



Nottinghamshire County CAMHS Partnership Joint Workforce Plan

2008/2009

[September 2008]

Healthy
Young
Minds

Acknowledgements

The support of CSIP within the development process and the significant contribution from the Health and Social Care Advisory Service (HASCAS) working with Nottinghamshire County CAMHS Partnership is valued.

The commitment and enthusiasm of senior leaders, practitioners and managers from Nottinghamshire Healthcare Trust, Nottinghamshire Community Health and NHS Nottinghamshire County has helped develop this Workforce Development Plan as an evolving document to proactively support, develop and equip the CAMHS workforce to deliver to the diverse and changing needs of children and young people and their families across Nottinghamshire.

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1 THE CAMHS JOINT WORKFORCE PLAN

1.1 Introduction and context

This workforce plan has been drawn up by a Workforce Project Team which initially met on 23rd March 2008, the launch of this work secured commitment and engagement from a large group of stakeholders (representatives from commissioning, human resources and a range of practitioners from provider organisations). The working group size was refined with a commitment to keep stakeholders informed of the progress.

The plan covers the period 2008-11, which aligns with the timeframe of the CAMHS Strategy 2008-11. The Workforce Plan will be refreshed to reflect CAMHS Mapping information and local Health Needs Assessment intelligence in April 2009 and 2010 .

1.2 Scope

At the time of development of the Workforce Plan, the available CAMHS Mapping Data (2007)* did not capture new service investment in targeted CAMH provision – namely District Emotional Health and Well-being Teams delivered by Nottinghamshire Community Health from 2008-09, or the remodelling arrangements within CAMHS workforce employed by Nottinghamshire Healthcare NHS Trust (NHT). The remodelling was effective from May 2008.

The plan therefore places emphasis on the NHT workforce working in the directorate of child and adolescent mental health. The directorate represents what is known nationally as a specialist CAMHS. References to CAMHS are made within the following commonly used framework. The refreshing of the document in April 2009 will provide an important opportunity to capture CAMHS Mapping Data (2008) that is reflective of the current targeted and specialist CAMHS provision and configuration in Nottinghamshire County.

Tier 1 (Universal Services)

Services that promote mental health and emotional wellbeing for all children and young people; are able to identify problems early in their development, support the needs of children with mild early stage problems. Service Providers: schools, children's services, GP's, health visitors, school nurses.

Tier 2

Services that;

- Work with universal service providers to promote mental health and emotional wellbeing and identify and address problems early in their development through training, consultation and support;
- Support children and young people with moderately severe problems through community based and integrated children's provision e.g. extended schools, children's centres.

Tier 3

Services supporting children and young people with severe and complex problems that require input from a multidisciplinary team of child and adolescent mental health specialists.

Tier 4

Services supporting children and young people with very serious problems that require specialist treatment that may include inpatient and secure services

1.3 Purpose

This plan addresses the recruitment and retention of staff in specialist CAMHS (Tiers 2, 3, 4) as well as education and training, as it relates to CAMHS, of staff working in all universal, targeted and specialist services (Tiers 1, 2, 3, 4).

1.4 Policy context

This workforce plan aims to fulfil objectives of national and local policy and strategy. National guidance concerning workforce for CAMHS can be found in several key publications. Particularly significant guidance is listed below:

1.4.1 National policy

Department of Health (2004) National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06–2007/08.¹

This document sets out the framework for all National Health Service (NHS) organisations and social service authorities to use in planning over the next financial three years. It looks to Primary Care Trusts (PCT's) and Local Authorities (LA's) to lead community partnership by even closer joint working to take forward the NHS Improvement Plan.

Building on joint work on Local Strategic Partnerships (LSP's), they will need to work in partnership with other NHS organisations in preparing Local Delivery Plans (LDP's) for the period 2005/ 06 to 2007/ 08.

Specifically, meeting the requirements set out under *Local Target Setting*, the workforce planning group will ensure that this plan:

- is in line with population needs;
- addresses local service gaps;
- delivers equity;
- is evidence-based;
- is developed in partnership with other NHS bodies and LA's; and
- offers value for money.

CSIP/NIMHE (2007) Mental Health: New Ways of Working for Everyone²

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

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

¹ <http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf> 3

² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490

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

NWW should be an explicit strategy and direction for the whole of the mental health workforce. (pages 8-9)

Implications for the workforce planning team include consideration of:

- new roles
- role re-design - clear role definition, staff working according to their expertise/specialism, roles designed around skills required
- creating capable teams.

Department of Health (2004) National Service Framework for Children, Young People and Maternity Services³ (Core Document)

This is the main policy driver for CAMHS and children's health, and states:

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

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

The workforce planning group will address workforce requirements by referring to local evidence of need and demand, correlating this information with evidence of what works.

³ <http://www.dh.gov.uk/assetRoot/04/09/05/66/04090566.pdf> 5

Department for Education and Skills (2004) Every Child Matters Children's Workforce Strategy⁴

Our vision now is of a world-class children's workforce which:

- strives to achieve the best possible outcomes for all children and young people and reduce inequalities between the most disadvantaged and the rest;
- is competent, confident and safe to work with children and young people;
- people aspire to be part of and want to remain in – where they can develop their skills and build satisfying and rewarding careers; and
- parents, children and young people trust and respect (page 6).

We will:

- support the development of local workforce strategies;
- strengthen safeguarding and improve outcomes for looked after children;
- tackle the key strategic challenges.

To do this we set out action to:

- improve recruitment, retention and the quality of practice;
- bring services together around the needs of children, young people and families;
- strengthen leadership, management and supervision (page 17).

The workforce planning group will ensure that this CAMHS workforce plan is fully compatible with the children's services workforce planning and development.

1.4.2 Local policy

This plan is also linked to the Nottinghamshire CAMHS strategy, which in turn feeds into the Nottinghamshire Children's and Young Peoples Plan 2007-2009 and Local Area Agreement (LAA) Targets. Synergy needs to be captured with the Nottinghamshire County Adult Mental Health Strategy and the CAMHS Strategy for the City of Nottingham.

Within the CAMHS strategy objective 6.7 states:

Workforce

Commissioners and providers work together to ensure the available workforce is sufficient and competent. A collective and proactive Workforce Planning process informs the strategic planning process. There is investment in the development of new roles and competencies to meet the specific needs of children and young people who present with a range of mental health needs. Staff who provide services for children, young people and their families receive appropriate supervision, training and development opportunities. Systems are implemented to QA services.

The vision of NHT is of "an organisation whose needs are matched by the skills development of our staff." (Annual Report 2007)

⁴ http://www.everychildmatters.gov.uk/_files/7D2DD37746721CC8E5F81323AD449DD7.pdf

2 LOCAL POPULATION PROFILE AND MENTAL HEALTH NEED OF CHILDREN AND YOUNG PEOPLE

2.1 Total Population and Age Profile

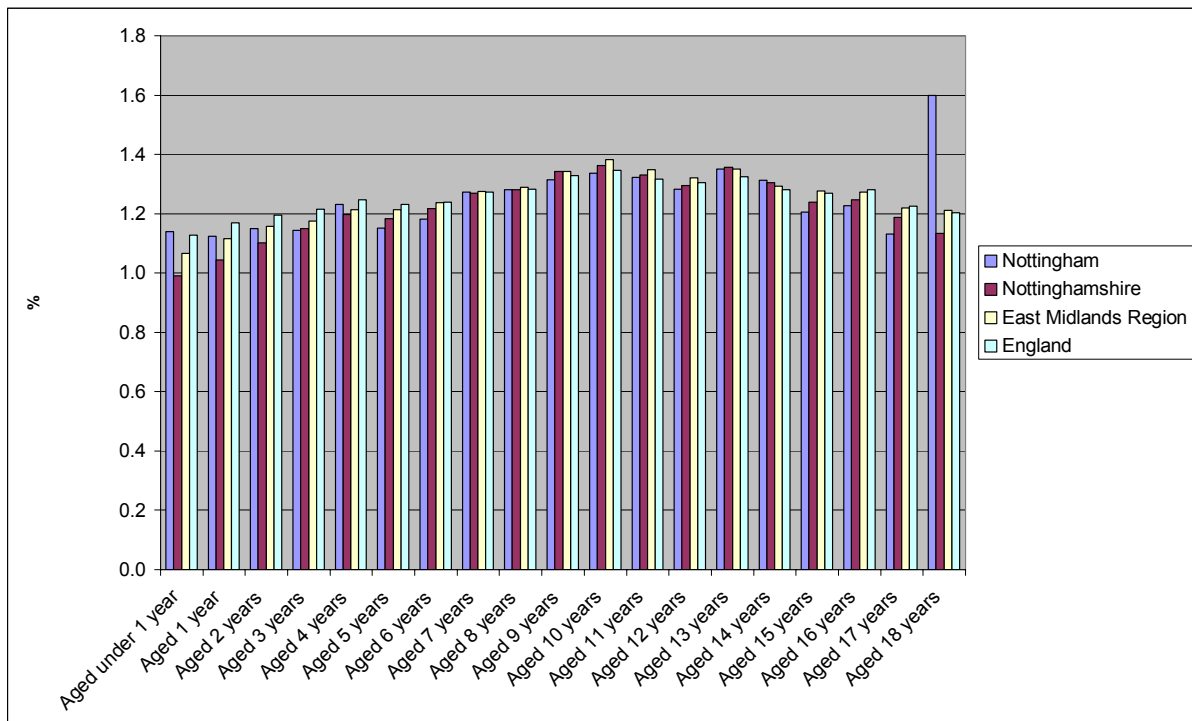
Across Nottingham city and county the proportion of under-19s is close to that of England and the East Midlands region, just very slightly lower.

Table 1 Comparative population data across Nottingham, Nottingham, East Midlands, and all England⁵

	Nottingham UA	Nottinghamshire	East Midlands	England
All Ages	286,400	769,100	4,364,200	50,762,900
0-19 years	68,800	180,700	1,055,400	12,341,200
Percentage of total	24.0%	23.5%	24.2%	24.3%

Figure 1 below shows the distribution of ages within the populations (using 2001 census data), again compared with England and the east Midlands region. There are no discernible differences excepting at age 18, where the city is markedly higher. This looks like an anomaly, and in any case this age group is now out of the CAMHS age population.

Figure 1 Comparative populations between Nottingham, Nottingham, East Midlands, and all England (ONS Census 2001)



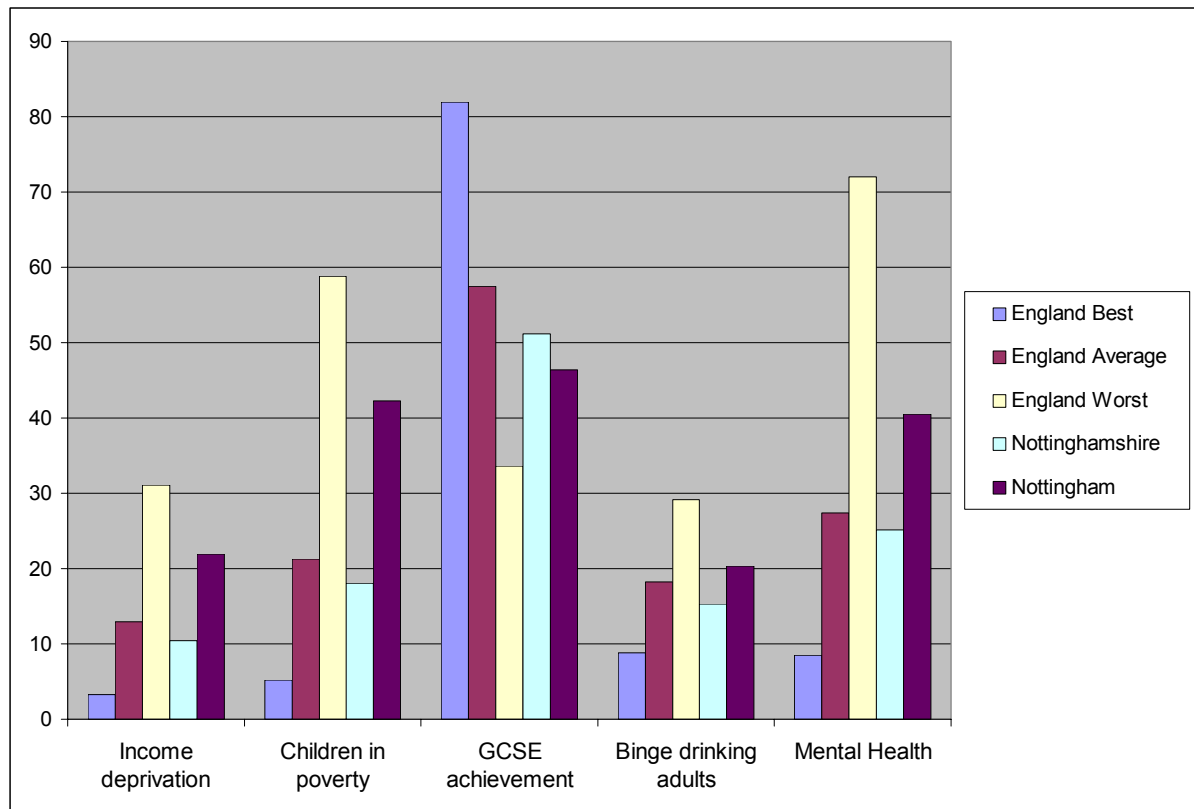
⁵ Source: ONS Mid year estimates 2006

2.2 Health profiles/ indicators of need

Health Profiles⁶ provide a snapshot of health for each local council in England using key indicators that enable comparison locally, regionally and nationally as well as over time. They are designed to help local councils and the NHS decide where to target resources to tackle health inequalities in their local area. Health Profiles are quality assured by APHO, and have clear and explicit methodology, which should eliminate the need for local production of identical indicators.⁷

A description of the indicators is included at Appendix 1.

Figure 2 Health profile indicators



2.2.1 Nottingham

Overall, the indicators of health for people living in Nottingham are worse than average when compared to England and the East Midlands.

Deprivation is closely linked with poor health. Nottingham has higher than average levels of income deprivation, with more than 20% of residents dependent on means-tested benefits. The level of statutorily homeless households and the rate of reported violent crime are both higher than the England average.

Teenage pregnancy rates are high compared to the England average. Lifestyle indicators are generally worse than average. It is estimated that more than 1 in 3 adults in Nottingham smoke and only 1 in 5 eats healthily.

⁶ <http://www.communityhealthprofiles.info>

⁷ <http://www.communityhealthprofiles.info/>

On average people live shorter lives in Nottingham than in England as a whole. For males, there is a 6 year gap between the life expectancy in the fifth most and least deprived areas. Early death rates from heart disease, stroke and cancer are higher than average but are falling. Infants in Nottingham are more likely to die in their first year of life than average for England. The rate of people claiming benefits because of mental health problems and the rate of hospital admissions for alcohol specific conditions are both higher than the England average.

2.2.2 Nottinghamshire

Overall, the indicators of health for people living in Nottinghamshire show a mixed picture when compared with England and the East Midlands.

GCSE achievement in Nottinghamshire is lower than average. The level of statutorily homeless households and the rate of reported violent crime are both lower than average.

Teenage pregnancy rates are low compared to the England average. Lifestyle indicators are generally similar to average. It is estimated that more than 1 in 4 adults smoke. However, it is estimated that more than 1 in 4 adults are obese which is above average.

Early death rates from heart disease and stroke are lower than average. The proportion of people who rated their health as "not good" and the rate of hip fracture in people aged over 65 are higher than average.

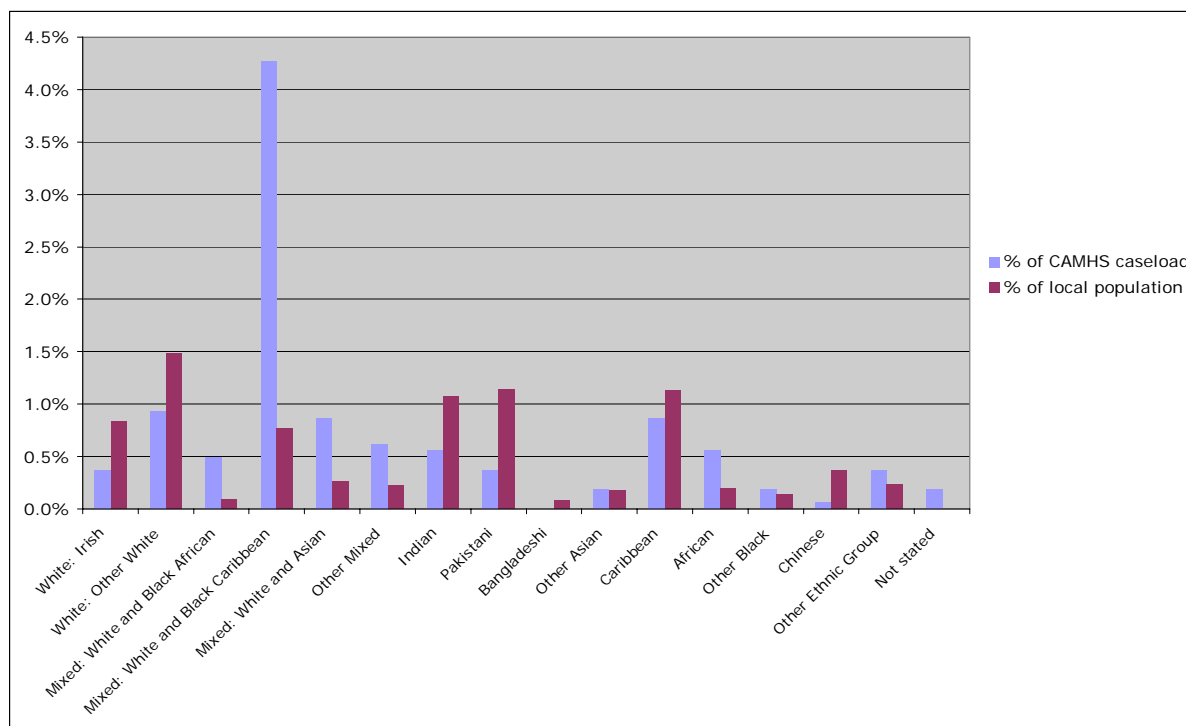
The rate of people claiming sickness benefit because of mental health problems and the rate of people admitted to hospital for alcohol specific conditions are lower than average.

Although the percentage of people with recorded diabetes is lower than the England average, 1 in every 28 people is recorded with diabetes in Nottinghamshire.

2.3 Ethnicity

Ethnicity of the Nottinghamshire population is shown at Appendix 2, and ethnicity of the CAMHS caseload at November 2007 is shown at Appendix 3. These two data sets are used to provide the comparison in Figure 3 below.

Figure 3 Ethnicity of caseload compared with local population⁸



The chart shows that children and young people of all mixed groups and of African heritage are represented in the CAMHS caseload higher than would be expected from the local population. This is particularly notable in relation to the Mixed White and Black Caribbean population, although this may be less contrasting if the picture for City and County were shown separately. Unfortunately this is not possible at present within the constraints of the data available from CHMM.

Groups that are under-represented on the CAMHS caseload compared to the local population are White Irish, Other White, Indian, Pakistani and Chinese. Some of these mismatches may be related to user-preferred options for management of mental health within families of the various ethnic/ cultural groups in the local population, but there may also be implications for service and workforce development, such as access facilitation, ethnicity of workforce and developing cultural competency.

Some caution however should be assumed with the data for two principle reasons:

(i) The local population data is from the 2001 census (Crown Copyright 2003, Nottinghamshire County Council) while the CAMHS caseload data is from 2007/08. The population profile may have changed since 2001, although this is the best profile of ethnicity available to use for such a comparison.

(ii) The data combines both city and county, and it is understood that the ethnic diversities of the two areas are in reality quite different, so the picture here is somewhat simplified. As a result any actions arising from this analysis would ideally pay closer attention to localised ethnicity profiles.

⁸ The graph excludes "White British" due to the adverse effect on scaling of the chart.

3 LOCAL SERVICES

Key relevant local organisations are outlined below, as described in their own publicity/websites.

3.1 Mental Health services

Nottinghamshire has one mental health trust:

[Nottinghamshire Healthcare NHS Trust](http://www.nottinghamshirehealthcare.nhs.uk/)⁹

Nottinghamshire Healthcare is one of the country's leading mental health and learning disability service providers. The Trust was formed in April 2001 from a number of organisations providing mental health and learning disability services to the whole of Nottinghamshire.

The Trust's services are provided in a variety of settings, from community psychiatric services through to acute wards as well as low, medium and high secure provision. The Trust manages two medium secure units, Arnold Lodge in Leicester and Wathwood Hospital in Rotherham as well as the high secure Rampton Hospital near Retford.

3.2 Primary Care

There are three Primary Care Trusts (PCTs) serving Nottinghamshire.

[Nottingham City Primary Care Trust](http://www.nottinghamcity-pct.nhs.uk/)¹⁰

Nottingham City Primary Care Trust was established in April 2001 and serves a population of more than 305,000 who live mainly in the geographical area represented by Nottingham City Council.

[Nottinghamshire County Teaching PCT](http://www.nottinghamshirecountyteachingpct.nhs.uk/)¹¹

Nottinghamshire County Teaching PCT was established in April 2001 and serves a population of more than 650,000 people in Nottinghamshire.

[Bassetlaw Primary Care Trust](http://www.bassetlaw-pct.nhs.uk/)¹²

Bassetlaw PCT has been in existence since 2002 and covers a population of 109,400.

3.3 Acute Hospital services

Nottingham has one acute hospital trust:

[Nottingham University Hospitals NHS Trust](http://www.qmc.nhs.uk/)¹³

Nottingham University Hospitals NHS Trust is one of the largest NHS Trusts in the UK with an annual budget of more than £500 million.

The Trust was formed on 1 April 2006, when two top-rated trusts - Queen's Medical Centre and Nottingham City Hospital - merged in order to develop a range of high-quality, sustainable patient services across the two campuses.

⁹ <http://www.nottinghamshirehealthcare.nhs.uk/>

¹⁰ <http://www.nottinghamcity-pct.nhs.uk/>

¹¹ <http://www.nottinghamshirecountyteachingpct.nhs.uk/>

¹² <http://www.bassetlaw-pct.nhs.uk/>

¹³ <http://www.qmc.nhs.uk/>

As a major teaching Trust, it enjoys close links with the city's universities and attracts and develops the highest calibre of staff. It continues to be the hospital of choice for patients, encourage investment and remain at the forefront of research.

It has one of the busiest emergency departments in the UK and has a total of 2,200 hospital beds across both campuses.

3.4 Local Authorities

Nottingham City Council is a unitary authority providing all local government services within the City of Nottingham administrative district. The Children's Services department provides services to children in need and the education provision includes almost 120 schools across the city.

In the County Council, Children and Young People's Services cover the range of child and family support and protection, specifically for children in need, as well as formal education.

3.5 Specialist CAMHS

3.5.1 Service description

Services, staff and caseload information included in this analysis and plan are quantified in Child Health and Maternity Mapping using 2007/08 submissions made in November 2007. Extracts from the website giving service descriptions are shown in Appendix 4, and the staffing data is shown at Appendix 5.

However, since November 2007 there have been significant service developments in Nottinghamshire including a reconfiguration into a smaller number of teams, as a result of which the service descriptions in Appendix 4 are no longer fully accurate. Nevertheless, that CHMM information is the fullest available dataset that is still largely accurate in terms of size, if not shape. It integrates team, staff and caseload information and was by design the basis for this workforce plan. Integrated data on the new configuration will not be available until publication of the 2008/09 CHMM submission based on data of November 2008.

As a result the 2007/08 data will still be used here to provide the analysis of current workforce, and although the analysis will be limited to overviews of the service, it will nevertheless be useful as a high-level analysis which can be developed in subsequent periods as a 'living' document or on-going development process.

There are two further data issues:

- (i) As Nottingham City Council is not fully involved in this planning process Tier 2 services provided in the City have not been included,
- (ii) Significant additional resources have recently been committed by Nottinghamshire PCT for Tier 2 development in the County for which staff are currently being recruited, but which is not recorded through the latest CHMM data.

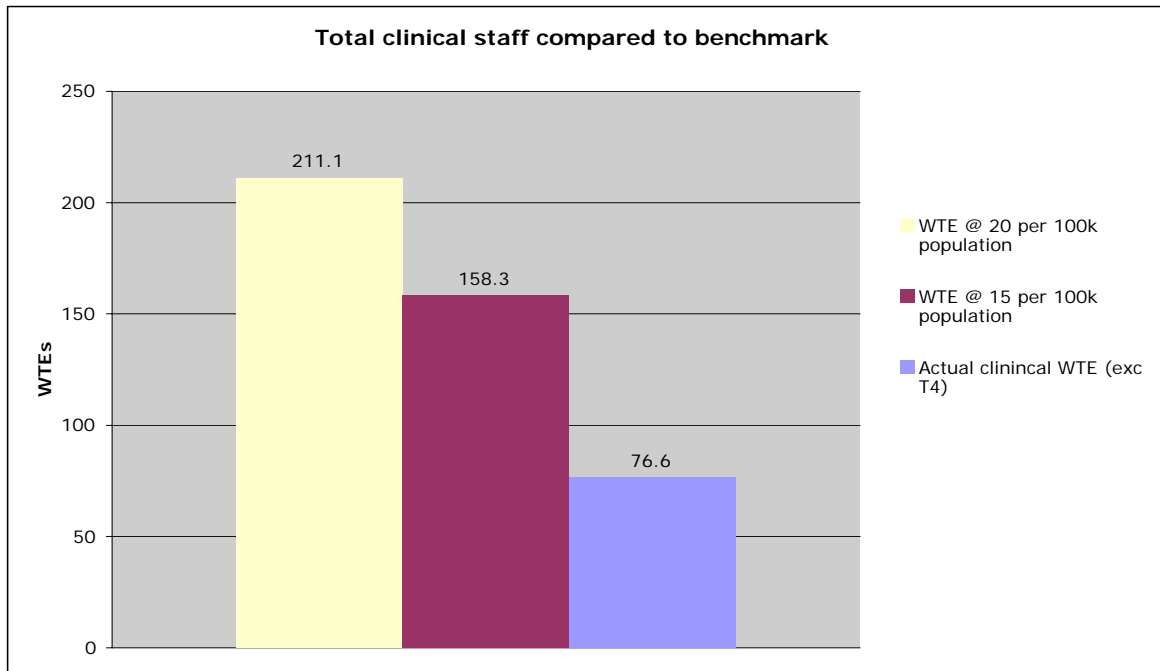
The findings described below should be considered in the light of these restrictions, an unfortunate by-product of reconfiguration and development. If the missing Tier 2 data were available in a form consistent with the CHMM dataset that could be added into some of the analyses, i.e. it would improve the staff resource analysis, but would not be able to support the associated caseload analysis used elsewhere in this report.

3.5.2 Staffing

The emphasis of the CAMHS workforce plan is on using existing resources more effectively. The NSF however has recommended that numbers of specialist CAMHS practitioners should be 15 WTE per 100,000 population for a non-teaching service and 20 WTE per 100,000 for a teaching service. Figure 4 below shows how the actual staffing numbers compare with those recommendations.

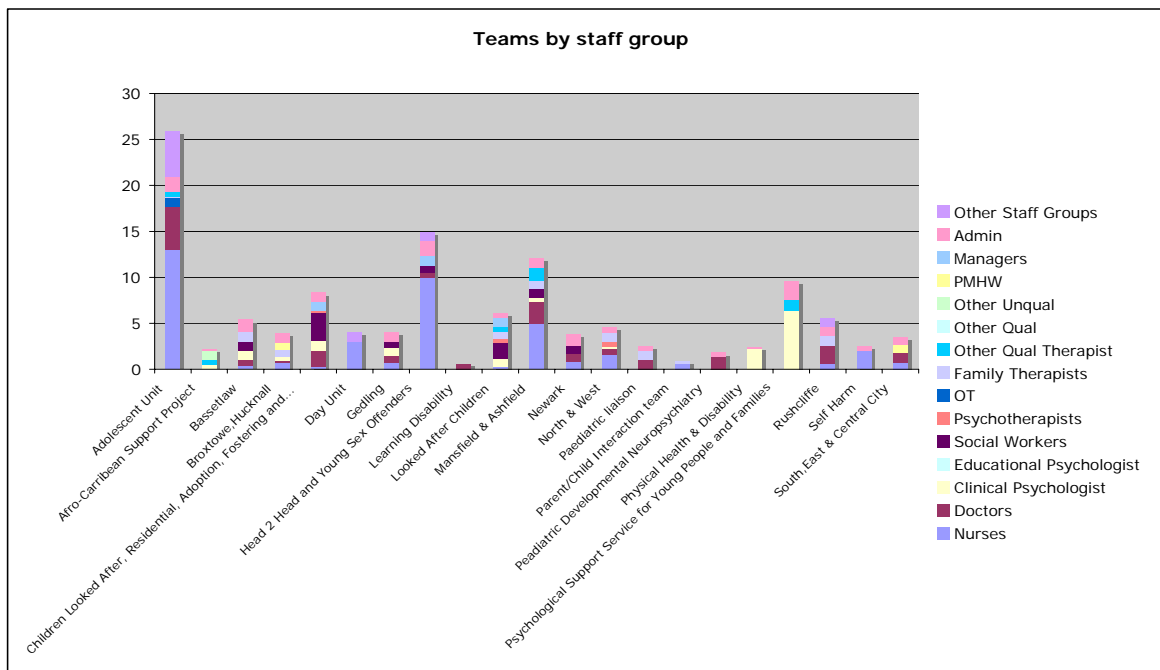
(The population figures used for these calculations are from ONS 2006 mid-year estimates).

Figure 4 Clinical staff in community services (non-Tier 4) per 100,000 population (compared to 15 per 100,000 population (NSF))



The overall clinical staffing level is well below the NSF benchmark, at about half what would be expected. However, as mentioned above, the data available from the latest CHMM (2007/08) does not include the Tier 2 services in Nottingham City or the new Tier 2 staffing recently commissioned for the County. These would move the local staffing levels towards the benchmark.

Figure 5 Clinical staff in community services (non-Tier 4) per 100,000 population (compared to 15 per 100,000 population (NSF))



The figure above shows the staff group breakdown of each team. One point to note from this is the large number of teams and the small numbers of staff in many of them. This issue, that raises some questions about the viability of such teams, was identified in the HASCAS

Review (2007), and has been addressed by the subsequent reconfiguration and service enhancements.

Figure 6 Staff groups per 100k population compared to England

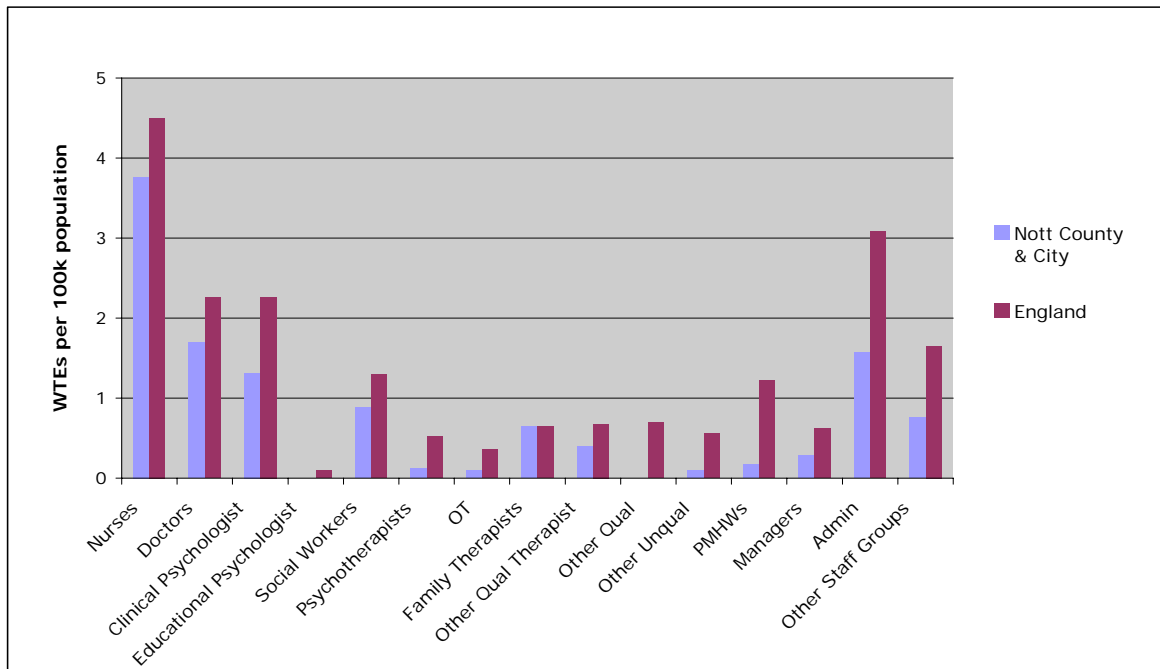


Figure 6 above shows that the service in Nottinghamshire is below the average levels for England against all staff groups, except family therapists.

As mentioned above there will be some error in this due to the absence from the data of City Tier 2 services and the newly commissioned Tier 2 services in the County, which, if they were included, may bring some of the disciplines at least further towards the national average.

Figure 7 Comparison of disciplinary composition with England averages

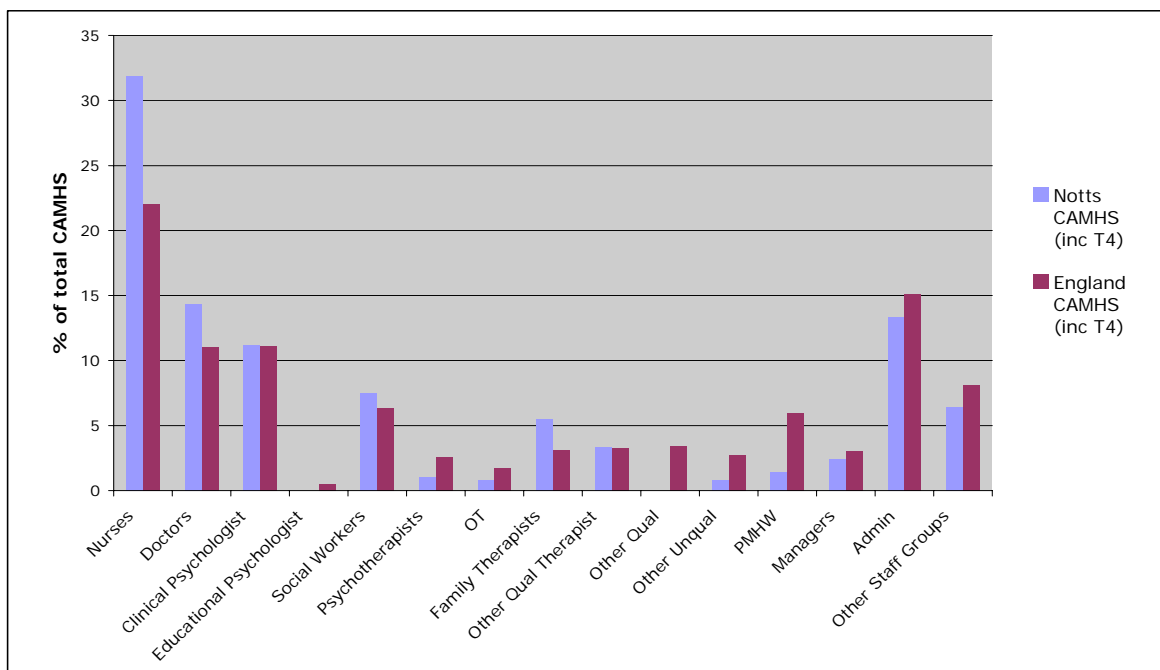
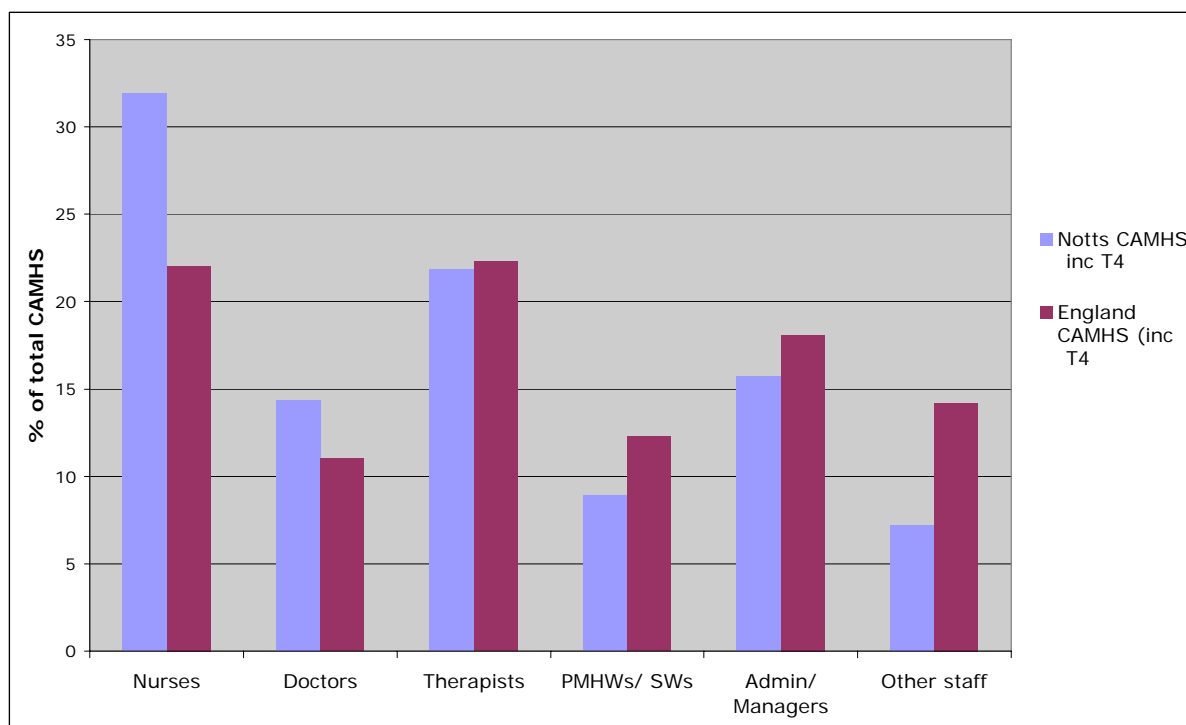


Figure 7 shows how the proportions of each discipline in Nottinghamshire Healthcare NHS Trust CAMHS workforce compared with the English averages, as reported in the CHCMM. Figure 8 below shows these in a simplified form of broader functional groups.

Figure 8 Comparison of functional groups with England averages



Significant differences from the England disciplinary profile are:

- Higher proportions of nurses and doctors
- Lower proportions of PMHWs, social workers, and “other” staff groups

This view of the disciplinary composition should be regarded in the context of the (currently apparent) overall low level of staffing. Without knowing the disciplinary profile of the non-included recent Tier 2 additional staff it is not clear whether these features of the profile will remain, or whether the additional staff may have moved the profile closer to the England average. N.B. The England average profile is used here as a benchmarking tool, which is not necessarily the same as an ‘ideal’ disciplinary mix in terms of effectiveness, for which there is no established evidence, and therefore is not to be used as a target.

3.5.3 Case mix and indicative skill mix

Case mix is an approximate indicator of demand and can be used as a guide to required inputs in terms of professional staff and skill mix.

Figure 9 Case mix

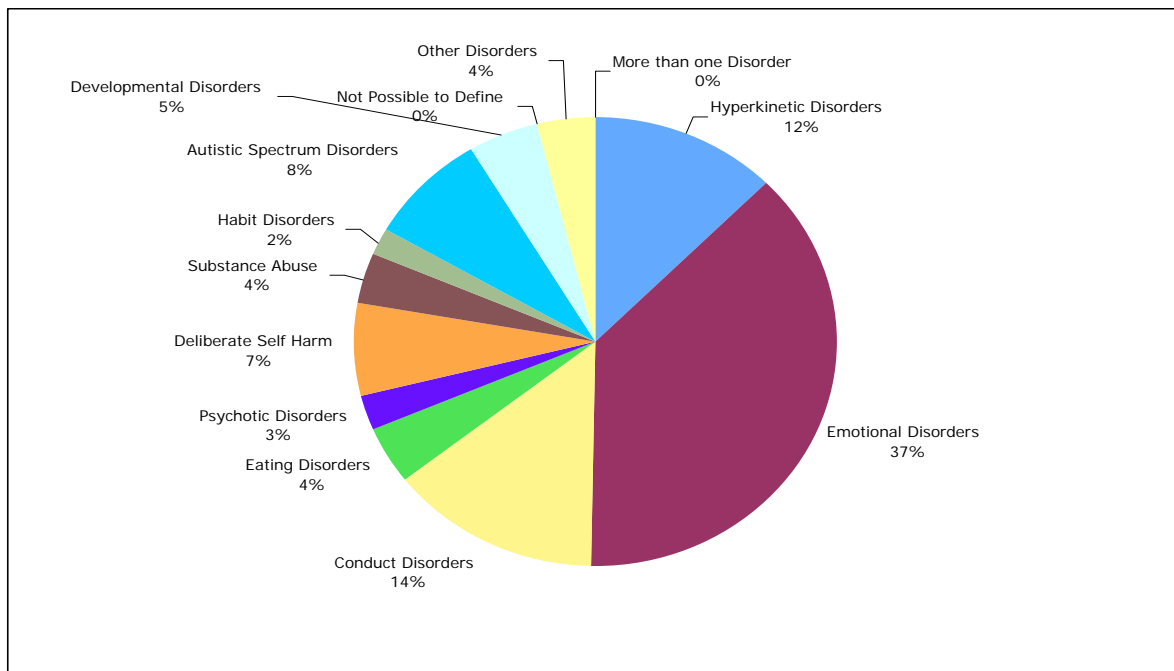


Figure 9 above shows a snapshot of the case mix at November 2007 (also shown in Appendix 6 by case numbers and team), and indicates that five presentation categories make up the majority (78%) of the caseload – hyperkinetic disorders (12%), emotional disorders (37%), conduct disorders (14%), deliberate self harm (7%) and autistic spectrum disorders (8%). The remaining presenting problems account for 22% of the total, none individually greater than 5% of the total.

There will be fluctuations year by year in respect of the volumes of presenting problems, so the picture should be viewed as approximate and variable. Further with the CAMH service volume currently being increased shifts in referral and presentation patterns may change this presentation profile in the future.

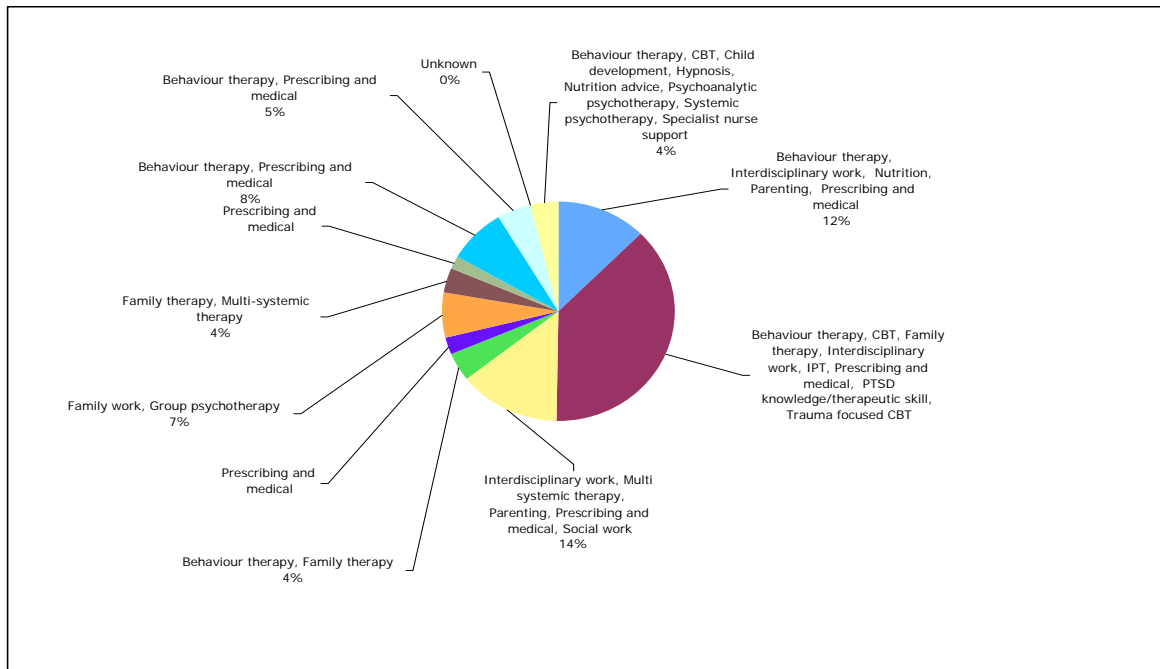
Employing the best available evidence it is possible to use case mix as a proxy indicator of the skill mix needed, in order to offer the most effective or evidence-based interventions.

Indicative skill mix has been calculated by taking evidence for effective interventions and isolating the skills required to deliver them. (To see how this process works, please read the full explanation of the evidence for effectiveness, by Wolpert, et al, (2006)¹⁴. Figure 10 below shows the translation of case mix to indicative skill mix.

¹⁴ Wolpert, M., et al, (2006) *Drawing on the Evidence*

<http://www.ucl.ac.uk/clinical-health-psychology/pdfFiles/DotEBooklet2006.pdf>

Figure 10 Indicative skill mix



Using this same evidence base for translating case mix into skill requirements the table below attempts to identify the key skill areas required based on the majority presentations in the case mix, i.e. the 78% of caseload identified above.

The shaded cells show the range of interventions/ skills that would be required to respond to this majority of the caseload. This is shown to gain a focus on the majority requirements, to identify what the main skill requirements are. This is not to suggest that the other presentations should be ignored, but the top 80% is an indication of the dominant needs.

Also it should be noted that the above translation from diagnosis to effective intervention using Wolpert et al (2006) focuses on the highest levels of evidence robustness, and should not be regarded as absolute. Nor should other interventions that do not have an established evidence base be dismissed, such as play therapy and art therapy. Practice-based evidence may also be available locally, or if not, might be encouraged to develop.

To progress this assessment it would be useful to know the skills currently available within the CAMH services in order to identify gaps. This would require an audit of skills and may be a useful subsequent stage for the workforce plan.

Figure 11 Top presentation categories of Notts (City and County) casemix translated into evidence-based intervention/ skills requirements

Presentation	Behaviour therapy	Interdisciplinary work	Nutrition	Parenting	Prescribing and medical	Cognitive Behaviour Therapy (CBT)	Family therapy	Interpersonal therapy	PTSD knowledge/ therapeutic skill	Trauma focused CBT	Multi systemic therapy	Social work	Family work	Group psychotherapy	Child development	Hypnosis	Psychoanalytic psychotherapy	Systemic psychotherapy	Specialist nurse support
Hyperkinetic disorders	✓	✓	✓	✓	✓														
Emotional disorders	✓	✓			✓	✓	✓	✓	✓	✓									
Conduct disorders		✓		✓	✓						✓	✓							
Eating disorders	✓						✓												
Psychotic disorders					✓														
Deliberate self harm													✓	✓					
Substance abuse							✓				✓								
Habit disorders					✓														
Autistic spectrum disorders	✓				✓														
Developmental disorders	✓				✓														
Not possible to define															✓	✓	✓	✓	✓
Other	✓		✓			✓													

- Ticks represent findings from Wolpert et al 2006 (Drawing on the Evidence) showing mental health presentations and the interventions that have been associated with successful outcomes
- Shaded cells indicate the most common presentations in Nottinghamshire and Nottingham City, accounting for approximately 80% of the total workload. These boxes therefore also indicate the interventions and skills that would be needed to provide an evidence-based service for that majority part of the workload.

4 LABOUR MARKET

4.1 Local labour markets

Nottinghamshire has a diverse local economy. It is home to 23,000 businesses, over 80% of which employ less than 10 people. The economy continues to recover from the coal closures of the early 1990s and the later clothing and textiles job losses and is diversifying out of dependence on manufacturing into services, food and drink and knowledge based industries.

The Outreach Flexible Routeway¹⁵ is part of the European Social Fund Programme. 2007-2013. Its provision addresses the needs of people who face barriers to work and who are subsequently disadvantaged in the labour market. The provision enables people to achieve their potential by identifying and providing the skills to find sustainable work.

Innovative and flexible delivery approaches are encouraged, demonstrating effective working with Employment and Skills Boards, Local Strategic Partnerships, local community/neighbourhood/voluntary groups, “Making the Connections”, health professionals, children’s centres and other specialist services to engage appropriate clients, thereby presenting a seamless service.

Actions include measures to ensure early identification of needs including individual action plans and personalised services and/or signposting to:

- Work experience placements/tasters
- Activities to reconcile work and private life including access to childcare and support for those with other caring responsibilities
- Activities to prolong working lives by re-engaging inactive older workers
- Activities to help lone parents and parents enter and make progress at work, addressing the DWP’s priority to eradicate child poverty and also reducing inter-generational worklessness in households and/or families
- Activities to help offenders and ex-offenders enter and make progress at work
- Soft skills such as building trust, addressing of barriers, confidence building
- Referral to education
- Establishing and administering a discretionary fund, where Advisor Discretionary Fund (ADF) or other funding is not applicable, to remove individuals’ barriers to work
- Specialist support to help people with mental health conditions to return to work.

Whilst this initiative is unlikely to produce the type of skills necessary for qualified therapist roles, it could be helpful in filling new roles, particularly those in which NHT has fewer than the English average, such as unqualified therapists. New roles could include health care assistants or liaison workers reaching out into specific ethnic communities or cultural groups.

4.2 National and international labour markets

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses, although these disciplines are well represented in Nottinghamshire.

¹⁵ http://www.dwp.gov.uk/supplyingdwp/what_we_buy/em01_notts_flexible.pdf

However many of the issues raised around recruitment and retention of doctors and nurses apply equally to other professions.

4.2.1 Psychiatrists

Pidd (2003: page 408)¹⁶ offers key messages from senior house officers (SHO) about their training, reporting that they want:

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

Pidd also suggests various strategies to attract students and SHO's into psychiatry:

- Getting enthusiastic young psychiatrists to promote the speciality at career fairs
- Developing promotional material targeted at graduate entrants
- Developing recruitment initiatives for those already in mental health
- Ensuring that undergraduate experiences are positive
- Identifying and nurturing interested students through to SHO posts
- Developing special study modules in psychiatry and promoting them to students
- Encouraging more pre-registration house officer posts in psychiatry (Pidd, 2003: page 405)

4.2.2 Nurses

In the 1990s one in ten new nurse registrations were from overseas; by 2000-2001 this had risen to over half of all new registrants. The Royal College of Nursing (2005)¹⁷ has responded to this upsurge by producing good practice guidance for recruiting and employing nurses from overseas.

The guidance covers recruitment, retention, continuing professional development and culturally competent practice.

The Royal College of Nursing (2004) has also produced *The Future Nurse Project*,¹⁸ in which it is made clear that the shortage of registered nurses is not just about increasing numbers entering nursing but also about understanding the exit routes out of the profession. If the number leaving, either early by retiring, exceeds the number joining, then an increase in the workforce cannot be achieved. Retention may therefore be seen as critical to future workforce levels.

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

Sixty-four percent of nurses employed in the NHS work full-time (around 44 hours per week) and most (51%) of these work internal rotation shift patterns. In contrast 20% of nurses in

¹⁶ Pidd, S.A., (2003) Recruiting and retaining psychiatrists. *Advances in Psychiatric Treatment* (2003), vol. 9, 405–413

¹⁷ <http://www.rcn.org.uk/publications/pdf/IRN.pdf>

¹⁸ http://www2.rcn.org.uk/resources/policy_unit/projects/future_nurse_future_workforce_project

general practice work full-time. The level of choice and control over working hours also varies between employment sectors. Nurses working in NHS hospitals or independent care homes are less positive about the choice they have over their hours and those who work internal rotation shift patterns particularly dissatisfied. Control over working hours and achievement of a work-life balance will be an important determinant to their choice of employment.

4.2.3 Attracting people to work in the NHS

Arnold et al (2003) researched the reasons why people join, stay and leave the NHS¹⁹.

They conclude that:

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

The report recommends the following:

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

¹⁹ Arnold, J., Loan-Clarke, J., Coombs, C., Park, J., Wilkinson, A., and Preston, D., (2003) Looking Good? The Attractiveness of the NHS as an Employer to Potential Nursing and Allied Health Profession Staff. Loughborough University

5 STRATEGIC VISION FOR FUTURE SERVICES

5.1 Vision for CAMHS in the county

A Comprehensive CAMH Service in Nottinghamshire County will achieve an improvement in the mental health of all children and young people and enable effective and meaningful multi-agency partnership working to promote the mental health of all children and young people, thus ensuring that:

'All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, have access to timely, integrated, high quality, multidisciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.' Children and Young Peoples National Service Framework (Department of Health 2004)

The 'whole system' approach to commissioning and service delivery captures a shared vision of an integrated, responsive, inclusive, equitable and accessible service. Delivering evidence-based, high quality, appropriate and timely provision within a continuum of care, through the spectrum of need, from universal, to targeted, specialist and highly specialist services.

Provided through a blend of consultation, assessment, evidence-based intervention, and multi agency integrated working that values, respects and seeks service user involvement. Services will be developed and delivered to create an inclusive journey for children and young people, embracing effective partnerships with a range of stakeholders across the county.

5.2 Six aims of workforce development

This plan addresses the local issues identified within the six aims of CAMHS workforce planning. The local opinion and views to support this were gained through a facilitated workforce development workshop on 23 April 2007, comprising a selection of staff, listed at Appendix 7.

5.2.1 Improve workforce design and planning

- Workforce planning should be based upon the CAMHS needs assessment – targeting the most appropriate groups with the right workforce
- We need better communication between tiers
- There should be free communication between service providers and commissioners, in which the plan is commissioner-led but professional-informed
- Providers need knowledge of commissioners' expectations
- The workforce plan should provide a structure and timeframe
- Primacy should be given to skill mix

5.2.2 Identify and use creative means to recruit and retain

- The skill mix should reflect the community being served, around ethnicity, culture and religious diversity
- Create new roles based on skill mix and recruit creatively based on this within appropriate financial levels

- Competency and capability issues need to be addressed – with clear lines of accountability
- Develop clinical supervision frameworks.

5.2.3 Facilitate new ways of working across professional boundaries

- Promote collaborative working across the tiers in an integrated way
- Well-defined and integrated working
- Facilitation of working across the tiers

5.2.4 Creating new roles

- Adopt a skills-based approach
- Developed within clear limits of clinical accountability to manage risk
- Identify distinct areas of clinical expertise – what do we want at tier 2/3? New roles could include interface staff who can do both
- Interface specialist working roles
- The needs assessment will help to identify gaps and create new roles, e.g. working in a diverse/ multi-cultural way
- Promote knowledge sharing between teams
- We need a gap analysis between tiers 2/3/4

5.2.5 Develop leadership and change management skills

- Create a baseline to identify training required and match against service needs (specific evidence based/ mapped)
- Create a support network to facilitate change

5.2.6 Develop the workforce through revised education, training and development

- All staff should have access to needs based training and development
- Develop competency-based training, including cultural competence
- Relate to new ways of working and evidence based practice
- Aim for consistency across all partner agencies
- Develop appropriate levels of supervision
- Clinical development should be available for staff
- Aim to pool training budgets
- Education and training on skills-based learning rather than professional group-based learning

5.3 Increasing capacity and capability

The Workforce Group considered:

- Recruitment incentives, effective HR support, new markets

- Retention, opportunity, development, career pathways, training, flexible working
- Education and training, linked to competence/ effective practice
- New ways of working
- Education and training through universal, targeted, specialist and highly specialist services:
 - Up skill universal workforce
 - Specific Post Qualifying Therapy, Linked To Evidence for example CBT
 - Leadership and management
 - CAMHS Training to create competency within new roles

6 IMPLEMENTATION PLAN

6.1 Action Plan

A CAMHS Workforce Action Plan was developed at a planning session held on 30th July 2008 –refer to page 24. The actions within the plan will be taken forwards during September 2008- March 2009. A cross cutting action centres on the continued development (and embedding within organisational culture(s)) of an integrated delivery philosophy. This is seen as fundamental to achieve positive outcomes for children and young people within a complex, tiered service, delivered from a range of providers.

6.2 Monitoring and review

The actions within the Action Plan will be taken forward during September 2008- March 2009, with a number of themes expected to re-occur within the process over a new year.

The Working Group will reconvene in April 2009 and refresh the Workforce Plan, incorporating CAMHS Mapping Data (2008) that reflects current workforce and structure. From this the Action Plan will be updated.

The Workforce Plan will be disseminated to a range of stakeholders including operational managers, Human Resource and workforce leads, CAMHS Strategic and Executive Group members and to Care Service Improvement Partnership (CSIP) - CAMHS within NHS East Midlands.

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
New Ways of Working Creating capable teams initially Specialist/Highly Specialist 5 Stage process	<ul style="list-style-type: none"> Responsive service provision with a range of highly competent staff who can deliver a tailored approach to individual needs Service provision aligns with service users and stakeholders views 	Five stages that include all practitioners in developing a needs led service. Day events to identify service needs with external facilitation	Stakeholder event scheduled for 1 st September 2008	Lindsey Wallis/ Lorraine Babbington-Fowles/ Sam Sykes	01.06.08	31.03.09	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
Detailed CAMHS HNA reflective of district and ward specific need	Commissioners are able to effectively commission, decommission and /or redesign services based on evidence of factors which will influence positive outcomes	Combination of quantitative and qualitative data capture, to include practitioner, user and wider stakeholder views on service delivery and integrated mechanisms for change. 4 key HNA components: - <ul style="list-style-type: none"> • Newark early intervention consultation • Manor early intervention consultation • Rushcliffe /Principia consultation • JSNA revision to include specialist tier3/4 data, maternal health and health-education partnership evidence 		Julie Meldrum	<ul style="list-style-type: none"> • Newark • Manor • Principia • JSNA revision 	28.02.09	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
	The review is designed to establish a coherent and integrated Tier 3 provision leading to positive mental health/emotional well being outcomes for young people in this secure setting.	A number of key stakeholders are members of the T&F group including practitioners as currently providers with plans to consult with a range of stakeholders within the process		Pat Harty	27.6.08	30.11.08	31.3.09
Service Review Paediatric Liaison	Commissioners will be assured that commissioning arrangements reflect an equitable and responsive service to meet the 4 elements within the PSA 12 Target and local need.	<i>Process to be decided</i>	<i>Process to be decided</i>	Mike Caston/ Sally Handley	01.10.08	30.11.2008	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
Service Review Specialist Learning Disability provision	Commissioners will be assured that commissioning arrangements reflect an integrated approach to meet the 4 elements within the PSA 12 and local need.	To be consulted as part of Phase 2 of the review	To be consulted as part of Phase 2 of the review	Sally Handley/ Lucy Davidson/ CSIP CSIP leading the review as part of the CAMH CSIP support, working to an agreed Service Review Brief	01.10.08	31.01.2009	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
<p>Development of an Integrated Delivery Philosophy</p> <p>Joint identity and shared vision for CAMHS</p> <p>Capture reference group for LAA NI 50</p>	<ul style="list-style-type: none"> • Joint identity & shared vision • Seamless service • Easy access • Increased range of interventions /treatment options • Increased choice • Removing barriers to Specialist care 	Engage in and contribute to the planning of development sessions/ days	Information sharing stakeholder events, meetings improving communication channels with specific groups of referrers	Lorraine Babbington-Fowles/ Clare Staley <i>Include on working group</i> Anumita Saha, Pat Williams	01.05.08	On going into plan year 2009-10	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
Creating new roles Flexible interface within CAMHS workforce/sharing knowledge and skills/ workplace secondments	Flexible, Individualised care package to meet individual needs.	To be engaged as key stakeholders	To be included and consulted	Lorraine Babbington-Fowles/ Clare Staley Include Elayne Forster & Mel Harding, Anumita Saha, Katrina Singhatey, Jane Fox, Pat Williams	July 08	Ongoing into plan year 2009-10	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
Integrated Eating Disorder Delivery Strategy	<ul style="list-style-type: none"> Children and young people engaged with ED services report a coordinated approach to provision with consistent advice. Practitioners supporting children and young people with ED diagnosis report clarity in relation to approach and joined up /integrated provision. 	As stakeholder group with additional inpatient staff	CAMHS ED Group & in addition invite: R Damian Wood Jo McLoughlin Liz Tatham Claire Mellors (Dietician) Janine Smith Alexia Ringrose Ros Hill Clare Staley Sally Handley Lucy Davidson School Nurse from Rushcliffe Carolyn Marshall Alison Newsham-Kent	Janine Smith /Sally Handley	01.10.08	28.02.09	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
Eating Disorder Working Group cross tier work targeted within Rushcliffe	<ul style="list-style-type: none"> • Integrated, preventative approach will provide a coordinated reach around ED across the district • A reduction in number of presenting cases of ED within the district • Children and young people engaged with ED services report a coordinated approach to provision with consistent advice. 	Range of relevant multi agency front line practitioners form the focus group	Evaluation and feedback from young people	Ros Hill /Alexia Ringrose Link with targeted Health Promotion work taking place within Principia PBC	01.11.08	On going into plan year 2009-10	

CAMHS Workforce Development Action Plan July 2008 - 31st March 2009 v1

Action	Anticipated Outcomes for service users <small>As an indication of the effectiveness of the action plan</small>	Plans to include Front line practitioners	Plans to engage with Key stakeholders	Lead person & Working Group Members	Key dates		
					Start	Finish	Eval'
Clarification management of OA LAC placed in NCC area Principles and protocols	Pathways in place that reflect appropriate arrangements to meet the mental health/ emotional well being needs of all looked after children living in NCC area.	Clinicians currently providing services will be part of the process	A consultation programme will be devised to include all key partners and stakeholders	Pat Harty/Yvonne Cottingham	02/09/2008	30/11/2008	
Identify leadership responsibility/ performance monitoring arrangements	Sign off of plan... SAH to clarify at Sept 2008 Strategic CAMHS Group how progress to Workforce Action Plan will be monitored Clarify any HR Input/support.						

Appendix 1 Health profiles

Income Deprivation

Adults and children living in families receiving means-tested benefits.

Measure - % of residents dependent on means-tested benefits 2003.

Children in Poverty

Prevalence of children living in families receiving means-tested benefits.

Measure - % of low income households 2001.

GCSE achievements

Pupils achieving 5 or more GCSEs at grades A*-C or equivalent, percentage of pupils at end of Key Stage 4 in schools maintained by the Local Education Authority, at the end of academic year 2005-2006.

Measure - achieving 5 A*-C 2005/06.

Binge drinking in Adults

Prevalence of binge drinking, percentage of resident population, adults.

Measure - Modelled estimates from the Health Survey for England. 2000 - 02

Mental Health

Claimants / beneficiaries of Incapacity benefit / severe disablement allowance with mental or behavioural disorders males and females, working age, per1000 working age population.

Measure - Crude rate claimants of benefits/allowances for mental or behavioural disorders/1,000 working age pop. 2005.

Appendix 2 Ethnicity of local population

	Nottinghamshire	Nottingham UA	Nottinghamshire and Nottingham UA	England
All people	748,510	266,988	1,015,498	49,138,831
White: British	715,934	216,401	932,335	42,747,136
White: Irish	4,827	3,629	8,456	624,115
White: Other White	8,315	6,680	14,995	1,308,110
Mixed: White and Black Caribbean	2,550	5,297	7,847	231,424
Mixed: White and Black African	389	540	929	76,498
Mixed: White and Asian	1,372	1,254	2,626	184,014
Mixed: Other Mixed	996	1,279	2,275	151,437
Asian or Asian British: Indian	4,763	6,096	10,859	1,028,546
Asian or Asian British: Pakistani	1,869	9,725	11,594	706,539
Asian or Asian British: Bangladeshi	321	533	854	275,394
Asian or Asian British: Other Asian	816	1,001	1,817	237,810
Black or Black British: Caribbean	2,316	9,189	11,505	561,246
Black or Black British: African	641	1,281	1,922	475,938
Black or Black British: Other Black	268	1,112	1,380	95,324
Chinese or other ethnic group: Chinese	2,014	1,715	3,729	220,681
Chinese or other ethnic group: Other Ethnic Group	1,119	1,256	2,375	214,619

Source: Nottinghamshire County Council, based on Crown Copyright 2003

http://search.nottinghamshire.gov.uk/cgi-bin/semaphoreserver.exe?PROP00=t%3Dp&SAVEDB=nottingham&SAVEQUERY00=ethnicity&SAVESTYPE=simple&CategoryResultCount=5&RelatedResultCount=4&MULTIVARS=HIDECONCEPT%3D1%26B2_DESC%3DPopulation+and+migration%26B2%3DI1populationandmigration&QUERY00=ethnicity&CMD%3Dsearch.run=Go&CMD=search.run

Please note that overall population figures here do not correspond with others used elsewhere in this report. This dataset is from Nottinghamshire County Council website, and therefore presumed to be the agreed most recent data available with ethnicity included. Other more recent data (ONS 2006 mid-year estimates), used in this report for comparing staff per head of population, only provide total estimated population figures without ethnic breakdown.

Appendix 3 Ethnicity of CAMHS caseload

(Source: 2007/ 08 Child Health CAMHS and Maternity Mapping, unvalidated)

	White: British	White: Irish	White: Any other white background	Mixed: Mixed white and black African and black Caribbean	Mixed: Mixed white and Asian	Mixed: Any other mixed background	Asian or Asian British: Indian	Asian or Asian British: Pakistani	Asian or Asian British: Bangladeshi	Asian or Asian British: Any other Asian background	Black or Black British: Caribbean	Black or Black British: African	Any other black background	Other Ethnic Groups: Chinese	Other Ethnic Groups: Any other ethnic group	Not stated	Total Number of cases with ethnicity reported
Adolescent Unit	25			2			2						1				31
Afro-Caribbean Support Project				14							3	1					18
Bassetlaw	111		2	1	1												115
Broxtowe, Hucknall	39		2		1												42
Children Looked After, Residential, Adoption, Fostering and Leaving Care	104	1		2	24	5	1			1	2	2				4	146
Day Unit	34			6								2					42
Gedling	10																10
Head 2 Head and Young Sex Offenders	169			2	6	1				1	5	1					185
Learning Disability	2																2
Looked After Children	48																48
Mansfield & Ashfield	286	1		1	1	1	1										290
Newark	89		1														90
North & West	53		2	3	1	1		1		1			1			3	66
Paediatric liaison	35	3					1	1									40
Parent/Child Interaction team	23			1		2					1						27
Paediatric Developmental Neuropsychiatry	17		1								1	1	1				21
Physical Health & Disability Psychological Support Service for	48			1													49
Young People and Families	238		5	1	4	2	2	5	3	1	1	2		1			265
Rushcliffe	59	1	1		4		2		1								68
Self Harm	17		1		1	1										1	21
South, East & Central City	34			2	2	2	1										41
Total (caseload)	1,441	6	15	8	69	14	10	9	6	3	14	9	3	1	6	3	1,617

Appendix 4 List of CAMHS that reflect the CAMHS Mapping Data 2007 (*Please note that the relevance of the information in this table is historical and does not capture new service configuration within NHS Nottinghamshire County, NHS Nottingham City or the remodelled Specialist CAMHS or Countywide targeted Tier 2 services.)

Name of service/ team	Brief description of provision	Age range covered
Adolescent Outreach (CAMHS) Adolescent Outreach Service Thorneywood Porchester Road Nottingham NG3 6LF	Tier 4 An adolescent outreach service which tries to engage with young people who are difficult to engage with and works on the principles of early intervention which seeks to reduce the number of occasions, the client attends hospital etc,	12- -18
Adolescent Unit (CAMHS) Child & Adolescent Unit Thorneywood Porchester Road Nottingham NG3 6LF	Tier 4 Description 12 bedded Tier 4 service	12 - 18
Afro-Caribbean Support Project (CAMHS) C/o Duncan Macmillan House Porchester Road Nottingham NG3 6AA	Targeted A Clinical Psychology service that is designed to meet the special needs of the African Caribbean Community.	0-19

Name of service/ team	Brief description of provision	Age range covered
<p>Bassetlaw (CAMHS) Child and Family Therapy Dept. Langold Clinic Doncaster Road Langold Worksop S81 9QL</p>	<p>Generic - multidisciplinary Description A multi disciplinary team working in the Bassetlaw location. We provide consultation, training and supervision to Tier 1 and 2 services. We also provide a referral response service and initial screening appointment and multi professional therapeutic interventions and refer onto other agencies and Tier when appropriate.</p>	<p>0 - 18</p>
<p>Broxtowe, Hucknall (CAMHS) Nottinghamshire Healthcare NHS Trust CAMHS (Broxtowe and Hucknall Team) Thorneywood, Porchester Road Nottingham. NG36LF</p>	<p>Generic - multidisciplinary Description A multidisciplinary Child and Adolescent Mental Health Service offering a wide range of therapeutic interventions from a central base and locality settings. We offer individual work, family therapy, psychotherapy and CBT. We also offer consultation and liaison to other professionals in Health, Education and Social Services.</p>	<p>0 - 18</p>
<p>Children Looked After, Residential, Fostering and Leaving Care (CAMHS) Address Thorneywood Porchester Road Nottingham NG3 6LF</p>	<p>Targeted A specialist multi-disciplinary consultation and treatment service for looked after young people in Nottingham City and Nottinghamshire County districts.</p>	<p>0 - 18</p>
<p>Clinical Psychology (CAMHS) Clinical Psychology Dept Duncan Macmillan House Porchester Road Nottingham NG3 6AA</p>	<p>Generic - single discipline A community based Tier 2 service run by Clinical Psychologists and Counsellors.</p>	<p>0 - 18</p>

Name of service/ team	Brief description of provision	Age range covered
<p>Day Unit (CAMHS) Thorneywood Childrens Day Unit Thorneywood CAMHS Porchester Road Nottm NG3 6LF</p>	<p>Tier 4 A 10 place per day unit for children with mental health problems including emotional and behavioural difficulties providing assessment and treatment. Also provide parenting groups for birth and foster parents.</p>	<p>0 - 18</p>
<p>Gedling (CAMHS) Thorneywood Porchester Road Nottingham NG3 6LF</p>	<p>Generic - multidisciplinary Tier 3 Out patient MDT CAMHS. Open referral system. Partial booking and triage system in place</p>	<p>0 - 18</p>
<p>Head 2 Head and Young Sex Offenders (CAMHS) We have two bases, as we are a county wide service. 1. The Forest, Southwell Road West, Mansfield, NG18 4HH. 2. Thorneywood CAMHS, Porchester Road, Nottingham, NG3 6LF.</p>	<p>Targeted Description Head 2 Head is a specialist team that works on an assertive outreach basis with three groups of young people who are socially excluded and hard to engage. The groups of young people we work with are: 1) Young people who are involved in the criminal justice system via youth offending teams, who have mental health needs. 2) Young people who have dual diagnoses (mental health and substance misuse) needs. We also offer opiate detoxification in the city of Nottingham. As part of the substance misuse element of the team we also work with children and young people affected by the misuse of another (Parent/sibling) who have significant mental health needs. 3) Young people who sexually harm others, and who have mental health/learning disability needs.</p>	<p>0 - 18</p>
<p>Learning Disability (CAMHS) Thorneywood Porchester Road Nottingham NG3 6LF</p>	<p>Targeted A six session Consultant Psychiatrist offering specialist input to Tier 2/3/4 services for the assessment and treatment of mental health problems in children and young people with moderate/severe learning disabilities.</p>	<p>0 - 18</p>

Name of service/ team	Brief description of provision	Age range covered
<p>Looked After Children (CAMHS) County CAMHS Looked After Children The Forest Southwell Road Mansfield NG18 4HH</p>	<p>Targeted To ensure that all children Looked After or Adopted in North Nottinghamshire in need of CAMHS provision, receive a service aimed at achieving positive outcomes in terms of emotional well-being and the establishment and maintenance of stable family placements.</p>	<p>0 - 18</p>
<p>MALT (CAMHS) City Multi agency locality Team Denewood Centre Denewood Crescent Bilborough Nottingham NG8 3DH</p>	<p>Generic - multidisciplinary The team is the first point of referral for children who attend or will attend the 10 primary and 1 secondary school in the Bilborough area of Nottingham and are identified as potentially in need of a CAMH service. Formal support is offered from the specialist CAMH service through regular meetings with the CAMHS Psychiatrist. The team has a Tier 2 focus.</p>	<p>0 - 18</p>
<p>Mansfield & Ashfield (CAMHS) 18-19 St. Johns Street Mansfield Notts NG18 1QJ</p>	<p>Generic - multidisciplinary Out patient locality team providing a comprehensive Child & Adolescent Mental Health service to children and young people up to age 18. Services offered at Tier 1 are consultation, training and support to Tier 1 professionals, direct service to children and families at Tier 2 and 3, and some specialist work at Tier 4. A multidisciplinary team consisting of nurses, psychotherapists, psychiatrists and social workers.</p>	<p>0 - 18</p>
<p>Newark (CAMHS) Dept of Child & Family Therapy Northgate Business Centre 38 Northgate Newark, Nottinghamshire, NG22 1EZ</p>	<p>Generic - multidisciplinary A locality based multi-disciplinary child and family therapy out-patient service. Provides assessment, therapy, consultation and support to parents and carers, children and young people.</p>	<p>0 - 18</p>

Name of service/ team	Brief description of provision	Age range covered
<p>North & West (CAMHS) Entrance 3 Thorneywood CAMHS Porchester Rd Nottm NG3 6LF</p>	<p>Generic - multidisciplinary MDT CAMHS out patient team offering support to children, young people (up to 18) and their families who have GP's in the North & West area of the city of Nottingham</p>	<p>0 - 18</p>
<p>Paediatric liaison (CAMHS) Paediatric Liaison Dept E Floor South Block Queens Medical Centre Nottingham NG7 2UH</p>	<p>Targeted Description The Paediatric Liaison Team offers a tiered model of service provision within the paediatric hospital setting. The team provides a tier 3 service and offers high quality evidence based mental health and family therapy assessments/ treatments/consultations to children, their families, carers and professional networks which requires close liaison and in house support at the QMC including: Neurology, Gastroentology, Rheumatology, Diabetics/ Endocrinology, Oncology, Dermatology, and PICU. The clinical work is centred upon issues of serious illness, disability and death and dying in children, young people and their families. In addition to regular clinical commitments there are 2-4 weekly requests for urgent assessments and therapeutic input in managing paediatric in-patients The team support and also offer consultation to medical staff and professionals from welfare and external agencies involved with the above client group. There are regular teaching and supervision commitments to nurses in postgraduate training, play specialists, and medical staff.</p>	<p>0 - 18</p>
<p>Paediatric Neuropsychiatry (CAMHS) Dept of Child & Adolescent Psychiatry South Block E Floor QMC Nottm NG7 2UH</p>	<p>Targeted Tier 4 Paediatric neuropsychiatry service offers assessment, management advice to Tier 3 CAMHS and paediatrics serves Trent SHA region. Specialist expertise in complex co-morbid ADHD, ASD, Tourettes, LD, Neuropsychiatry disorders</p>	<p>0 - 18</p>

Name of service/ team	Brief description of provision	Age range covered
<p>Physical Health & Disability (CAMHS) The Forest Southwell Road Mansfield Nottinghamshire,</p>	<p>Targeted Evening clinics Description A specialist provision for children and young people with learning/physical disability and health needs.</p>	<p>0 - 18</p>
<p>Rushcliffe (CAMHS) Address Thorneywood Porchester Road Nottingham NG3 6LF</p>	<p>Generic - multidisciplinary A generic outpatient sector multi disciplinary team offering assessment, intervention and consultation working at a Tier 3 level. The team is also involved in the training and support to other professionals.</p>	<p>0 - 18</p>
<p>Self Harm (CAMHS) Thorneywood Porchester Road Nottingham NG3 6LF</p>	<p>Targeted On call self harm assessment service providing assessment and follow up for the under 16's admitted to paediatric wards at QMC</p>	<p>0 - 18</p>
<p>South, East & Central (CAMHS) South East and Central Team Thorneywood Porchester Road Nottingham. NG3 6LF</p>	<p>Generic - multidisciplinary A child and adolescent multi-disciplinary sector team offering therapeutic intervention, consultation and support to all Tiers.</p>	<p>0 - 18</p>
<p>Support After Adoption (Greater Nottm) (CAMHS) Thorneywood Porchester Road Nottingham NG3 6LF</p>	<p>Targeted A service commissioned to provide CAMHS intervention with adopted children, young people and their families. We are presently offering a service to families at various junctures in their adoption journey; some just prior to adoption, some immediately post, and others many years post adoption</p>	<p>0 - 18</p>

Appendix 5 Staffing

Source: Child Health and Maternity Mapping website, 2007/08 unvalidated (taken 14 August 2008)

	Adolescent Unit (T4)	Afro-Caribbean Support Project	Bassetlaw	Broxtowe Hucknall	Children Looked After (Resid, Adopt, Foster, Leaving Care)	Day Unit (T4)	Gedling	Head 2 Head and Young Sex Offenders	Learning Disability	Looked After Children	Mansfield & Ashfield	Newark	North & West	Paediatric liaison	Parent/Child Interaction team	Paed Developmental Neuropsychiatry	Physical Health & Disability	Psychological Support Service for Young People and Families	Rushcliffe	Self Harm	South, East & Central City	Total Notts CAMHS (inc T4)	Total England (inc T4)
Nurses	13		0.4	0.7	0.3	3	0.7	10		0.3	5	0.8	1.6		0.6				0.6	2	0.7	39.7	2,286
Doctors	4.6		0.6	0.2	1.7		0.8	0.5	0.6		2.3	0.8	0.6	1		1.3			1.9		1	17.9	1,145
Clin Psychol		0.5	1	0.5	1.1		0.8			0.8	0.5		0.2				2.2	6.3				13.9	1,149
Ed Psychol																							49
Social Workers			1		3		0.7	0.8		1.8	1	1										9.3	657
Psychotherapists					0.2					0.4			0.6						0.1			1.3	267
OT	1																					1	181
Family Therapists	0.2		1	0.7						0.8	0.8		1	1	0.3				1			6.8	326
Other Qual Therapist	0.5	0.5								0.5	1.45							1.25				4.2	342
Other Qual																							354
Other Unqual		1																				1	282
PMHW				0.8																	1	1.8	619
Managers					1			1		1												3	315
Admin	1.6	0.2	1.4	1	1		1	1.6		0.5	1	1.2	0.6	0.5		0.5	0.2	2	1	0.5	0.8	16.6	1,563
Other Staff Groups	5					1		1											1			8	839
Total staff	25.9	2.2	5.4	3.9	8.3	4	4	14.9	0.6	6.1	12.05	3.8	4.6	2.5	0.9	1.8	2.4	9.55	5.6	2.5	3.5	124.5	10,375

Appendix 6 Primary presentations of caseload (Nottinghamshire CAMHS County and City)

Source: Child Health and Maternity Mapping, 2007/08 (unvalidated)

Service	Hyperkinetic Disorders	Emotional Disorders	Conduct Disorders	Eating Disorders	Psychotic Disorders	Deliberate Self Harm	Substance Abuse	Habit Disorders	Autistic Spectrum Disorders	Developmental Disorders	Not Possible to Define	Other Disorders	More than one Disorder
Adolescent Unit	1	9	1	12	13			1	2	3			
Afro-Caribbean Support Project		17	11			6						23	
Bassetlaw	17	44	17	5	2	17		2	10	6			
Broxtowe, Hucknall	3	21	5	8		6			2	2			
Children Looked After, Residential, Adoption, Fostering and Leaving Care	16	59	26	5		8	10	2	9	11			
Day Unit	8	23	18						3	8			
Gedling		8		2									
Head 2 Head and Young Sex Offenders	15	108	51	3	27	14	48	4	3	2		2	
Learning Disability		2			1					2			
Looked After Children		43	1						2			2	
Mansfield & Ashfield	114	97	34	14	3	11	2	3	14	1			
Newark	25	48	13	8	1	8			5	4			
North & West	5	41	4	6		8	1	1	4			1	
Paediatric liaison	4	40	3	3		2		3	1			32	
Parent/Child Interaction team	1	21	20			2	1	1		3			
Paediatric Developmental Neuropsychiatry	10	3	3	1		1		8	3	2			
Physical Health & Disability		14	6					2	12	11		17	
Psychological Support Service for Young People and Families	17	94	58	2	2	17	4	10	85	38			
Rushcliffe	6	41	7	16	1	9	4	3	5	3		1	
Self Harm		2	2			20							
South, East & Central City	10	25	9		1	3	1		2	1			
Total	252	760	289	85	51	132	71	40	162	97		78	

Appendix 7 Six aim of CAMHS Workforce Planning

Six Aims of CAMHS Workforce Planning	Local issues identified at Workforce Planning Session held on 23 rd April 2008
<p>Improve workforce design and planning</p>	<ul style="list-style-type: none"> ▪ Workforce planning should be based upon the CAMHS needs assessment – targeting the most appropriate groups with the right workforce ▪ We need better communication between tiers ▪ There should be free communication between service providers and commissioners, in which the plan is commissioner-led but professional-informed ▪ Providers need knowledge of commissioners' expectations ▪ The workforce plan should provide a structure and timeframe ▪ Primacy should be given to skill mix
<p>Identify and use creative means to recruit and retain</p>	<ul style="list-style-type: none"> ▪ The skill mix should reflect the community being served, around ethnicity, culture and religious diversity ▪ Create new roles based on skill mix and recruit creatively based on this within appropriate financial levels ▪ Competency and capability issues need to be addressed – with clear lines of accountability ▪ Develop clinical supervision frameworks.

Six Aims of CAMHS Workforce Planning	Local issues identified at Workforce Planning Session held on 23rd April 2008
Facilitate new ways of working across professional boundaries	<ul style="list-style-type: none"> ▪ Promote collaborative working across the tiers in an integrated way ▪ Well-defined and integrated working ▪ Facilitation of working across the tiers
Creating new roles	<ul style="list-style-type: none"> ▪ Adopt a skills-based approach ▪ Developed within clear limits of clinical accountability to manage risk ▪ Identify distinct areas of clinical expertise – what do we want at tier 2/3? New roles could include interface staff who can do both ▪ Interface specialist working roles ▪ The needs assessment will help to identify gaps and create new roles, e.g. working in a diverse/ multi-cultural way ▪ Promote knowledge sharing between teams ▪ We need a gap analysis between tiers 2/3/4
Develop leadership and change management skills	<ul style="list-style-type: none"> ▪ Create a baseline to identify training required and match against service needs (specific evidence based/ mapped) ▪ Create a support network to facilitate change
Develop the workforce through revised education, training and development	<ul style="list-style-type: none"> ▪ All staff should have access to needs based training and development ▪ Develop competency-based training, including cultural competence ▪ Relate to new ways of working and evidence based practice ▪ Aim for consistency across all partner agencies ▪ Develop appropriate levels of supervision ▪ Clinical development should be available for staff ▪ Aim to pool training budgets

Six Aims of CAMHS Workforce Planning	Local issues identified at Workforce Planning Session held on 23rd April 2008	
	<ul style="list-style-type: none"> ▪ Education and training on skills-based learning rather than professional group-based learning 	
The following elements focus on increasing capacity and capability		
Recruitment Incentives, effective HR support, new markets	Retention Opportunity, development, career pathways, training, flexible working	Education and training Linked to competence/ effective practice
New ways of working Change management, leadership, new roles if appropriate	Education and training throughout tiers 1-4 Tier 1 Mental Health Awareness Training Specific Post Qualifying Therapy, Linked To Evidence, e.g. CBT Leadership and Management CAMHS Training For New Roles	