredictable and will typically simply replace the activity which would otherwise have occurred on any given day. However, reasonable notice should be given to administrative staff wherever possible.

**6) Other comments or agreements**

The various agreements made between staff and management through the Local Negotiating Committee will apply unless specifically stated otherwise. This includes the Additional Contractual Entitlements Document. It is agreed that medical audit, some administrative work and keeping up to date with the medical literature and journals may be done on a flexible basis in a setting which is most appropriate to the Consultant, which may include the Consultant’s home. Of course this does not apply to the fixed clinical sessions.

**7) Signed off and agreed**

Consultant name \_\_\_\_\_

Signed (Consultant) \_\_\_\_\_ Date \_\_\_\_\_

Children’s Services Clinical Lead \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Contact Details

<b>Lead Contact:</b>	Dr JWT Lovett, Consultant Child & Adolescent Psychiatrist, Children's Services Lead, NSCHT
<b>Name or organisation:</b>	North Staffordshire Combined Healthcare NHS Trust
<b>Contact details:</b>	<b>email:</b> <i>jonathanWT.lovett@northstaffs.nhs.uk</i>
<b>CAMHS Regional Development Worker:</b>	Helen Hipkiss
<b>Geographical area covered by project:</b>	North Staffordshire and Stoke-on-Trent





---

If you require further copies of this report please contact:

**Barry Nixon**, *National Workforce Lead for CAMHS*

**e:** *Barry.Nixon@wwl.nhs.uk*

This can also be downloaded from *[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)*

