

**National Workforce Programme**  
**Child and Adolescent Mental Health**

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Barnet Enfield and Haringey CAMHS

Joint Workforce Plan

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# Barnet Enfield and Haringey CAMHS

## Joint Workforce Plan

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### CONTENTS

|   |   |    |
|---|---|----|
| 1 | Introduction and purpose .....  | 1  |
| 2 | Policy context .....  | 2  |
| 3 | BEH vision and strategy for CAMHS and workforce planning stakeholder workshop.                              | 4  |
| 4 | Population profile and mental health need of children and young people in Barnet Enfield and Haringey ..... | 9  |
| 5 | Workforce in specialist CAMHS – Services, staffing, and skill requirements for current caseload.....        | 13 |
| 6 | The labour market .....   | 31 |
| 7 | Workforce plan and implementation .....   | 37 |

### Appendices

|      |  |         |
|------|--|---------|
| 1    | Issues and priorities identified through the workforce planning workshop ..... | 45      |
| 2(1) | Staffing (Barnet).....   | 48      |
| 2(2) | Staffing (Barnet).....   | 49      |
| 2(3) | Staffing (Barnet).....   | 50      |
| 3    | Case mix.....  | 51      |
| 4    | Case mix to skill mix translation matrix.....                                  | 53 - 65 |

# 1 Introduction and purpose

## 1.1 Ownership and scope

This workforce plan has been drawn up by the workforce team, comprising Jane Lythgow, CAMHS Director, with senior clinicians from the three boroughs and HR support co-opted.

The focus of this plan is the CAMHS workforce, the meaning of CAMHS being:

- All services commissioned by the Barnet Enfield and Haringey PCTs and LAs to support the mental health and emotional well-being of children and adolescents in these boroughs,
- Specifically, the services that function at Tiers 2, 3 and 4 of a comprehensive CAMHS but which may also provide support to Tier 1 services through consultation, training, or other means.

The service delivered by Barnet Enfield and Haringey Mental Health Trust<sup>1</sup> includes some specialist provision to the population of external PCTs/ LAs, and in the report this is made clear where necessary.

## 1.2 Workforce plan and approach

The plan intends to address

- **Recruitment and retention** of staff in specialist CAMHS (Tiers 2, 3, 4).
- **Education and training** as it relates to CAMHS, of staff working in all universal, targeted and specialist services (Tiers 1, 2, 3, 4).

The approach taken in this workforce plan comprises the following process

- 1 Accessing and acknowledging the existing service strategy
- 2 Analysis of existing workforce through examining numbers, disciplines, other characteristics, and activity. In particular this is all gained from the DoH CAMHS Mapping system, publicly available information that has been provided by all NHS Trusts in England
- 3 Analysis of demands on existing services and needs of the population through national demographic data The Office of National Statistics (ONS)
- 4 Accessing basic information about the local labour market
- 5 Facilitating views of local stakeholders on workforce issues and requirements (and capturing these under six principles of workforce planning)
- 6 Bringing together these strands of information to create a workforce plan and prioritise developments in line with service strategy based on an assessment of need and applying best evidence of effectiveness.

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<sup>1</sup> Barnet Enfield and Haringey will be abbreviated as BEH in this document

## 2 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:

**Department of Health (2004) National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06–2007/08.**<sup>2</sup>

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 (PCTs) and Local Authorities (LAs) to lead community partnership by even closer joint working to take forward the NHS Improvement Plan. Building on joint work on Local Strategic Partnerships (LSPs), they will need to work in partnership with other NHS organisations in preparing Local Delivery Plans (LDPs) 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 LAs; and
- offers value for money.

**Royal College of Psychiatrists (2005) New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts.**<sup>3</sup>

This report highlights the changing context of service delivery and the drivers for change. In essence, NWW is about using the skills, knowledge and experience of consultant psychiatrists to best effect by concentrating on service users with the most complex needs, acting as a consultant to multidisciplinary teams, promoting distributed responsibility and leadership across teams to achieve a cultural shift in services. It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce offering a high quality service.

Implications for the workforce planning team include consideration of:

- new roles
- role re-design

<sup>2</sup> <http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf> 3

<sup>3</sup> <http://www.lincoln.ac.uk/ccawi/publications/NWW%20Psychiatrists.pdf>

**Department of Health (2004) Core Document, National Service Framework for Children, Young People and Maternity Services<sup>4</sup>**

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).

**Department for Education and Skills (2004) Every Child Matters Children's Workforce Strategy<sup>5</sup>**

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).

<sup>4</sup> <http://www.dh.gov.uk/assetRoot/04/09/05/66/04090566.pdf> 5

<sup>5</sup> <http://www.everychildmatters.gov.uk/files/7D2DD37746721CC8E5F81323AD449DD7.pdf>

### **3 BEH vision and strategy for CAMHS and workforce planning stakeholder workshop**

#### **3.1 Local Delivery Plan**

In acknowledging national policy and responding to it Barnet Enfield and Haringey NHS Trust has developed a Local Delivery Plan for the whole of the Trust, including CAMHS, *Barnet Enfield and Haringey Mental Health Trust Local Delivery Plan Version 3 (04/02/2005)*.

The following sections from that strategy have been selected for their relevance to the development of this workforce plan. They are listed below in the order in which they appear in the document.

#### **1.3 Service Improvement Strategy**

1. Comprehensive CAMHS by 2006
2. Ensuring that there are effective transition arrangements of patients from CAMHS to Adult – particularly for those young people who on reaching 18 may not meet the admission threshold of adult services (e.g. those young people with ADHD)
3. Establishing a Trust-wide Personality Disorder Service (p5).
4. NICE guidelines - Self Harm – possibly through improvements to A&E liaison  
(Local Delivery Plan 2005/06, p4-15)

#### **2.4 Child and Adolescent Services**

The Directorate has been successful in developing adolescent services, both in terms of adolescent outreach and an acute inpatient unit (New Beginning – which serves the North Central London sector).

In considering the next phase of service improvement, a number of priorities have been put forward:

- a) Developing a single point of access to local services to improve equity and facilitate patient choice in booking.
- b) The introduction of a patient based information system to facilitate e-booking and the collection of data for research, audit and service management and commissioner priorities.
- c) Improving services to the most vulnerable young people in the community, particularly those looked after by the local authorities and those with learning disabilities.
- d) Establishing clear protocols for young people transferring to the care of adult services to ensure that this process is as supportive to the individual as possible.
- e) Developing a range of services for the support of parents with mental health problems so that they can better support the mental and emotional well-being of their children

(Local Delivery Plan 2005/06, p15)

**Objectives specific to workforce** in the Local Delivery Plan 2005/ 06 are highlighted below.

## **5 Workforce Development**

### **c) Temporary Staffing**

Continuing to develop and implement strategies to control and monitor the use of temporary staff, reducing costs and improving effectiveness

### **d) Remodelling roles and designing new jobs**

Introducing new roles including support, time and recovery worker, gateway worker and community development workers in partnership where appropriate with PCTs.

### **e) Recruitment and Retention**

Continuing to implement and develop a range of initiatives to improve recruitment and retention of staff and to support other strategies such as IWL PP:

- Introducing a Trust-wide harassment advisory service;
- Working with NCL SHA to provide pre-employment course to local people;
- Extending the e-recruitment service.

### **g) Equality and Diversity**

- Developing a revised Race Equality Scheme for 2005-2008;
- Ensuring robust monitoring systems are in place;
- Providing employment opportunities for local people, service users, and refugees and asylum seekers.

### **i) Management and Leadership Development**

Providing a range of opportunities for training and mentoring for managers at all levels of the Trust.

### **j) Mandatory Training**

Re-launch a programme of mandatory training for all staff planned around the needs of services making it easier for staff to attend. Organising and monitoring attendance at these and other training events through the new training database.

### **l) Integration**

Continuing to work with partner organisation to support section 31 agreements and facilitate joint working for staff.

(Local Delivery Plan 2005/06, p21)

The LDP also includes a statement of objectives in relation to equality and diversity which although not mentioning workforce directly indicates a strategic intention related to culturally sensitive services that can be taken to have implications for the workforce.

## **9 Delivering Equality and Diversity: Community Engagement**

The Trust is seeking to improve its engagement with local communities to develop capacity to help to understand and deal with:

- Structural barriers to service access
- Variations in treatment and outcome of different ethnic groups
- Stigma and Social exclusion

To this end the Trust is working on developing a strategic role around the equality and diversity agenda which would:

- develop closer involvement and links with community organisations;
- develop a programme to embed better understanding and sensitivity the issues in organisational development;
- provide a focus for the effective use of the 10 community development workers the full complement of who is planned by the end of 2006.

(Local Delivery Plan 2005/ 06, p31)

## **3.2 Workforce planning stakeholder workshop**

The purpose of the workshop was to enable broad participation in the planning process to ensure the plan reflected real issues experienced by the workforce. Issues and priorities were identified using six principles of workforce development, i.e.

1. Workforce Design and Planning
2. New Ways of Working
3. New Roles
4. Leadership
5. Education and Training
6. Recruitment and Retention

Key issues that arose from the workforce planning workshop have been simplified, collated and grouped below. Some may have been moved from their original discussion headings to ones where they are felt to belong more appropriately.

The issues represent a range of views, and may not be wholly consensual. They are recorded therefore as issues that might be informative and helpful for workforce planning, but some may require further attention within subsequent implementation.

The full recording of the meeting (flipchart notes) are shown at Appendix 1.

### **Workforce Design and Planning**

- There is enthusiasm for a workforce planning that is needs-based, outcomes-focused and transparent
- Service factors perceived to be affecting workforce design
  - Interface/ child service vs adult service
  - Tier relationships and relative capacities
- Difficulties and constraints identified include
  - working with multiple commissioners and funding streams
  - multiple provider configurations
  - tensions/ rigidity around professions

## **New Ways of Working**

### **Principles**

- Shift from clinic to community
- Senior person needed to co-ordinate decisions
- Could look at major changes to how existing staff work

### **Resources are felt to be unbalanced for effective care pathways**

- Tier 3 needs appropriate referrals
- Concern at Tier 3 about what happens at Tiers 1 and 2/ Skill needs to sit in Tiers 1 and 2
- Duplication in system

## **New Roles**

### **Better definition needed in relation to key interfaces**

#### **Some existing new roles**

- Outreach Tier 3 MH Workers Enfield
- PMHWs (Joint post with Haringey LA)
  - High turnover, complex caseloads

#### **Suggestions for development of new roles**

- Ensure well defined needs
- Avoid fragmentation
- Work across CAMHS/ AMH transition
- Clarify professional qualifications
- Need support through appropriate supervision, and training and development (see section on training and development)
- Proper involvement in planning and creating new roles

## **Leadership**

- Aspirations include
  - A desire for clarity of leadership and decision making
  - Awareness of the potential for leadership at different levels
- Ideas for potential leadership development include
  - On-the-job support
  - Coaching
  - Shared training

## **Education and Training**

### **Organisation of education and training**

- Education and training are felt to be unplanned and uncoordinated
- A strategic review of training requirements is needed
- A better approach to training needs analysis is needed (inc. specific skills, mandatory training)
- A review/ more consistency is needed in commissioning training and places available
  - Knowledge skills framework
- Learning across different boroughs should be enabled

- Follow on need for supervision

#### **Specific training needs identified**

- Training to support new roles and leadership
  - CBT
  - Risk assessment
- Management training

#### **Training delivery**

- Use of trainers should be effective and cost effective

#### **Recruitment and Retention**

##### **Need for recruitment**

- CAMHS workforce is generally felt to be stable (possibly with the exception of Primary Mental Health Workers)

##### **Bandings and issues about salary levels/ costs**

- Agenda for Change – mostly accepted as right level – good incentive
- Perceptions that staffing is “top heavy”
  - Rationale for top heavy is that specialist CAMHS are working with increasingly difficult and complex cases.
  - But how do lower levels come in?
- Need to recruit at lower end – with development programme – all disciplines
  - Need to look at what is cost neutral
- Tier 2 need similar skills to Tier 3

##### **Attractions and rewards**

- Have tried secondments in the past, but they have not worked well
- Person specifications should avoid being too rigid
- Location of specialist staff can have an impact, e.g. children’s centres
- Staff must feel valued, and have a development programme

##### **Ideas for enabling workforce change**

- Replacing with alternative professions when people leave
- Succession planning

## 4 Population profile and mental health need of children and young people in Barnet Enfield and Haringey

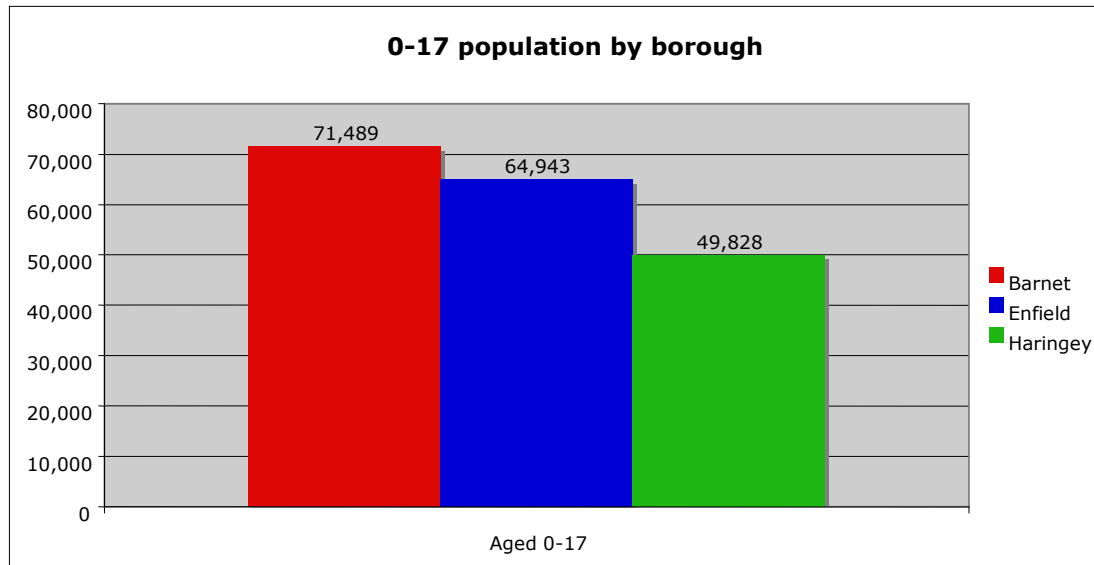
The population is considered in respect of three dimensions potentially affecting demand and specific needs of CAMHS. The dimensions are

- Age profile of the user population
- Ethnicity
- A health profile of the area/ selection of socio-demographic factors

### 4.1 Age profile of user population

Figure 1 below shows the numbers of CAMHS-aged population in each borough and the distribution across the years 0-17. Barnet has the greatest total number, followed by Enfield and Haringey.

**Figure 1 Children and young people in each borough**



As a proportion of the total population the CAMHS-eligible population in all boroughs is identical to the London figure and England overall at 23%-24% (see Figure 2 below).

**Figure 2 0-17 year olds as proportion of total population**

|                               | Barnet  | Enfield | Haringey | BEH     | London    | England    |
|-------------------------------|---------|---------|----------|---------|-----------|------------|
| Aged 0-17                     | 71,489  | 64,943  | 49,828   | 186,260 | 1,618,582 | 11,132,847 |
| Total population (2001)       | 314,564 | 273,559 | 216,507  | 804,630 | 7,172,091 | 49,138,831 |
| 0-17 as % of total population | 23%     | 24%     | 23%      | 23%     | 23%       | 23%        |

In comparison to London and England the population of new-borns each year in the BEH area, over the 18 years up to 2001, was between 5% and 6% of the total population (see Figure 3). However within this range the lower age group was diminishing in England as a proportion of the total population but in London and BEH staying relatively consistent, marginally differentiating BEH and London from England.

**Figure 3 Trend of CAMHS-age population with comparisons**

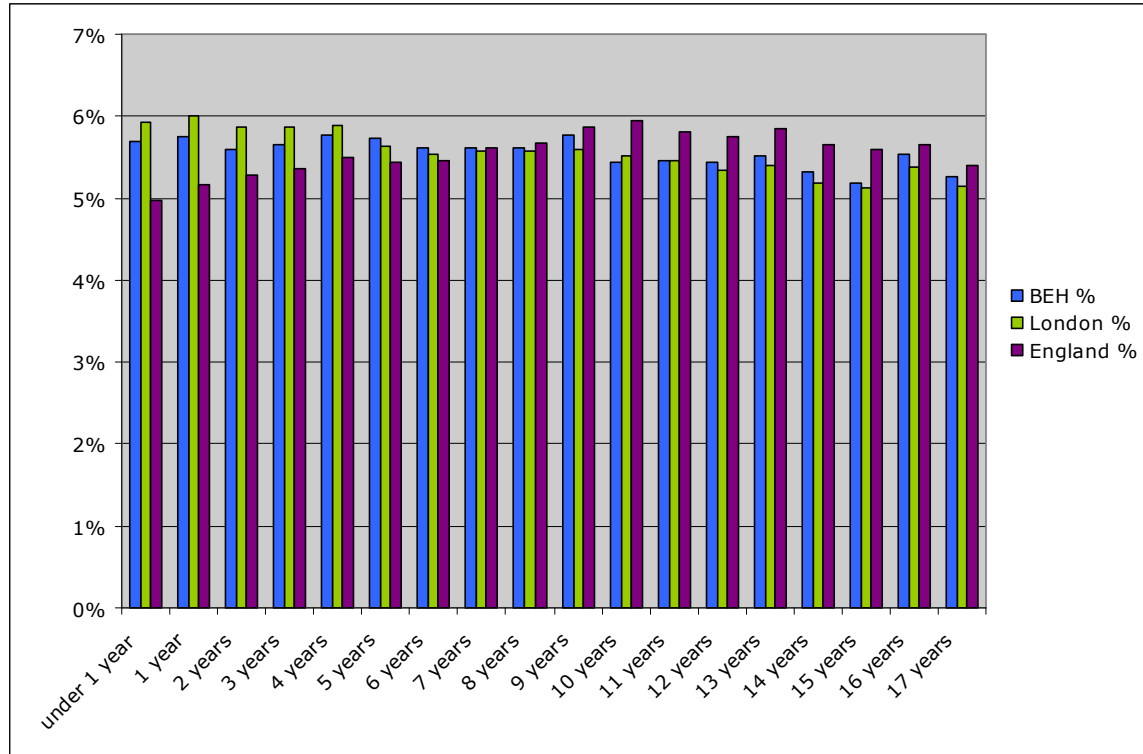
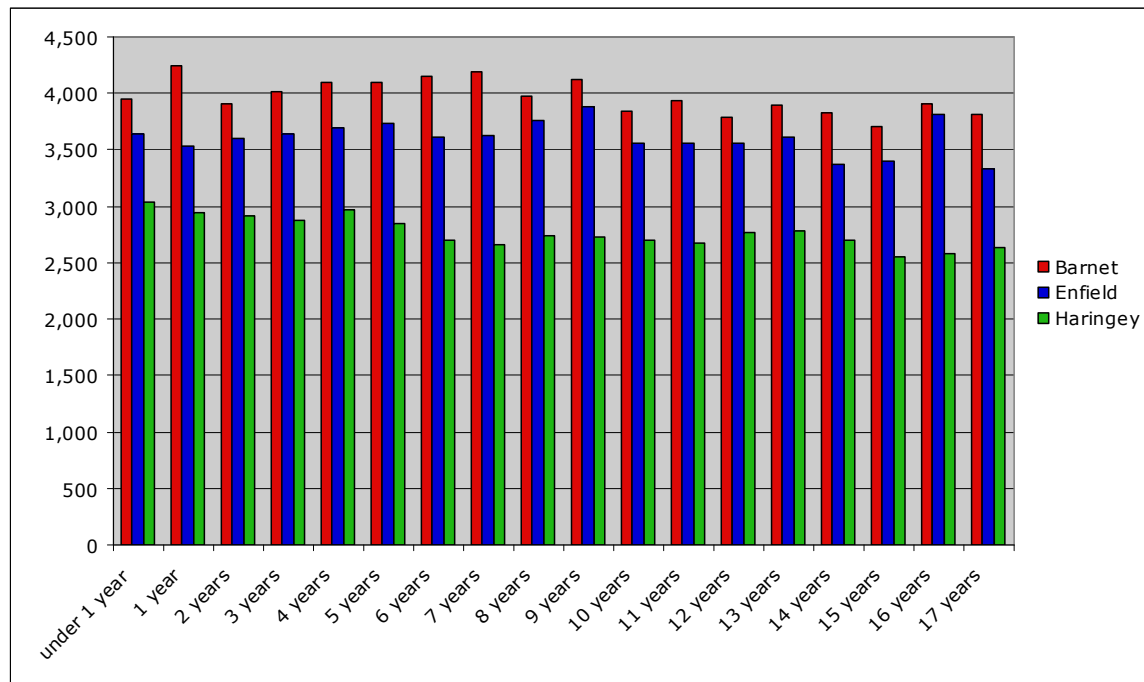


Figure 4 shows a small variation year by year between the boroughs, but there is no particularly notable pattern of variation, with the exception of a gradual upward trend of newborns in Haringey.

**Figure 4 Children and young people by age (0-18) and borough**



The average number of children in each year group for each borough and BEH are:

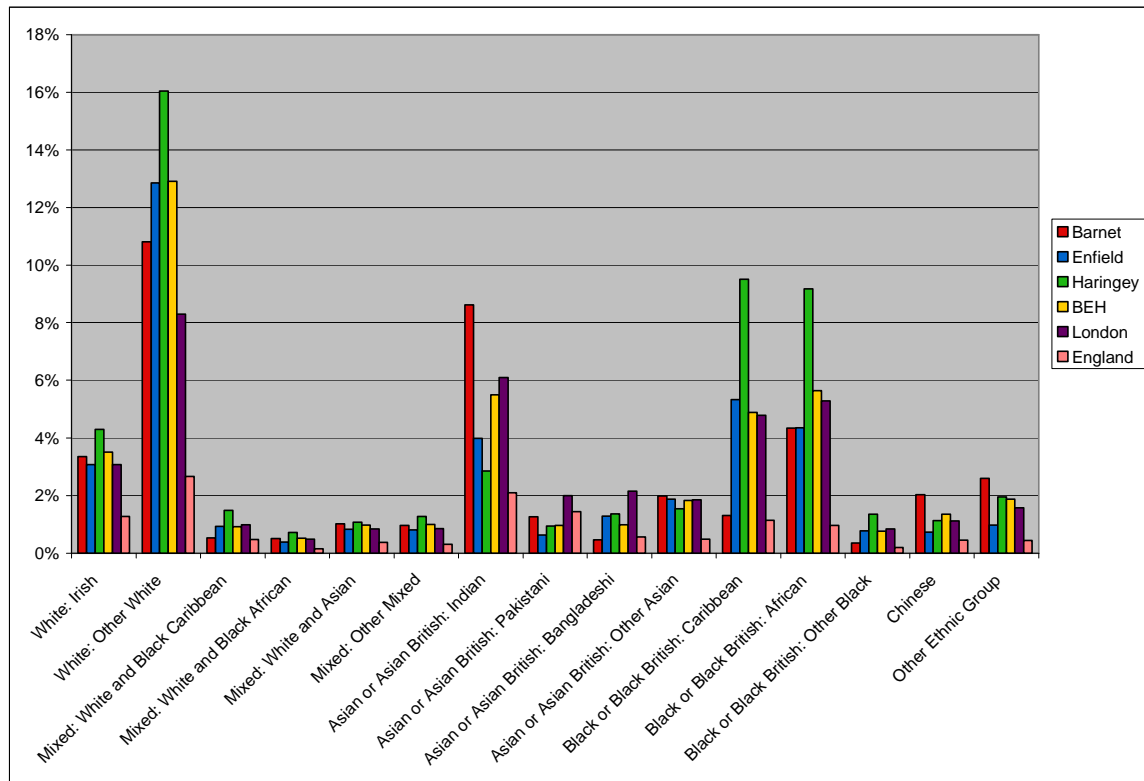
|          |        |
|----------|--------|
| Barnet   | 3,972  |
| Enfield  | 3,608  |
| Haringey | 2,768  |
| BEH      | 10,348 |

**NB** With this analysis based on 2001 ONS data these people in these bands have now (2008) all moved up 7 years. As a result those aged over 11 are no longer in the cohort. Details of births since 2001 are not currently available from ONS data.

## 4.2 Ethnicity

Figure 5 shows a broad range of ethnicities within BEH although many at low levels around 1% - 2% of the total population.

**Figure 5 Ethnicity by borough with comparison areas**



NB White British are excluded from this chart as the large proportion diminishes the scale of the other groups.

Many of the minority ethnic groups are represented at low levels, many at or around 2% of total population. Those groups making up relatively high proportions of the population have particular significance for the demand on CAMHS services. Those representing over 4% of the population are:

|          |  |
|----------|--|
| BEH      | Other white, Indian, African, Caribbean      |
| Barnet   | Other white, Indian, African                 |
| Enfield  | Other white, Caribbean, African, Indian      |
| Haringey | Other white, Caribbean, African, White Irish |

### 4.3 Demand levels for CAMHS/ needs assessment

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

Other information readily available in England is provided by Department of Health community health profiles<sup>6</sup>. Although these do not comprise an established index, a number of health and social indicators may reasonably be assumed to relate to the incidence of mental health problems in children and young people. A small number have been chosen from the full profiles that give an indicative prediction of CAMHS demand, i.e.

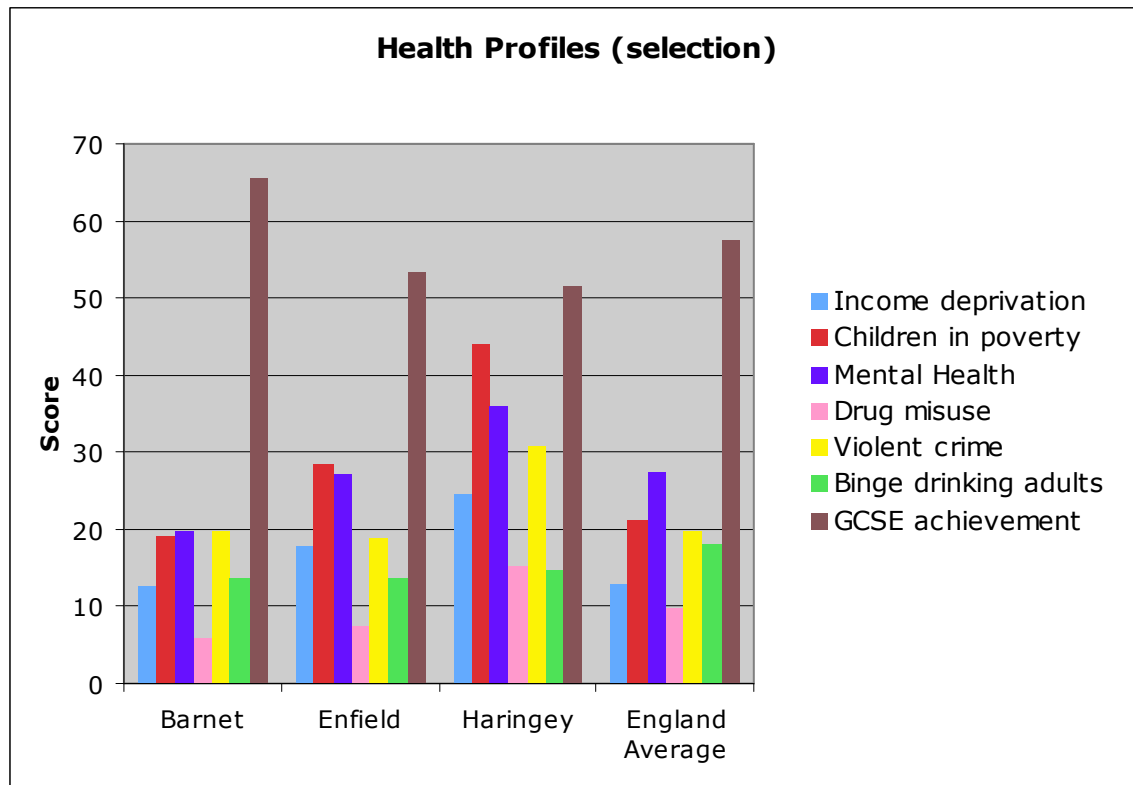
- Income deprivation
- Children in poverty

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

- Binge drinking adults
- Mental Health (of adults)
- Drug misuse
- GCSE achievement (inverse relationship)
- Violent crime (this was added on suggestion of a participant from Haringey based on a perception of the significance of this factor).

Figure 6 below shows a cluster of these factors for each borough and BEH (total) that may be considered a proxy for demand. The overall effect (without any weighting to these factors) suggests an increasing level of expected demand from Barnet to Enfield to Haringey for equal sized populations, in which Barnet is marginally below the England average while Enfield is slightly above, and Haringey more so. Such variation in predisposing factors would suggest that to provide equitable resource levels across the Trust area would need some increases in levels per 100k of total population from Barnet to Enfield to Haringey.

**Figure 6 Proxy indicators of demand for CAMHS**



## **5 Workforce in specialist CAMHS – Services, staffing, and skill requirements for current caseload**

### **5.1 Service description**

Current service provision of specialist CAMHS in BEH comprises the teams below (Source: <http://www.ChildHealthMapping.org.uk>, 2006).

#### **Barnet**

Barnet Adolescent Service  
Barnet CAMHS East  
Barnet CAMHS West  
Barnet Learning Difficulties Team  
Barnet SCAN  
Barnet Looked After Children Team  
Barnet Paediatric Liaison Team  
Barnet Primary Project

#### **Enfield**

Behaviour Improvement Project (Enfield)  
Behaviour Support Service (Enfield)  
Child Development Team (Enfield)  
Enfield CAMHS Dryden Road  
Enfield CAMHS Orton Grove  
Health & Education Access and Resources Team/ LAC (Enfield)  
Hospital Paediatrics (Enfield)  
SCAN Service for Children & Families with neurodevelopmental disorders, En  
Service for Adolescents and Families in Enfield  
Sure Start Edmonton  
Teenage Parents Project (Listening 2 U), Edmonton  
Youth Offending Service (Edmonton)

#### **Haringey**

Haringey Adolescent Outreach Team  
Haringey CAMHS

#### **Wider area and shared services**

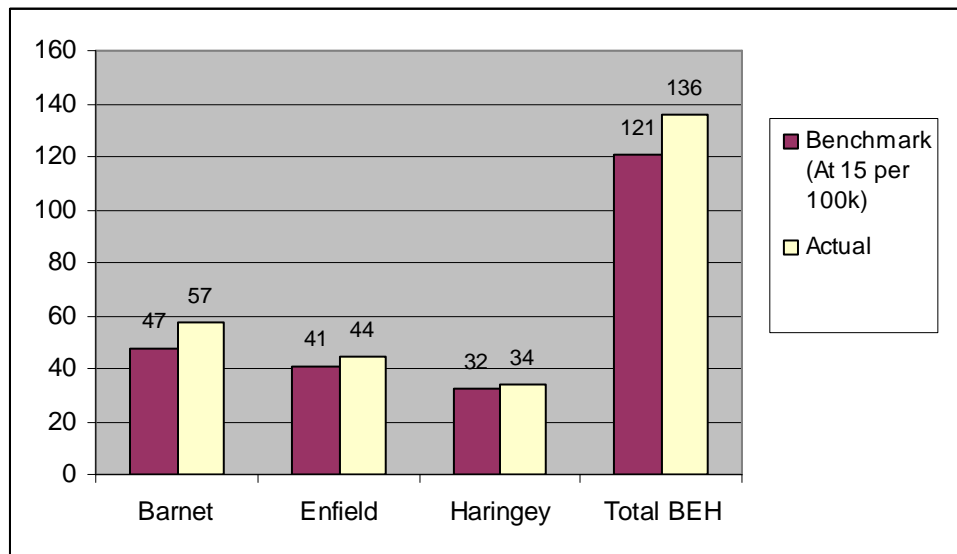
New Beginning (Provides to BEH + Camden & Islington)  
Northgate Clinic (Provides to BEH and several external PCT areas)

## 5.2 Service staffing (overall levels)

Actual staff numbers, as recorded on CAMHS mapping 2006 are shown in Appendix 2. Staffing levels are compared to the benchmark set out in the Children's NSF (2004) of 15 WTE staff per 100,000 total local population. The comparisons made here provide indications of the level of resource in BEH and in each borough service compared to this benchmark.

The established benchmark is for all England and is based on total population numbers, and does not take account of varying levels of need in different areas, according to factors that may impact on the incidence of mental health issues for children and young people, as described in Section 4 above. Figure 7 below shows a comparison of staffing per 100,000 total local population..

**Figure 7 Numbers of clinical staff in Tier 2 and 3 services compared to benchmark (NSF, 2004)**



(These figures exclude staffing judged to be providing to non-BEH boroughs, i.e. a proportion of those from Northgate Clinic and New Beginning.)

The profile suggests that BEH overall has a level of staffing slightly above what might be expected at NSF benchmark levels, by about 15 staff (12%). However the distribution across the boroughs shows the majority of this difference is taken up in Barnet. Without a more refined formulation for staffing levels it is difficult to assess the true significance of this. However based on the indicative needs assessment offered by the health and social profiles shown in Section 2 it might be expected that any surplus above the benchmark level would be most needed in Haringey rather than Barnet. Any difference from the benchmark in Enfield is minimal.

## 5.3 Disciplinary mix

### Composition of service by disciplinary group

Figures 8 show the disciplinary composition of BEH CAMHS

**Figure 8 Proportion of disciplines in total BEH CAMHS**

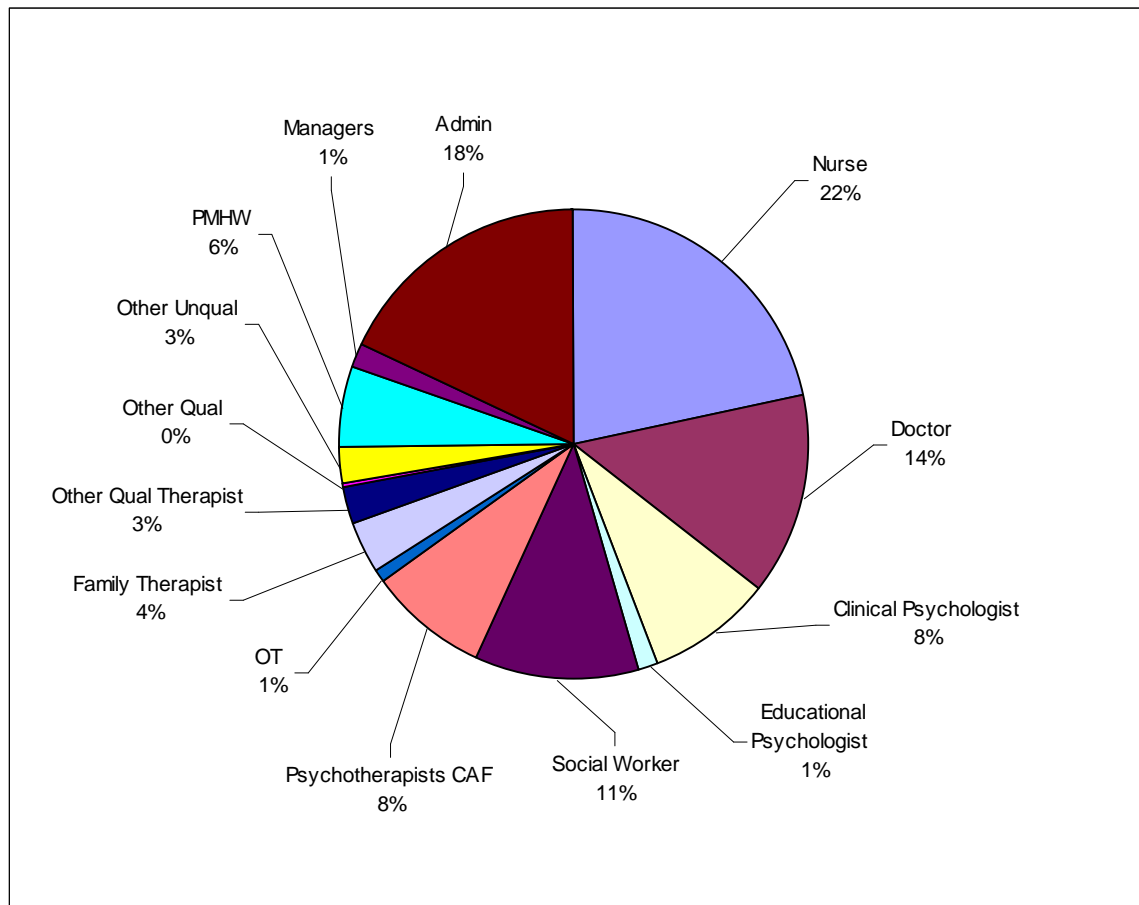


Figure 12 shows the share of staff by disciplines between boroughs. This analysis includes all BEH CAMH services including Northgate Clinic and New Beginnings.

**Figure 9 Share of disciplines across the borough services**

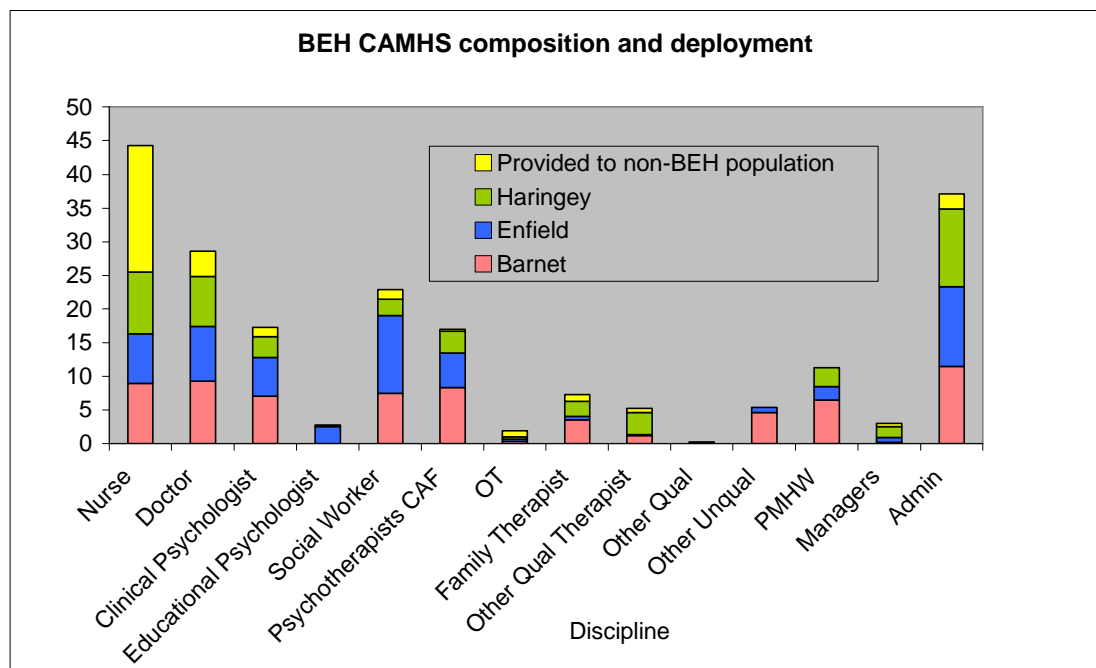
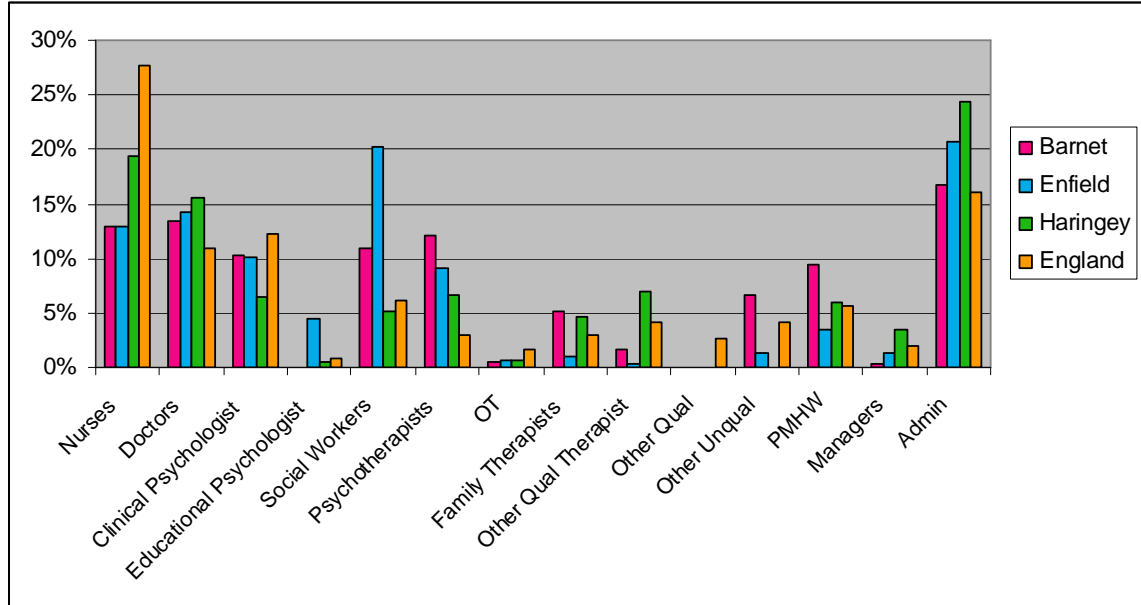


Figure 9 shows a comparison of BEH with the totals of CAMHS across all England.

Some of the resources at New Beginnings and Northgate Clinic are delivered to young people from non-BEH boroughs. An appropriate proportion of these resources has been extracted from the resource levels in the following calculations<sup>7</sup>. Disciplinary mix of Tier 4 services are shown in Figure 11 below.

**Figure 10 Proportion of workforce by discipline (and comparison to England)**

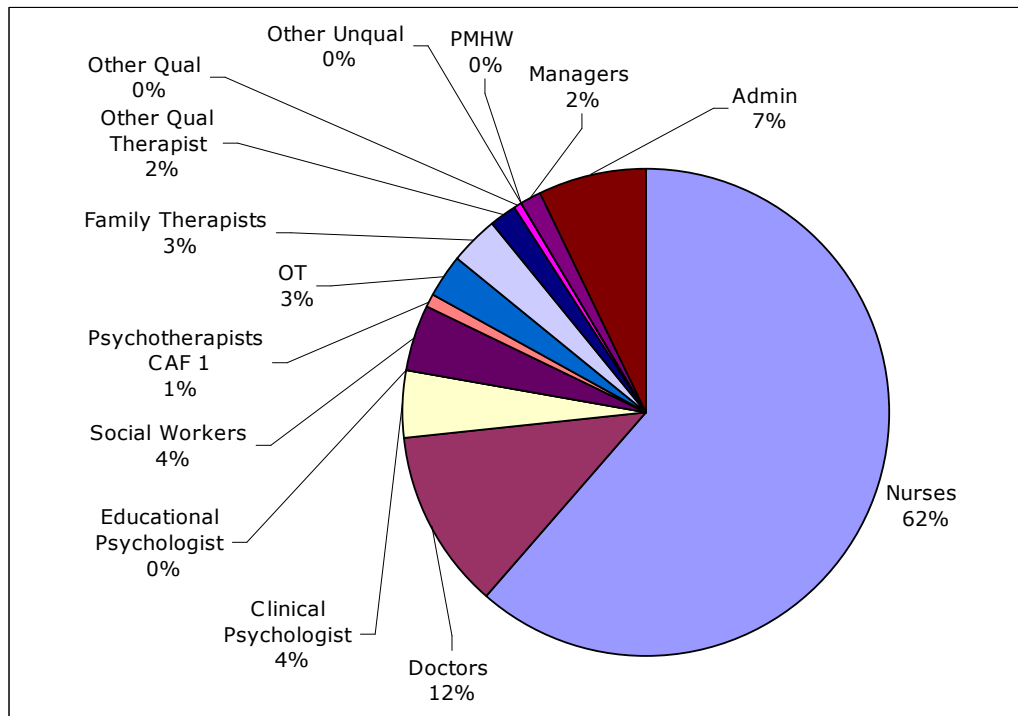


The most significant differences of the whole BEH service from the profile across all England are shown in the table below.

| Lower proportion than England | Higher proportion than England |
|-------------------------------|--------------------------------|
| Nurses                        | Doctors                        |
| Clinical psychologists        | Social workers                 |
| 'Other' qualified therapists  | Psychotherapists               |
| 'Other' qualified staff       | Administration                 |

<sup>7</sup> New Beginning and Northgate Clinic are Tier 4 services. New Beginnings provides to BEH and also Camden and Islington. Northgate Clinic provides to a number of other London boroughs. For the purpose of calculation here it is assumed that New Beginnings provides 20% of it resource to each borough it serves, and that Northgate Clinic provides 15% of it resource to each borough it serves.

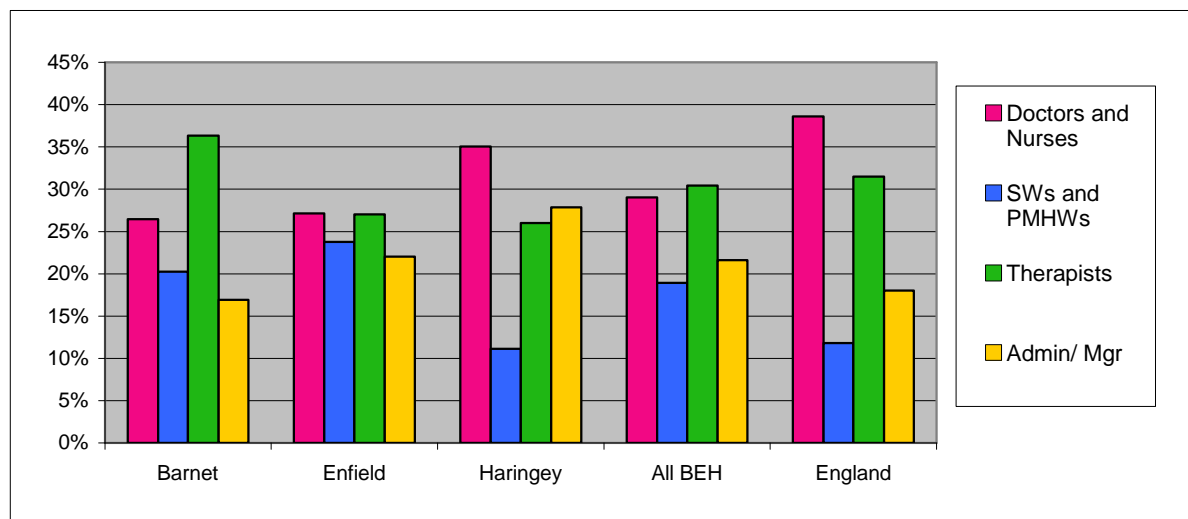
**Figure 11 Disciplinary mix of New Beginning and Northgate Clinic (Tier 4)**



**Functional staff grouping**

Simplifying the staff disciplines into fewer groups may help to make comparisons. The table below draws together staff into 4 related functional groupings:

- i Doctors and nurses
- ii Social workers and Primary Mental Health Workers (similar through both offering screening and signposting functions, enabling intervention focus by other professionals)
- iii Therapists (inc. OTs and psychologists)
- iv Administration and managers



This grouping shows the somewhat different profiles of the services for the different boroughs.

**Barnet**

Barnet has shaped its service with a strong presence of therapists and PMHWs/ social workers compared to the England average. Admin and manager levels are close to the England average. Its proportion of doctors/ nurses is also lower than that of the other two boroughs and of England.

**Enfield**

Enfield’s distinctive characteristic is its relatively high proportion of PMHWs and social workers. This is mostly due to the number of social workers, but it is reported that a high proportion of social workers are trained as family therapists and therefore would add to the level of therapists in this profile). Otherwise Enfield, like Haringey, has lower levels of therapists than England. It has a relatively low proportion of doctors and nurses like Barnet, and similarly below the England average.

**Haringey**

Haringey has a similar profile to England overall, high proportions of doctors/ nurses and admin/ managers, and particularly low on PMHWs and social workers.

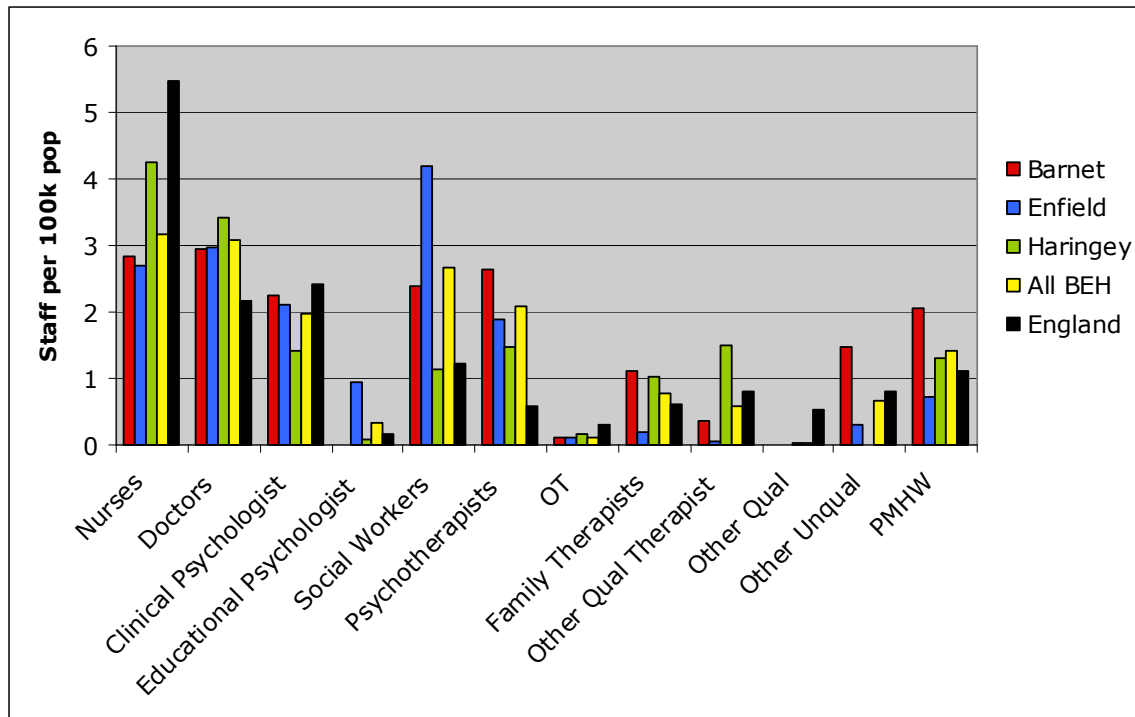
Compared to Barnet and Enfield the Haringey service comprises relatively high proportions of doctor, nurses, and administration/ managers. From a purely quantitative perspective it looks like a service that has maintained a relatively traditional structure which has not yet developed as much diversity in professional mix as the other two boroughs.

**Share of staff groups across the boroughs**

Figure 11 shows the numbers of staff per 100,000 total population by discipline and compares these figures to those in London and England.

The figures for Barnet Enfield and Haringey have excluded the estimated proportion of staff working in Northgate Clinic or New Beginnings on behalf of other boroughs, as these are not relevant to the service provided to the BEH population.

**Figure 12 Staff per 100k population (Boroughs and England)**



This analysis compares levels of staff group across boroughs and compares with London and England. The most significant differences are:

- The level of provision of nurses in Haringey is higher than in Barnet or Enfield, although still lower than for England and London (which is higher than England)
- The level of provision of Doctors in BEH is lower than in London but higher than in England. There is not much difference between the boroughs
- Clinical psychologists in BEH are provided at a lower level than in England and a lot lower than in London, particularly in Haringey
- A big variation in levels of social workers deployed between the 3 boroughs, with Enfield at very high level and Haringey low, especially compared to London
- Very low level of family therapists in Enfield
- Other qualified therapists at high level in Haringey, comparatively (although a low level in absolute terms)
- High level of PMHWs in Barnet compared to both other boroughs and London and England

NB. The average for England or London, or indeed any other area, is not necessarily a target to be achieved. Indeed it might not be desirable. This comparison simply identifies issues that suggest questions about the local service and prompt discussions that may help options for local development.

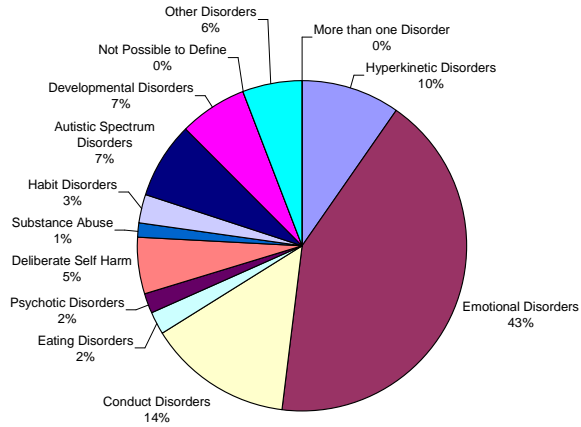
## **5.4 Current case mix and indicative skill mix**

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

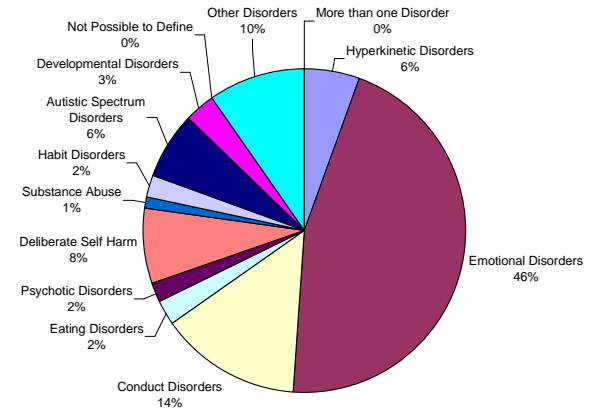
### **Case mix**

The charts in Figure 13 below show the case mix distribution in BEH and in each of the boroughs. This data from DH Child Health Mapping website was collected from the Trust for 2007/08, and at time of downloading was unratified. However it looks quite similar to the previous year's data, and is not expected to be misleading. The raw data is shown in Appendix 3.

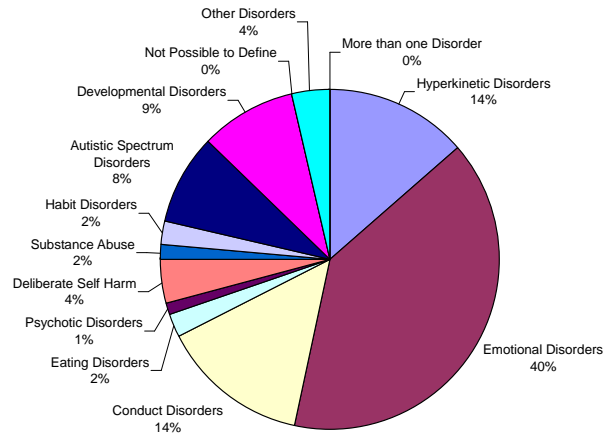
**Figure 13 Case mix by borough**  
**Case mix (BEH)**



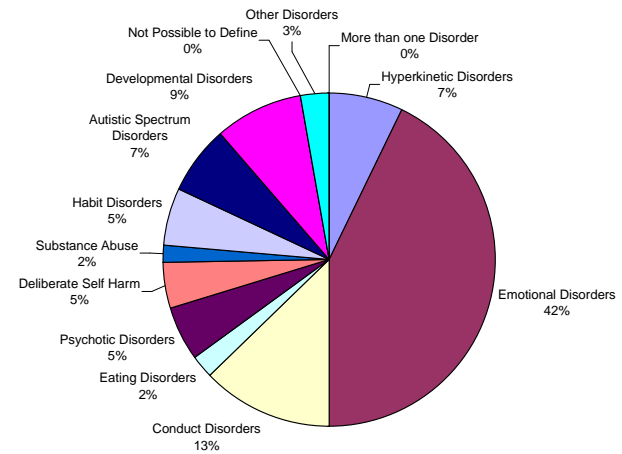
**Case mix (Enfield)**



**Case mix (Barnet)**



**Case mix (Haringey)**



For those who prefer tables to pie charts to examine case mix Figure 14 below shows the same information with comparison to London and England norms.

**Figure 14 Case mix and comparisons (% of total caseload)**

| <b>Presenting problem</b>   | Barnet | Enfield | Haringey | Tier 4 - resident across Trust + Out of Trust | BEH total (inc Tier 4) | London | England |
|-----------------------------|--------|---------|----------|---|------------------------|--------|---------|
| Hyperkinetic Disorders      | 14%    | 6%      | 7%       | 1%  | 9%                     | 9%     | 13%     |
| Emotional Disorders         | 40%    | 46%     | 43%      | 28%   | 42%                    | 36%    | 34%     |
| Conduct Disorders           | 14%    | 14%     | 13%      | 16%   | 14%                    | 13%    | 15%     |
| Eating Disorders            | 2%     | 2%      | 2%       | 5%  | 2%                     | 4%     | 4%      |
| Psychotic Disorders         | 1%     | 2%      | 5%       | 12%   | 3%                     | 3%     | 2%      |
| Deliberate Self Harm        | 4%     | 8%      | 5%       | 22%   | 6%                     | 5%     | 6%      |
| Substance Abuse             | 2%     | 1%      | 2%       | 11%   | 2%                     | 2%     | 2%      |
| Habit Disorders             | 2%     | 2%      | 5%       | 1%  | 3%                     | 2%     | 3%      |
| Autistic Spectrum Disorders | 8%     | 6%      | 7%       | 1%  | 7%                     | 7%     | 8%      |
| Developmental Disorders     | 9%     | 3%      | 9%       | 1%  | 7%                     | 5%     | 6%      |
| Not Possible to Define      | 0%     | 0%      | 0%       | 0%  | 0%                     |        |         |
| Other Disorders             | 4%     | 10%     | 3%       | 1%  | 5%                     | 14%    | 9%      |
| More than one Disorder      | 0%     | 0%      | 0%       | 0%  | 0%                     |        |         |

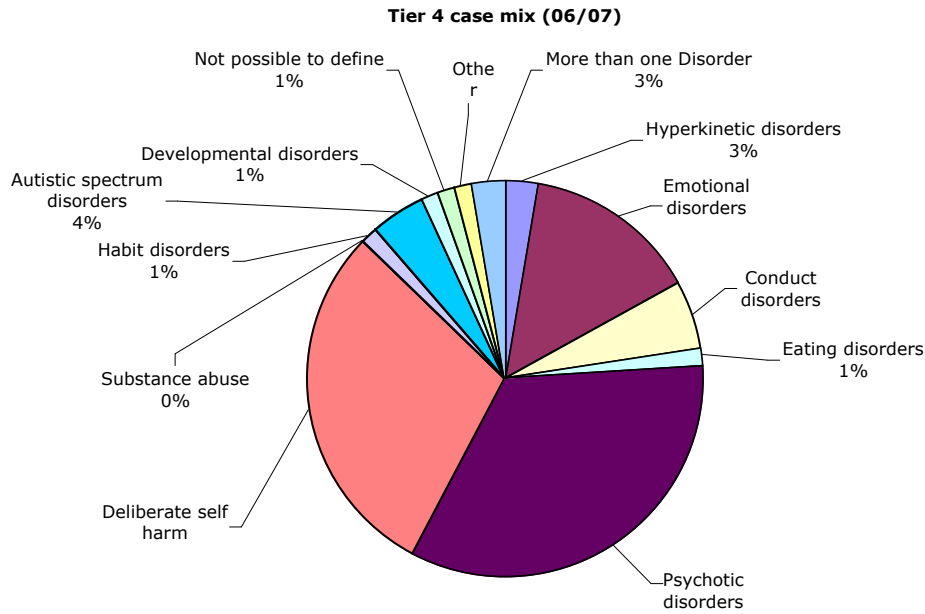
(Source: Child Health Mapping 2007/08 (unratified))

Firstly it is worth noting that the patterns of presenting problems in England and London are very similar, the largest difference being for hyperkinetic disorder, where in London it occupies 4% of total caseload less than in England. As such whether to choose London or England as comparator for BEH does not make much difference. (There may be particular other London boroughs or local authorities that may be preferred comparators, e.g. from ONS).

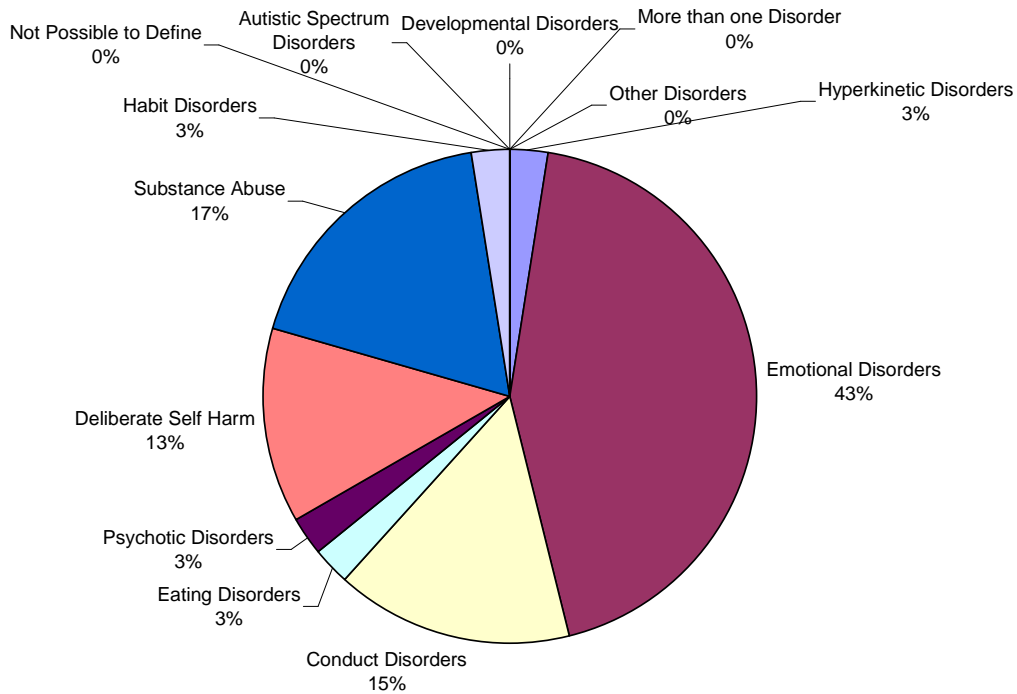
Looking at BEH overall there is very little difference from the benchmark average of London or England. However if we look at the individual boroughs there is more variation at this level. Those with most notable differences are shaded in the table above (blue signifies below the England/ London average, and yellow above the average).

Figure 15 below shows the distinctive case mix of the Tier 4 services at Northgate Clinic and New Beginnings.

**Figure 15 Case mix of Tier 4 services (Northgate Clinic and New Beginnings) (contributing to overall BEH caseload)**



The figure above relates to 2006/07, and below to 2007/ 08. There is considerable difference between the two years which suggests that the case mix may be quite variable in Tier 4 and therefore that the skill mix required needs to be broad in order to cope with the variation over time.



### **Indicative skill mix**

*Drawing on the Evidence*, Wolpert, et al, (2006)<sup>8</sup> has summarised evidence of effective interventions, relating CAMH presentations to a range of interventions that have been found to be effective. Using a translation process based on this it is possible to produce an outline of the skill mix that would be indicated for a particular case mix. To see how this analysis has been developed, please read the full explanation in the original report.

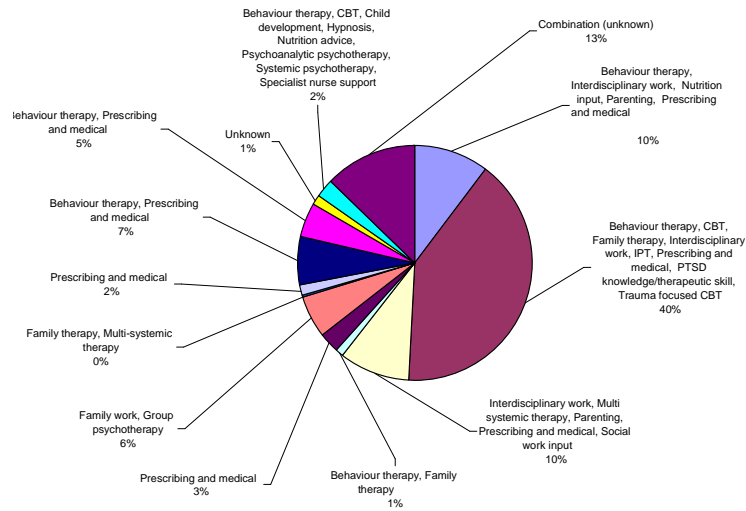
*Drawing on the Evidence* recognises there are several levels of robustness to the various evidence sources, at the top being randomised control trials, and some levels below this. For a fuller explanation of the evidence please see the actual publication. The matrix used here to translate case mix into skill mix uses just the top level of evidence. This matrix is shown in Appendix 4.

From this analysis the charts below show the translation of case mix to indicative skill mix for each borough and BEH.

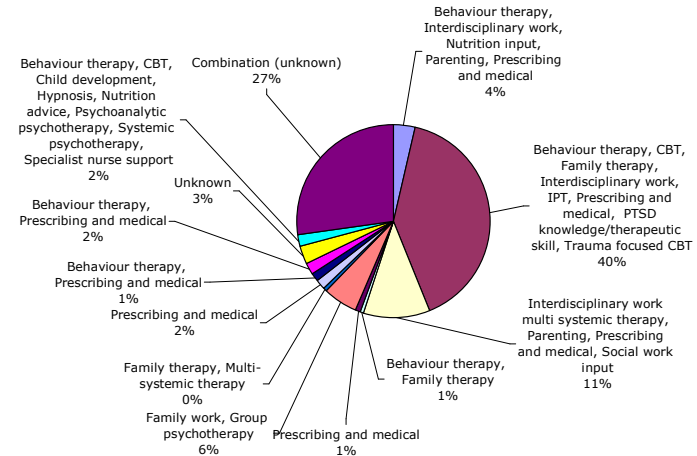
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<sup>8</sup> Wolpert, M., et al, (2006) *Drawing on the Evidence*  
<http://www.ucl.ac.uk/clinical-health-psychology/pdfFiles/DotEBooklet2006.pdf>

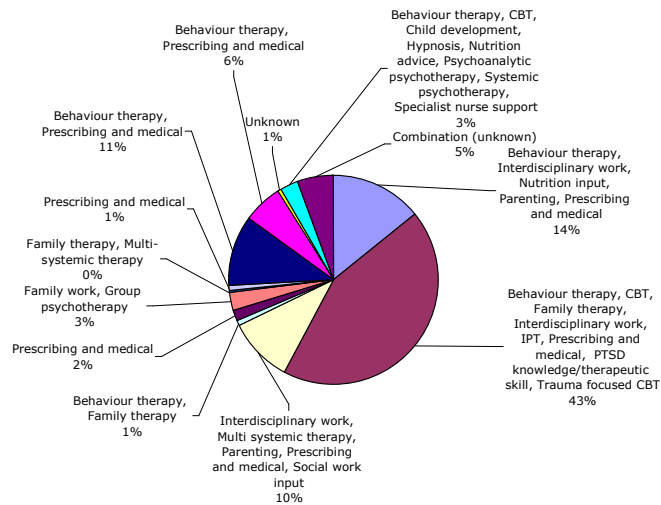
**Figure 16**  
**All BEH**  
**Indicative Skill Mix (by borough)**



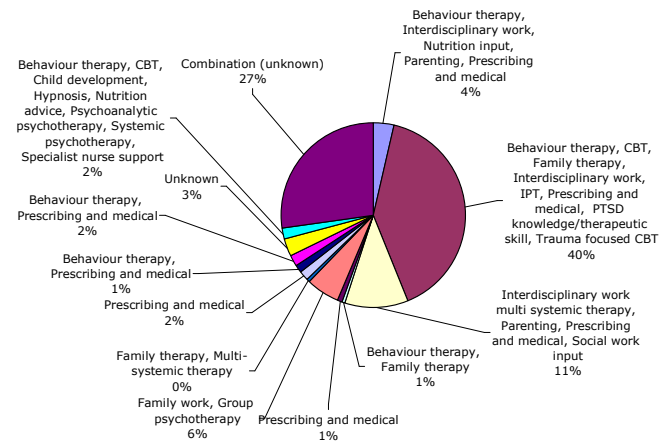
**Enfield**



**Barnet**



**Haringey**



## 5.5 Ethnicity of caseload and local population

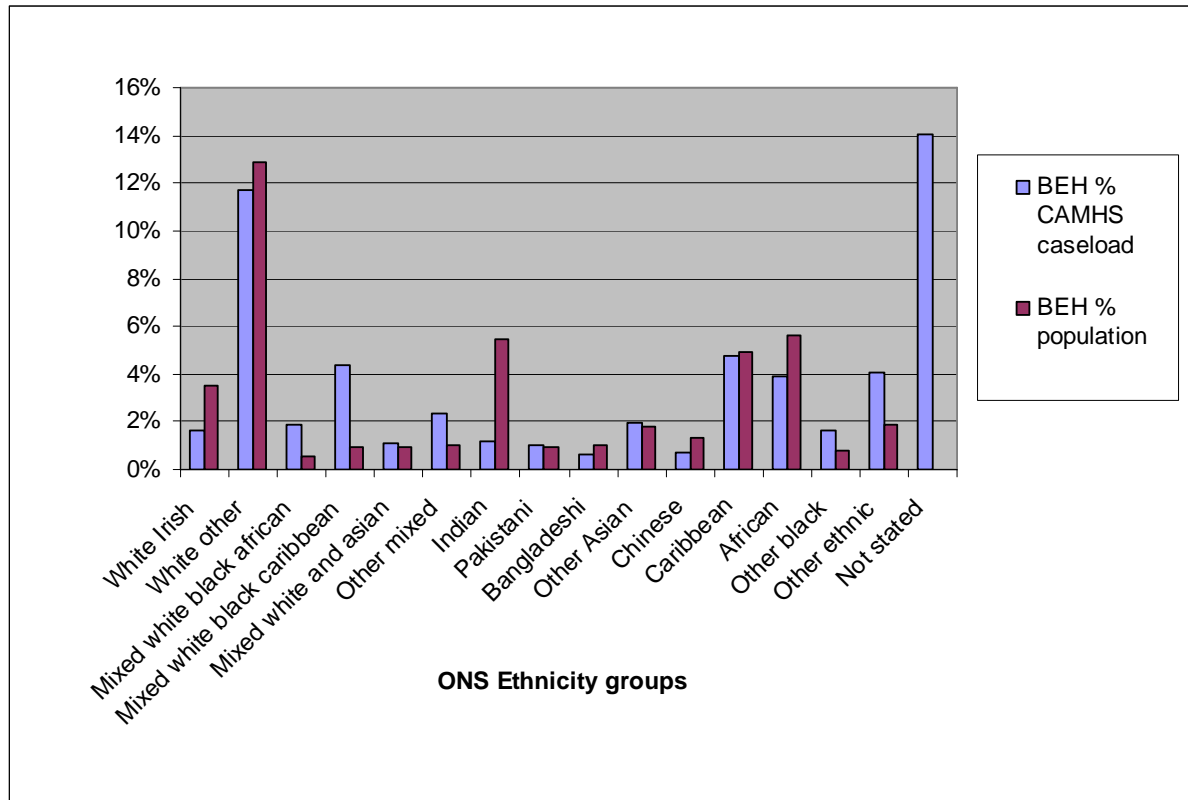
### All BEH

Key features of the BEH caseload ethnicity profile compared to the local total population profile (Figure 16 below) suggest some points of interest concerning variance of levels of various ethnic groups in the caseloads compared to the proportions resident in the local population.

- The most significant ‘under-representations’ in the caseloads are White Irish, Indian, and Chinese.
- The most significant ‘over-representations’ are Mixed White Black African, Mixed White Black Caribbean, Other Mixed, Other Black, and Other Ethnic.

In the charts below White British is excluded due to the adverse effect its inclusion has on scaling in the charts.

**Figure 17 Ethnicity of BEH caseload compared with local population**



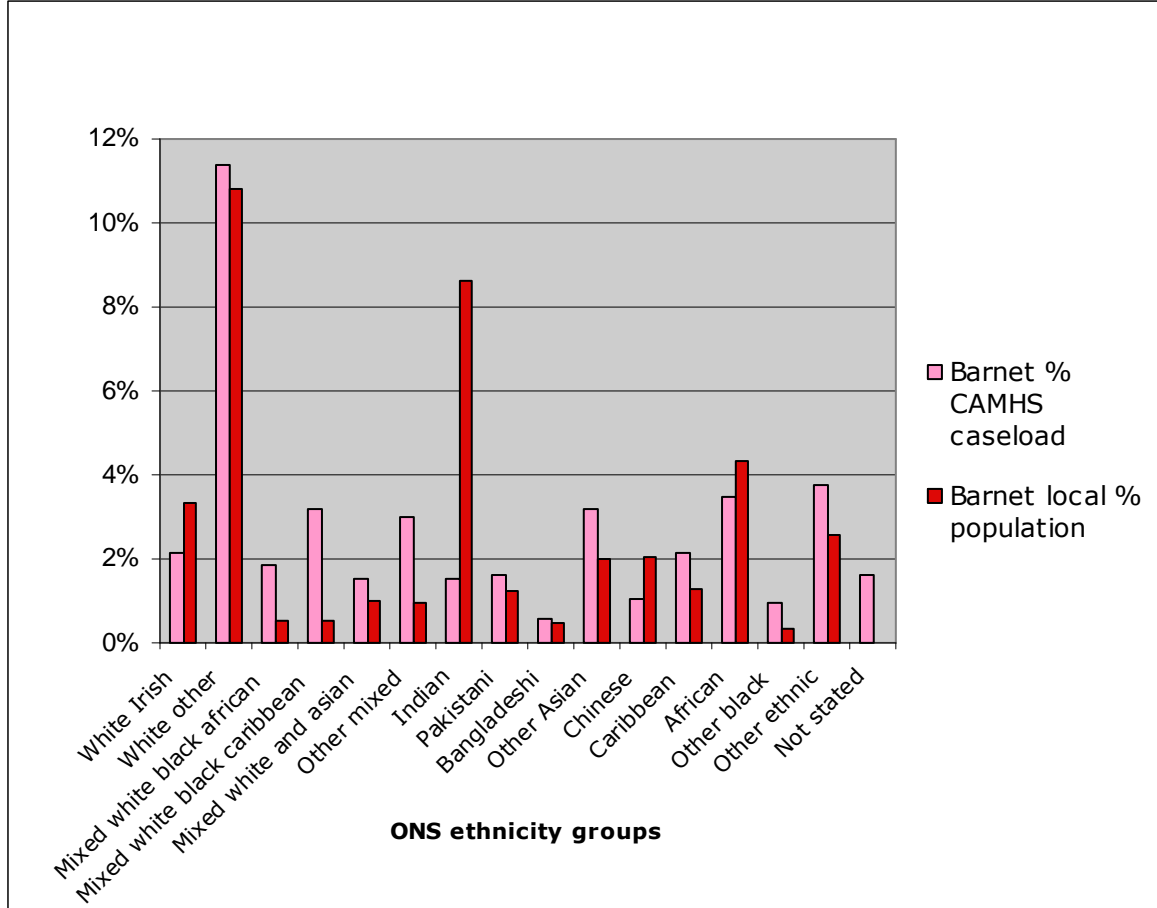
NB<sup>1</sup>. Some of these populations comprise only small percentages of the total BEH population, making the significance less reliable, and are further complicated by the presence of over 300 cases (14%) of total caseload without ethnicity recorded. This is largely due to the effect of a high unrecorded number of cases in Enfield.

NB<sup>2</sup>. Disproportionate representations of specific ethnic groups are also common in other areas of the UK and internationally, relating to a range of factors from varying incidence of morbidity among different ethnic groups, through varying attitudes to engagement with formal services, to discriminatory practice affecting some groups

more than others<sup>9</sup>. This should also be noted in relation to the individual borough profiles, below.

**Barnet**

**Figure 18 Ethnicity in Barnet (caseload and population)**



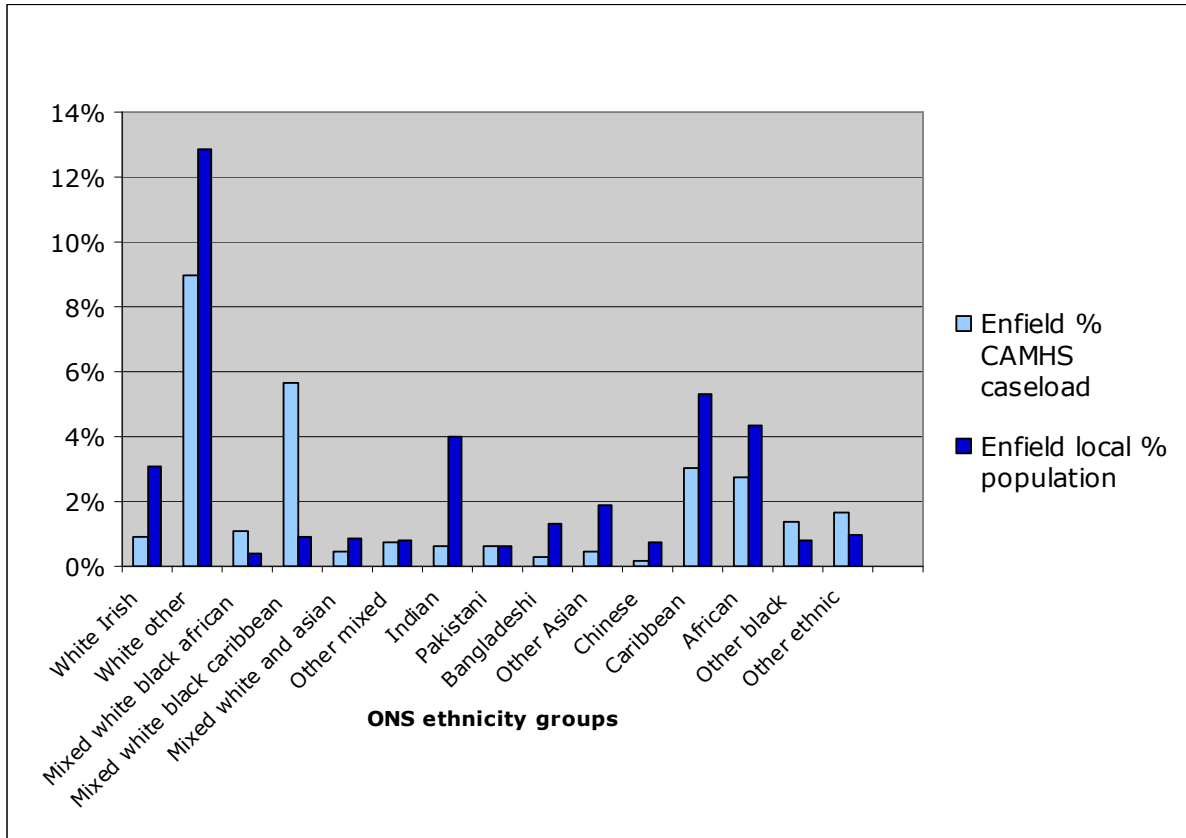
Key disparities between population and caseload in Barnet are:

- Under-representation in the caseloads of Indian population, which is a significant proportion of the local population.
- Over-representations in the caseloads include mixed white-black African, mixed white black Caribbean, and other mixed.

<sup>9</sup> Minority Voices: Young Minds (2005) <http://www.youngminds.org.uk/publications/all-publications/minority-voices/file>

**Enfield**

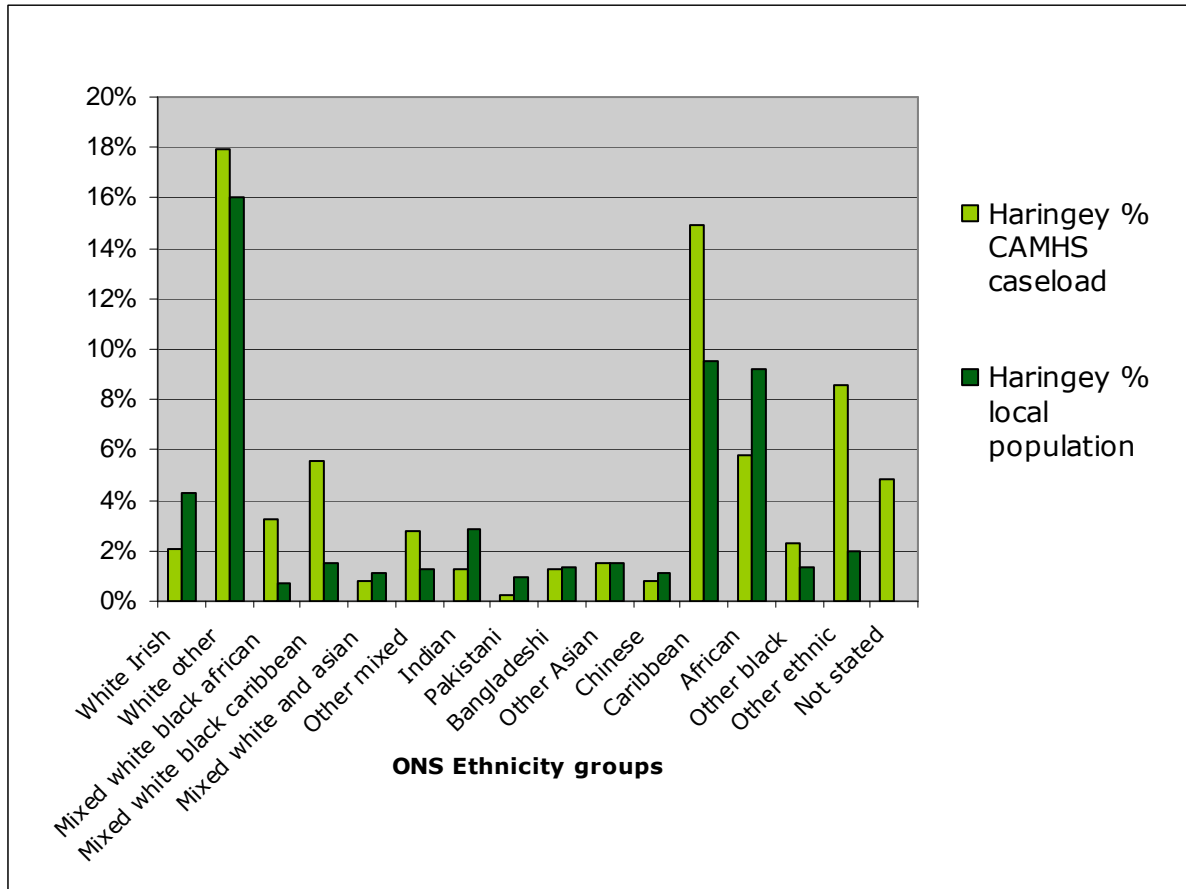
**Figure 19 Ethnicity in Enfield (caseload and population)**



NB 40% of cases in Enfield are recorded with ethnicity 'not stated'. This affects the reliability of these figures substantially, so no comments are made here at this stage, except a recommendation that reasons behind this low level of ethnicity recording should be investigated with a view to improving its usefulness.

**Haringey**

**Figure 20 Ethnicity in Haringey**



Key disparities in Haringey are:

- Under-representation in the caseloads of white Irish, Indian and African, although of these only the African group is significant in terms of size of proportion of the population.
- Over-representations in the caseloads include mixed white-black African, mixed white black Caribbean, and other mixed, Caribbean, and other ethnic.

The observations for each borough may have implications for workforce. One possibility is that inequities in access, particularly under-representation, may be related to a mismatch in the staffing of services compared to that of the local population, particularly that a low relative level of staff with a common cultural background, and maybe language, may be a disincentive to engagement with services. However this would need further investigation to be clear, as other factors may be involved, as mentioned above. Also it might be noted that some of the disparities are common in many other areas of the UK and even internationally.

## 6 The Labour Market

### 6.1 Local labour market

Information about the local labour market is available from ONS, and a locally-focused outline is provided by North London Business. The summary, based on data up to 2006, states:

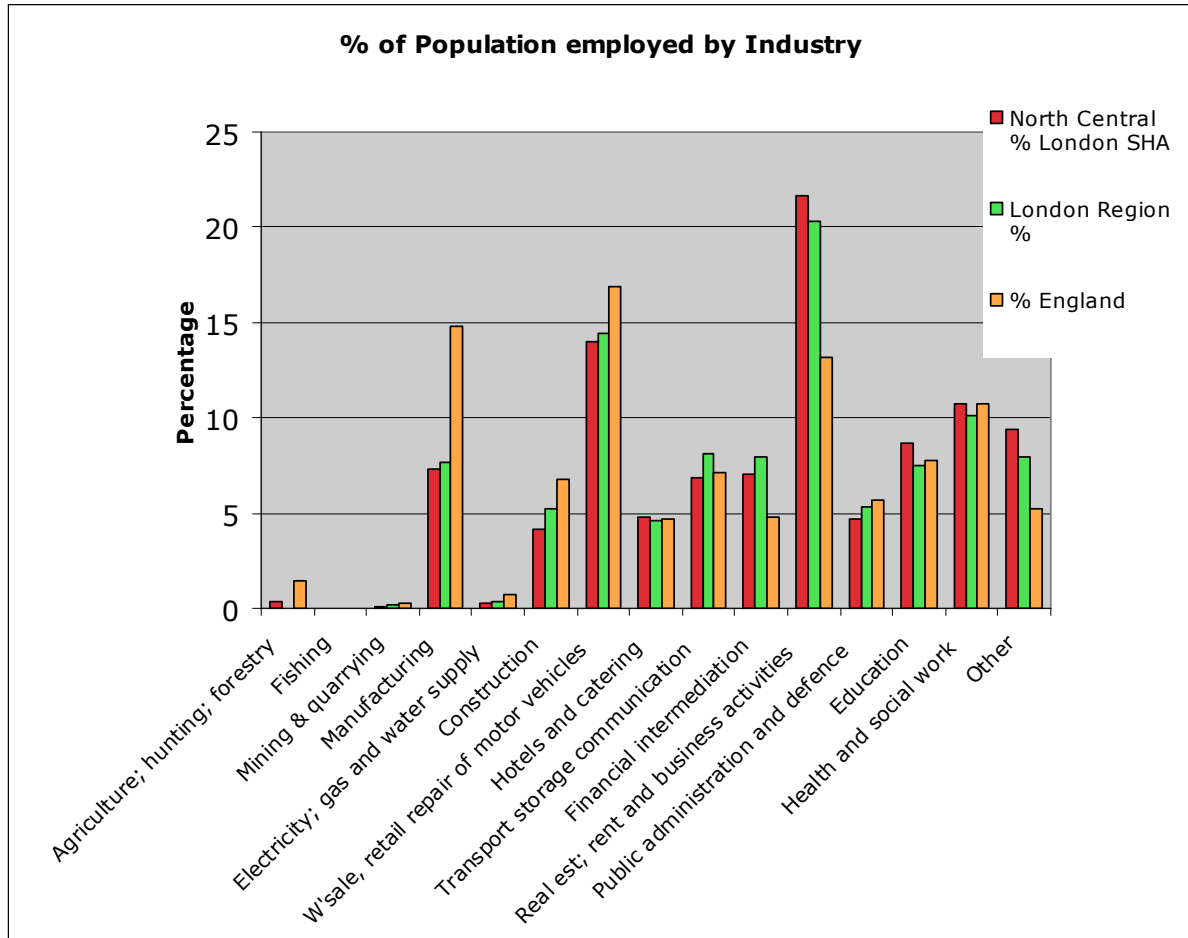
“North London (*this includes BEH and Waltham Forest boroughs*) comprises of 665,000 economically active adults. Due to its accessible location North London businesses have available a pool of well in excess of two million workers with London, Hertfordshire, Bedfordshire, Cambridgeshire and Essex all within comfortable commuting distance. North London has a large proportion of workers in managerial, professional, technical, administrative and educational professions. On average 37% of workers are qualified to degree or professional level. 15% of workers in the borough are self employed and over 30% of all workers work more than 45 hours per week.”<sup>10</sup>

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<sup>10</sup> <http://www.northlondon.org.uk/index.php/38/labour-market/>

### Employment by industry and occupation

**Figure 21 Industries of Employment (North Central London compared to London and England)**



North Central London appears to have a similar profile to London overall. Its main differences compared to England are lower proportions in manufacturing, wholesale and retail, and much more in real estate, rental and business. It has similar proportions of people working in health, social care and education as England overall and London, perhaps slightly above these.

### Proportion of population available for employment/ currently economically inactive

The number of people who are economically inactive gives an indication of the spare capacity in the local population potentially available to employers. Particularly of interest is the number of people in this category who are also 'wanting a job'.

**Figure 22 People who are economically inactive (Apr 2006-Mar 2007)**

|                       | Barnet |      | Enfield |      | Haringey |      | London | GB   |
|-----------------------|--------|------|---------|------|----------|------|--------|------|
|                       | Nos    | (%)  | Nos     | (%)  | Nos      | (%)  | (%)    | (%)  |
| <b>All people</b>     |        |      |         |      |          |      |        |      |
| Economically inactive | 53,800 | 24.2 | 44,000  | 24.7 | 39,100   | 25.7 | 25.0   | 21.5 |
| Wanting a job         | 10,400 | 4.7  | 14,700  | 8.2  | 10,800   | 7.1  | 6.8    | 5.5  |
| Not wanting a job     | 43,400 | 19.5 | 29,400  | 16.4 | 28,200   | 18.6 | 18.2   | 16.0 |

Source: ONS annual population survey  
<http://www.nomisweb.co.uk/reports/lmp/la/2038431881/report.aspx>

Notes: Numbers and % are for those of working age  
 % is a proportion of total working age population

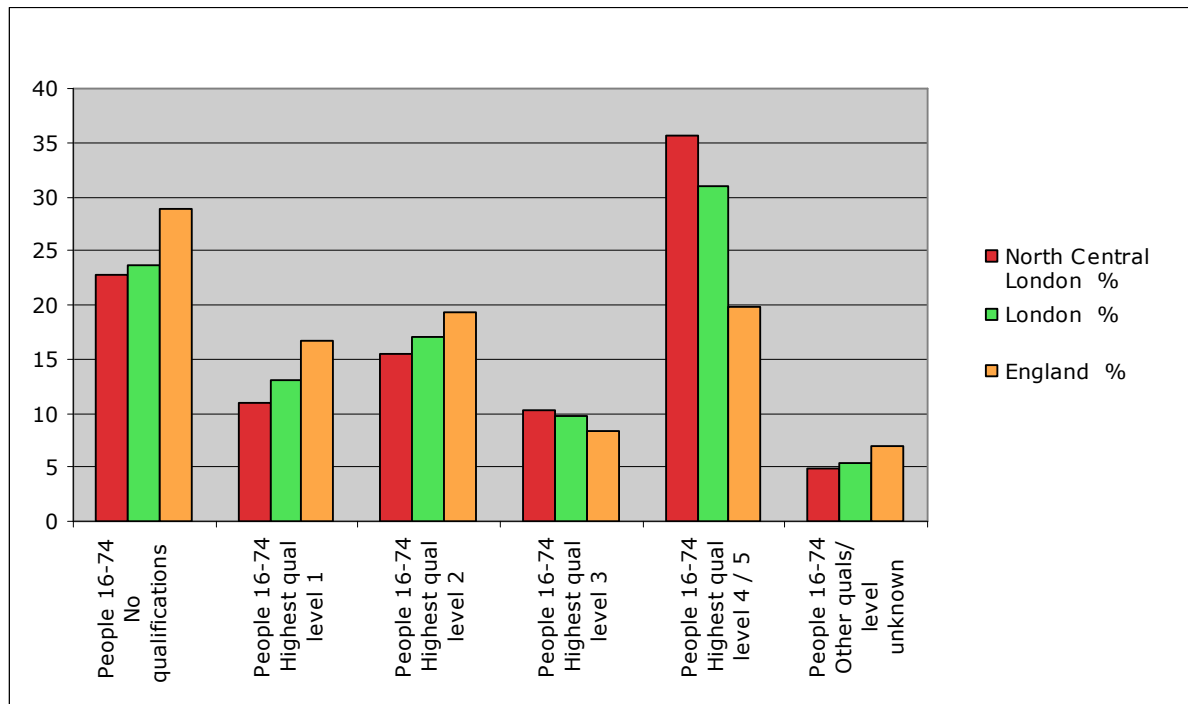
The available figures however do not inform of which educational/ qualification categories those wanting a job are in.

**Qualifications and education of population**

The educational status of the population in BEH gives some indication of whether the local population has the capacity to fulfil workforce requirements or whether it might be necessary to search a wider area in terms of educational levels.

Figure 22 below is based on the population of the SHA area of North Central London which includes the BEH boroughs and also Camden and Islington. There are also other areas to the north east and west of BEH which may also be expected to supply some of the workforce to BEH, but the immediate area is used to give a relatively simple description of the educational and qualification status of the nearby population.

**Figure 23 Qualifications of population of North Central London SHA area**



See footer for explanation of qualification levels<sup>11</sup>

The picture in North Central London is of a population highly qualified (Level 3 and above) in relation England and even to surrounding London, but with lesser percentages of people qualified up to Level 2 (i.e. 5+'O' level passes; 5+ CSE (grade

<sup>11</sup> Level 1 qualifications cover: 1+'O' level passes; 1+ CSE/ GCSE any grades; NVQ level 1; or Foundation level GNVQ.

Level 2 qualifications cover: 5+'O' level passes; 5+ CSE (grade 1's); 5+GCSEs (grades A-C); School Certificate; 1+'A' levels/'AS' levels; NVQ level 2; or Intermediate GNVQ.

Level 3 qualifications cover: 2+ 'A' levels; 4+ 'AS' levels; Higher School Certificate; NVQ level 3; or Advanced GNVQ.

Level 4/5 qualifications cover: First Degree, Higher Degree, NVQ levels 4 and 5; HNC; HND; Qualified Teacher Status; Qualified Medical Doctor; Qualified Dentist; Qualified Nurse; Midwife; or Health Visitor.

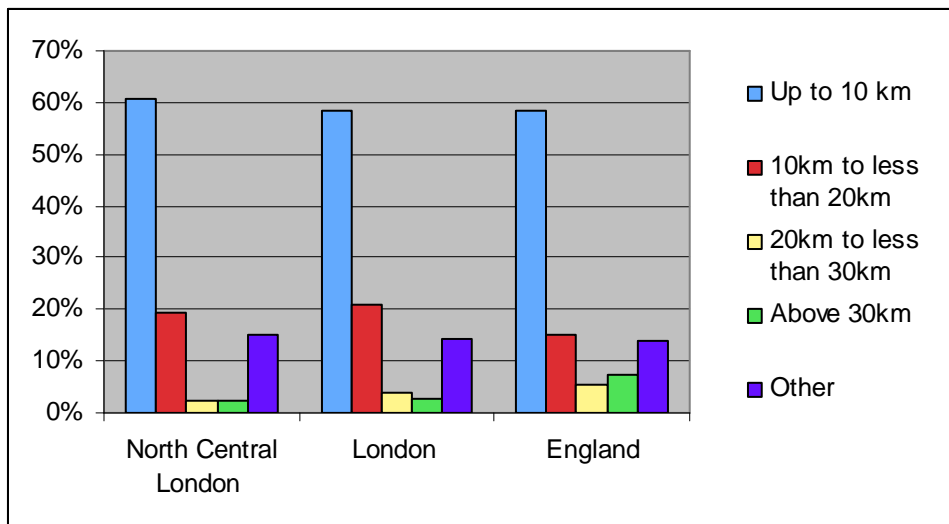
1's); 5+GCSEs (grades A-C); School Certificate; 1+'A' levels/'AS' levels; NVQ level 2; or Intermediate GNVQ). This suggests the local population would be expected to be as able as anywhere to supply the needs of the BEH workforce in terms of qualification levels.

**Distance travelled to work**

The distance travelled to work suggests the potential range from which employees may be recruited. Figure 24 indicates similar patterns of travel for people resident in the North Central London SHA area compared to other parts of London, but some variation from the picture for England, mostly that a slightly greater proportion of the working population in England travel distances above 20km.

Approximately 80% of the population of London travel up to 20km to work, while for England overall it is about 73%.

**Figure 24 Distances travelled to work by people in the North Central London SHA area**



Source:<http://neighbourhood.statistics.gov.uk/dissemination/LeadTableView.do?a=3&b=789824&c=north+central+london&d=81&e=16&g=332161&i=1001x1003x1004&m=0&r=1&s=1200931226187&enc=1&dsFamilyId=121>

NB Other = working from home, no fixed place of work, working outside UK, working at offshore installation

Although there are variations in the distance travelled to work when looked at in these bandings

**6.2 Regional, national and international labour markets**

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses. However, many of the issues raised around recruitment and retention of doctors and nurses apply equally to other professions.

**Psychiatrists**

Pidd (2003: page 408)<sup>12</sup> offers key messages from senior house officers (SHO) about their training, reporting that they want:

<sup>12</sup> Pidd, S.A., (2003) Recruiting and retaining psychiatrists. *Advances in Psychiatric Treatment* (2003), vol. 9, 405–413

- 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 SHOs into psychiatry:

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

## 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)<sup>13</sup> 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<sup>14</sup>, in which it is made clear that the shortage of registered nurses is not just about increasing numbers entering nursing but also about understanding the exit routes out of the profession. If the number leaving, either early by retiring, exceeds the number joining, then an increase in the workforce cannot be achieved. Retention may therefore be seen as critical to future workforce levels.

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

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

Control over working hours and achievement of a work-life balance will be an important determinant to their choice of employment.

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<sup>13</sup> <http://www.rcn.org.uk/publications/pdf/IRN.pdf>

<sup>14</sup>

[http://www2.rcn.org.uk/resources/policy\\_unit/projects/future\\_nurse\\_future\\_workforce\\_project](http://www2.rcn.org.uk/resources/policy_unit/projects/future_nurse_future_workforce_project)

### **Attracting people to work in the NHS**

Arnold et al (2003) researched the reasons why people join, stay and leave the NHS<sup>15</sup>. 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.

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<sup>15</sup> 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 <http://www.lboro.ac.uk/departments/bs/lookinggood/>

## **7 Workforce plan and implementation**

This workforce development plan focuses on challenges for the workforce to meet the needs of the local population. Key dimensions of workforce development will be capability and capacity, but these need to be shaped by the strategic context and to respond to known operational issues.

Through this planning process some strategic objectives were identified through key local documents and stakeholder views. The most significant were:

- 1 Developing strategies to control and monitor the use of temporary staff reducing costs and improving effectiveness (It was reported however that the CAMHS workforce is reasonably stable, so possibly this is more related to Adult services).
- 2 Ensuring equality and diversity in employment
- 3 Continuing to work with partner organisations ... to facilitate joint working for staff

It may be considered that this is an incomplete formulation, and especially so in relation to CAMHS. The following may be useful additions that highlight key workforce issues:

- 4 Ensuring overall effectiveness of services
- 5 Developing services in relation to known needs and demands
- 6 Development of care pathways, or means of ensuring the various teams within CAMHS (as well as with partner agencies) work in a productive, effective and harmonious way.

### **7.1 Developing capacity and capability**

In response to this context, drawing together local strategy with the evidence of local stakeholder views and service data, actions are proposed here derived from the six principles of workforce and its development.

#### **1 Improving workforce design and planning**

##### **Aims/ principles**

A small number of fundamentals were identified as important values behind workforce development in BEH that need to be the basis of the plan. Specifically those identified were:

1. Workforce development should be needs-based, outcomes-focused, and transparent
2. Workforce development needs to support a shift from clinic to community
3. There should be proper involvement in planning and creating of new roles

In relation to the known needs of the local population there may also be a case to include further principles for workforce design, e.g.

4. The workforce should be responsive to the cultural context of the population (and this might be addressed by encouraging for a workforce comprising a match to the local population in cultural diversity, and also a workforce that is culturally competent.

- The workforce should be equipped to deliver services that reflect the best evidence of intervention effectiveness.

### Action 1

These guiding principles should be incorporated into the workforce plan.

### Needs and capacity

In orientating workforce design according to the above principles the needs and capacity indicators suggest some key factors with respect to which the workforce should be shaped:

- The most significant minority ethnic populations are
  - Other white (all boroughs). In spite of the relatively high proportion of this group it is non-specific which is not very useful for workforce planning, and since 2001 (date of the census data) it is likely this group will have grown in line with the national or regional trend of immigration from new EU countries.
  - Asian, particularly in Barnet
  - Caribbean in Haringey
  - African in Haringey
- Marginally increasing numbers of newborns in Haringey (2001 data). If this remains a feature of the population it would suggest some slight weighting in favour of Haringey compared to the other boroughs.
- Differential additional need levels above the England average due to higher incidence in the population of income deprivation and mental illness among adults (ranked by level)

|           | Income deprivation | Mental illness among adults |
|-----------|--------------------|-----------------------------|
| 1 Highest | Haringey           | Haringey                    |
| 2         | Enfield            | Enfield                     |
| 3 Lowest  | Barnet             | Barnet                      |

- Overall capacity of BEH services is close to or above the benchmark NSF recommended levels. However, there is variation in staff numbers per head of population between boroughs: Barnet is relatively high compared to Enfield and Haringey. Additional capacity therefore is unlikely to be a development priority, except if it can be justified on other grounds such as those mentioned immediately above.

### Action 2

The workforce should be assessed in terms of matching the ethnicity of the local population, and additionally, an estimation should be obtained of the extent of cultural competency in the respective workforces. This might be assessed in the context of a wider skills audit, more of which will be mentioned in the section below on capability.

## 2 Recruitment and retention

The CAMHS workforce in BEH is felt to be generally stable and the overall capacity is close to or just above the benchmark NSF recommended level. In consequence there is no clear demand for recruitment processes to enhance current capacity. Any non-replacement recruitment adding capacity would need to be justified on other grounds.

Had that been the case a development recommendation might have entailed a consideration of the labour market and how to better access suitable staff. However this is not the issue, and intensified recruitment efforts within the labour market is therefore not a key objective for improving services.

Concerns that do exist though, possibly as a result of low turnover and also of the outcome of Agenda for Change (A4C), are that many staff are now towards the top end of salary scales and incurring high costs. A4C was mostly accepted as leading to the right levels because specialist CAMHS are working with increasingly difficult and complex cases and require experienced staff, and was therefore perceived as a good incentive. But this is thought by some to have resulted in a workforce that is "top heavy".

The challenge therefore for the workforce plan concerns how numbers and capability can be maintained and developed while also enabling staff at lower levels to be brought in and to achieve good value for money. This is not any easy transformation to make in a service where capacity is at its target level and vacancies are not frequent. The key areas of flexibility seem to be around two areas

- Developing capability among existing staff in line with case mix requirements,
- Taking opportunities to replace high cost staff with others at lower scale points at times of replacement, or by appointing staff of different grades.

### **Action 3**

To take opportunities when recruiting to gradually shift towards a needs-driven and indicative skills-based workforce with strategically matched disciplinary mixes. This will need to take account of the current mix and skill gaps identified, and will therefore vary between boroughs due to the differing starting points. It will involve determining the best disciplinary group to target to provide the particular range of skills being sought and may also be influenced by an effort to create some rebalancing in the total profession mix that has previously arisen.

In some situations it may be possible to achieve cost savings through

- Replacement of high cost staff with alternative grades
- Appointment at the lower end of salary scales, but with development programmes for all disciplines assured

Further in relation to aiming for the workforce to reflect the local community opportunities should be taken to identify how the population can be find suitable roles within workforce.

At times of recruitment certain factors are thought to be helpful in making successful appointments. Specifically

- Person specifications should avoid being too rigid
- Location of specialist staff can have an impact, e.g. children's centres

It was also noted that secondments have been tried in the past but are often felt not to have worked well, and as such is not generally considered a preferred option for developing capacity.

### **Retention**

A possible exception to the general stability of the workforce is among Primary Mental Health Workers, and this group may need some special attention.

Issues identified above under Developing New Roles and Action 5 may also serve the function of supporting the retention of these staff, alongside two other factors identified

- Staff must feel valued

- Staff must have a development programme

#### Action 4

- To establish a process to build in support for PMHWs in the first instance, and any staff groups with high turnover, by means of ensuring that role development and support are identified as functions of line managers.
- To ensure all staff have a development programme
- To make connections to this action with development under Action 5

### 3 New Ways of Working

Particular aspects of service delivery were identified that were felt to need attention and development

- 1 The interface between children's and adult mental health services
- 2 Relationships and relative capacities within CAMHS tiers, ensuring Tiers 1 and 2 directly deliver suitable interventions, make appropriate referrals to Tier 3, and avoid duplication in the system,
- 3 Changing services so they can be delivered more 'in the community' and less constrained by a clinic base.

While such issues that concern care pathways and configuration require collaborative development between services and teams it was also reported that the organisational complexity in the area covered by BEH makes such development difficult, in particular multiple provider configurations and the need to work with multiple commissioners and funding streams.

This militates against a single solution across the Trust area, but does suggest that local borough services need to focus with partner agencies and teams to address the issues, and that configuration issues will need to be considered alongside the capacity and capabilities required.

It was recognised that making such adjustments could involve significant changes to how existing staff work, and that to enable this it was felt that leadership and support is needed from levels of the organisation able to co-ordinate decisions on potential changes.

These can be regarded from the perspective of *New Way of Working*<sup>16</sup> and the *Creating Capable Teams Approach*.

#### Action 5

A consideration of the Creating Capable Teams Approach and engagement in its process may provide a suitable means to addressing these issues. Alternatively these issues could be dealt with through a process mapping approach, alongside an evaluation of the capabilities required for the specific functions involved.

### 4 Creating new roles

In support of some aspects of new ways of working, such as those mentioned above, there have already been some new roles created, namely

- Outreach Tier 3 Mental Health Workers, Enfield
- PMHWs, joint posts with Haringey LA

There is a perception that these posts have attracted complex caseloads and there has been a high turnover of staff. This suggests the job/ role design may not have fully taken account of the issues that can lead to strain, e.g. functions required,

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<sup>16</sup> New Ways of Working for Everyone: A best practice implementation guide CSIP (October 2007)

demands of the new workers, pressures on their performance in new care pathways, capabilities required, support systems, or tensions in lines of accountability. These would need to be further explored to resolve existing issues, but similar processes should be considered in relation to any other future new roles.

#### **Action 6**

Further support through service redesign structures and processes should be put in place for these and other new roles and their development to ensure

- Proper involvement in new role design
- Well defined needs
- Role definition in relation to key interfaces, such as CAMHS/ AMH transition, to avoid fragmentation and/ or duplication
- Support through appropriate supervision, training and development (see section on training and development)
- Clarity of professional qualifications

## **5 Development of leadership and change management**

The analysis of leadership requirements was not carried out in depth in the planning workshop. Nevertheless, two initial aspirations of stakeholders for leadership in the CAMHS system were outlined:

- Clarity in leadership and decision making,
- An awareness of the potential for leadership at different levels.

This is a fairly typical response to working in a complex multi-agency, multi-team environment where there is much opportunity for flux in working arrangements and fragmentation of leadership. It recognises not only that there may be a need for improvement in the strategic and operational management of services in terms of coherence and clarity, but also that the burden of leadership may be shared more widely at different levels of the services, given the authority, suitable role design, and support.

#### **Action 7**

A first step in developing leadership would be to gain a fuller picture of the expectations and challenges for leadership from the leaders and 'the led'. This might start with a process to extend the initial work and identify

- who the current and potential leaders are
- the areas of service delivery where leadership could be extended to
- to distinguish what can be conducted as leadership and what is more properly line management

A key challenge for leaders in the current agenda is to oversee the developments of New Ways of Working, as described above, and this might be a 'real life' focus for developing leadership.

Preferences were expressed that the means of enabling leadership development would be through on-the-job support, coaching, and shared training.

## **6 Education and Training**

The indicative skills assessment, described earlier, offers a way to provide a more rational approach to planning training and development based on actual existing caseloads and the range of interventions best suited in response to the case-mix on the evidence of most effective interventions (Wolpert et al, 2006).

This can offer a response to the sense of needing a better approach to training needs analysis (inc. specific skills, mandatory training) and provide a basis for consistency in commissioning training.

In addition to the core framework for a needs-based skills-focused workforce a number of other supporting features have been identified as desirable to support the fundamental capabilities.

### **Action 8**

An education and training plan should identify the core skill set required for a borough based on the existing caseload and the indicative skills mix.

Commissioning training and development would further be supported by an assessment of the skills compliment currently available and any gaps in relation to boroughs and teams. A simple skills audit compatible with the skills framework used here should be undertaken in order to make that assessment.

In addition to intervention-based skills development training should also include other generic training

- cultural competency (to reflect knowledge of local ethnicity where appropriate)
- risk management
- leadership and management

To support and enable the workforce in its learning a number of other factors should be incorporated or acknowledged

- Training should support the Knowledge Skills Framework
- Tier 2 needs similar skills to Tier 3
- Supervision should be available as follow-on from new learning to ensure it is effectively integrated into practice, including in relation to new roles and leadership
- Learning across different boroughs is thought to be useful

## 7.2 Implementation

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

### Action plan

| Task  | Who is responsible?                                   | Deadline for completion |
|---|---|-------------------------|
| 1. Conduct skills audit of the workforce, to include: <ul style="list-style-type: none"> <li>- Cultural competence</li> <li>- Evidence-informed practice</li> </ul>   | All to be agreed at action planning sign-off meeting. |                         |
| 2. Establish development programmes for all staff, specifically PMHWs, through line management processes.<br>(Support for line managers)  |   |                         |
| 3. Explore the potential for achieving 1 and 2 above through the Creating Capable Teams Approach (CCTA)   |   |                         |
| 4. Implement service redesign structures and processes to ensure <ul style="list-style-type: none"> <li>- Proper involvement in new role design</li> <li>- Role definition in relation to key interfaces, such as CAMHS/ AMH transition, to avoid fragmentation and/ or duplication</li> <li>- Support through appropriate supervision, training and development (see section on training and development)</li> <li>- Clarity of professional qualifications</li> </ul> |   |                         |
| 5. Extend initial work on leadership to identify <ul style="list-style-type: none"> <li>- Who the current and potential leaders are</li> <li>- The areas of service delivery in which leadership could be extended</li> <li>- What can be conducted as leadership and what is more properly line management</li> </ul> (Using New Ways of Working as the framework)   |   |                         |
| 6. Develop leadership through on-the-job support, coaching, and shared training.  |   |                         |

|   |  |  |
|---|--|--|
| <p>7. Design and implement an education and training plan for each borough based on the existing caseload and the indicative skills mix.</p>  |  |  |
| <p>8. Support the commissioning of training and development by providing an assessment of the skills complement currently available and gap analysis for each borough.<br/>(In addition to intervention-based skills development training should also include cultural competence, risk management, leadership and management.)</p> |  |  |

**Goals and milestones TBA**

**Monitoring and review TBA**

## **Appendix 1 Issues and priorities identified through the workforce planning workshop**

### **Workforce Design and Planning**

- 3 boroughs – very different – resource, staffing, configuration. Different commissioners – different priorities. Different funding streams – big differential – some concurrent, some time limited.
- Haringey highest need (smallest team)
- Enfield – resource is slipping
- Inpatient – separate. Large service – regional across 3 boroughs. Medium – wider.
- Difficult to break professional boundaries – service/ profession led. Need model – what is around? Would need process of change.
- Up to now – how has workforce been planned? If at all – mystery. Impact funding – should be outputs/outcomes. Replacing like with like – who should congest – need to use staff leaving as an opportunity. Should be needs based – CAMHS grant has done that.
- Need succession planning.

### **Recruitment and Retention**

- Ask Cathy
- Stable workforce in CAMHS
- Agenda for Change – mostly accepted as right level – good incentive. (Some staff looking for higher banding threaten to leave – but no overflow so far)
- Issues over promises – potential movers
- Staffing top heavy
- Is top heavy a strength for cyp?
- Need to recruit at lower end – with development programme – across all disciplines
- Staff must feel valued - & have a developmental programme
- Gap – interface / child service vs adult service
- Tier system – hierarchy implication – but T2 need different pay/ similar skills to T3
- Specialist CAMHS – working with increasingly difficult and complex cases – rationale for “top heavy”. But how do lower levels come in
- PMHWs – used differently in each borough. Most turn over within this group – now struggling with complex caseload. Has T2 been expanded enough? E.g. Haringey Adolescent Project – should have been T2 but caseload = T3. Just keep them safe.
- Look at person specs – don't be too rigid
- In nursing – have tried creating posts in T4
- Location of specialist staff has an impact (e.g. children's centres) – 3 currently
- Have had secondments in the past
- Not good at secondments – in & out
- Need to look at what is cost neutral. Down turn minimum cost. Could look at major changes to how existing staff work.

### **New Ways of Working**

Model: screaming at T1 – e.g. Leeds type?

Senior person co-ordinate decision-making

T3 – appropriate referrals (some clarification, please)

- Concern at T3 about what happens at Tiers 1 & 2
- Need a shift in thinking – stop duplication in system
- Skill needs to sit in Tiers 1 & 2
- Shift from clinic to community
- DNA Audit T3 – telephone users at home

### **New Roles**

MH Workers – Enfield – outreach from Tier 3

Haringey – PMHW – joint with LA – Tier 2/ 3

GP – some concerns about viability – PT(?) CAMHS not sufficiently involved in planning

#### **Way Forward**

- Define needs
- Consult but not for too long!
- Professional qualifications
- Training & development
- Supervision
- Not too much fragmentation
- Working across CAMHS/ AMH – transition

### **Education, training & development**

- Gaps – CBT
- Review of mandatory training
- Risk assessment – formal training – follow on monitoring
- Learning across different boroughs
- More consistent approach to commissioning training and utilising training
- Making use of internal resources – developing own trainers
- Better approach training needs analysis
- Knowledge skills framework
- Collating data from this
- More costs effective approach e.g. bringing trainers in
- Follow on need for supervision

### **Leadership**

- Clarity about leadership, management & clinical leadership – along individual discipline lines. More work on different roles
- Clarity about decision making
- Concerns about clarity for junior staff
- Need to look at different levels of leadership – on job support, coaching? Training – especially shared training
- Implications of preparing for change for all team members not just leaders
- Links to 'New ways of working' e.g. role of psychiatrists
- What do we want/ expect from leaders?
- Future planning for leadership
- Strategic overview of training requirements
- Mandatory training impacts on ability of people to go on professional training
- Specific need for management training – middle management – practice based training – organisational readiness
- Training available to be flexible and adaptable to needs of service
- User & Carer Involvement – a couple of initiatives happening

- DNA Review – initial HSS 2/ 3 weeks
  - ~ Need to do a “Newsletter” – update on when we are up to & the messages you would like to convey!

### **Education and Training**

- Have tried to co-ordinate – difficult. It is ad hoc/ unfair. Need costed plan. No strategic overview. But now have full set PDPs.
- Also muddle – what is mandatory – even that is not co-ordinated – what is optional?
- Specific need for management training – problem area. Need to influence commissioning of training places.

CAMHS Partnership Facilitation: Workforce Planning

**Appendix 2(1) Staffing (Barnet) (WTEs)**

| Service                                     | Utilisation per BEH borough (Estimate) | Nurses      | Doctors     | Clinical Psychologist | Educ Psychologist | Social Workers | Psychotherapists CAF 1 | OT          | Family Therapists | Other Qual Therapist | Other Qual  | Other Unqual | PMH W       | Managers    | Admin        | Current total staff |
|---|--|-------------|-------------|-----------------------|-------------------|----------------|------------------------|-------------|-------------------|----------------------|-------------|--------------|-------------|-------------|--------------|---------------------|
|   |  |             |             |                       |                   |                |                        |             |                   |                      |             |              |             |             |              |                     |
| <b>Shared + Wider area services</b>         |  |             |             |                       |                   |                |                        |             |                   |                      |             |              |             |             |              |                     |
| New Beginnings (BEH + Cam & Isl)            | 20%                                    | 18          | 3           | 1.3                   |                   | 1              |                        | 1           | 0.5               |                      |             |              |             | 0.5         | 1.7          | 27                  |
| Northgate Clinic (Wider than local service) | 15%                                    | 21          | 4.7         | 1.5                   |                   | 1.8            | 0.5                    | 0.9         | 1.5               | 1.15                 | 0.25        |              |             | 0.5         | 2.85         | 36.65               |
| <b>Barnet</b>                               |  |             |             |                       |                   |                |                        |             |                   |                      |             |              |             |             |              |                     |
| Barnet Adolescent Service                   |  | 1           | 0.8         | 0.47                  |                   | 0.4            | 0.4                    |             | 0.5               |                      |             | 0.4          | 1           |             | 1.93         | 6.9                 |
| Barnet CAMHS East                           |  | 0.6         | 3           | 1.3                   |                   | 3.32           | 3.46                   |             | 0.5               |                      |             | 1.6          |             |             | 3            | 16.78               |
| Barnet CAMHS West                           |  |             | 2.9         | 1.2                   |                   | 2.8            | 3.4                    |             | 1.7               | 0.4                  |             | 2            |             |             | 3.58         | 17.98               |
| Barnet Learning Difficulties Team           |  |             | 0.6         | 3.1                   |                   |                | 0.5                    |             | 0.2               |                      |             |              |             |             | 1.4          | 5.8                 |
| Barnet SCAN                                 |  |             |             |                       |                   |                |                        |             |                   |                      |             |              |             |             |              |                     |
| Barnet Looked After Children Team           |  |             | 0.2         | 0.5                   |                   | 0.5            | 0.4                    |             | 0.3               | 0.6                  |             | 0.6          |             |             | 0.2          | 3.3                 |
| Barnet Paediatric Liaison Team              |  | 0.6         | 0.5         |                       |                   |                | 0.1                    |             |                   |                      |             |              |             |             | 0.63         | 1.83                |
| Barnet Primary Project                      |  |             |             |                       |                   |                |                        |             |                   |                      |             |              | 5.5         |             |              | 5.5                 |
| Share of New Beginning                      |  | 3.60        | 0.60        | 0.26                  |                   | 0.2            |                        | 0.2         | 0.1               |                      |             |              |             | 0.1         | 0.34         | 5.4                 |
| Share of Northgate Clinic                   |  | 3.15        | 0.71        | 0.23                  |                   | 0.27           | 0.08                   | 0.14        | 0.23              | 0.17                 | 0.04        |              |             | 0.08        | 0.43         | 5.50                |
| <b>Total (Barnet)</b>                       |  | <b>8.95</b> | <b>9.31</b> | <b>7.06</b>           |                   | <b>7.49</b>    | <b>8.34</b>            | <b>0.34</b> | <b>3.53</b>       | <b>1.17</b>          | <b>0.04</b> | <b>4.60</b>  | <b>6.50</b> | <b>0.18</b> | <b>11.51</b> | <b>68.99</b>        |

**Appendix 2 (2) Staffing (Enfield) (WTEs)**

| <b>Service</b>  | Nurses      | Doctors     | Clinical Psychologist | Educational Psychologist | Social Workers | Psychotherapists | OT          | Family Therapists | Other Qual Therapist | Other Qual  | Other Unqual | PM HW       | Managers    | Admin        | Current total staff |
|---|-------------|-------------|-----------------------|--------------------------|----------------|------------------|-------------|-------------------|----------------------|-------------|--------------|-------------|-------------|--------------|---------------------|
| Behaviour Improvement Project (Enfield)                                     |             |             |                       |                          | 0.5            |                  |             |                   |                      |             |              |             |             | 0.05         | 0.55                |
| Behaviour Support Service (Enfield)   |             |             |                       |                          | 1.48           |                  |             |                   |                      |             |              |             |             | 0.08         | 1.56                |
| Child Development Team (Enfield)  |             |             | 0.4                   |                          |                |                  |             |                   |                      |             |              |             |             | 0.28         | 0.68                |
| Enfield CAMHS Dryden Road   |             | 1.3         | 1.25                  | 0.8                      | 3.45           | 1.5              |             |                   |                      |             | 0.4          | 0.7         |             | 3.9          | 13.3                |
| Enfield CAMHS Orton Grove   |             | 2.3         | 0.75                  | 0.8                      | 3.5            | 1.8              |             |                   |                      |             | 0.4          | 0.5         | 0.2         | 3.28         | 13.53               |
| Health & Education Access and Resources Team/LAC (Enfield)                  |             | 0.5         | 0.5                   | 0.35                     |                | 0.6              |             | 0.2               |                      |             |              |             | 0.25        | 0.2          | 2.6                 |
| Hospital Paediatrics (Enfield)  |             |             | 0.1                   |                          |                |                  |             |                   |                      |             |              |             |             |              | 0.1                 |
| SCAN Service for Children & Families with neuro-developmental disorders, En |             | 1           | 0.4                   | 0.1                      |                |                  |             |                   |                      |             |              |             |             | 0.7          | 2.2                 |
| Service for Adolescents and Families in Enfield                             | 0.6         | 1.7         | 1.4                   | 0.2                      | 1.5            | 1.1              |             |                   |                      |             |              | 0.7         | 0.1         | 2.4          | 9.7                 |
| Sure Start Edmonton   |             |             |                       | 0.3                      | 0.5            |                  |             |                   |                      |             |              |             |             | 0.1          | 0.9                 |
| Teenage Parents Project (Listening 2 U), Edmonton                           |             |             |                       |                          | 0.11           | 0.1              |             |                   |                      |             |              | 0.1         |             | 0.05         | 0.36                |
| Youth Offending Service (Edmonton)  |             |             | 0.5                   |                          |                |                  |             |                   |                      |             |              |             |             |              | 0.5                 |
| <b>Share of New Beginning</b>   | 3.60        | 0.60        | 0.26                  |                          | 0.20           |                  | 0.20        | 0.10              |                      |             |              |             | 0.10        | 0.34         | 5.40                |
| <b>Share of Northgate Clinic</b>  | 3.15        | 0.71        | 0.23                  |                          | 0.27           | 0.08             | 0.14        | 0.23              | 0.17                 | 0.04        |              |             | 0.08        | 0.43         | 5.50                |
| <b>Total (Enfield)</b>  | <b>7.35</b> | <b>8.11</b> | <b>5.79</b>           | <b>2.55</b>              | <b>11.51</b>   | <b>5.18</b>      | <b>0.34</b> | <b>0.53</b>       | <b>0.17</b>          | <b>0.04</b> | <b>0.80</b>  | <b>2.00</b> | <b>0.73</b> | <b>11.81</b> | <b>56.88</b>        |

### Appendix 2 (3) Staffing (Haringey) (WTEs)

|                                   | Nurses      | Doctors     | Clinical Psychologist | Educational Psychologist | Social Workers | Psychotherapists CAF 1 | OT          | Family Therapists | Other Therapist | Other Qual  | Other Unqual | PMHW        | Managers    | Admin        | Current total staff |
|-----------------------------------|-------------|-------------|-----------------------|--------------------------|----------------|------------------------|-------------|-------------------|-----------------|-------------|--------------|-------------|-------------|--------------|---------------------|
| Haringey Adolescent Outreach Team | 2.25        | 1.9         | 0.6                   | 0.2                      | 2              |                        |             | 0.5               |                 |             |              | 0.2         | 0.75        | 2            | 10.4                |
| Haringey CAMHS                    | 0.2         | 4.2         | 2                     |                          |                | 3.1                    |             | 1.4               | 3.1             |             |              | 2.6         | 0.7         | 8.8          | 26.1                |
| Share of New Beginning            | 3.60        | 0.60        | 0.26                  |                          | 0.20           |                        | 0.20        | 0.10              |                 |             |              |             | 0.10        | 0.34         | 5.40                |
| Share of Northgate Clinic         | 3.15        | 0.71        | 0.23                  |                          | 0.27           | 0.08                   | 0.14        | 0.23              | 0.17            | 0.04        |              |             | 0.08        | 0.43         | 5.50                |
| <b>Total (Haringey)</b>           | <b>9.20</b> | <b>7.41</b> | <b>3.09</b>           | <b>0.20</b>              | <b>2.47</b>    | <b>3.18</b>            | <b>0.34</b> | <b>2.23</b>       | <b>3.27</b>     | <b>0.04</b> |              | <b>2.80</b> | <b>1.63</b> | <b>11.57</b> | <b>47.40</b>        |

### Appendix 3 Case mix

| Service  | Hype<br>rkin<br>etic<br>Dis | Emot<br>ional<br>Dis | Con<br>duct<br>Dis | Eatin<br>g Dis | Psych<br>otic<br>Dis | Delib<br>Self<br>Harm | Subst<br>Abus<br>e | Habit<br>Dis | ASD<br>s   | Dev<br>Dis | Not<br>Poss<br>to<br>Define | Other<br>Dis | More<br>than<br>1 Dis |
|--|-----------------------------|----------------------|--------------------|----------------|----------------------|-----------------------|--------------------|--------------|------------|------------|-----------------------------|--------------|-----------------------|
| <a href="#">Barnet Adolescent Service</a>  | 4                           | 80                   | 12                 | 4              | 10                   | 30                    | 16                 |              | 3          | 3          |                             | 2            |                       |
| <a href="#">Barnet CAMHS East</a>  | 70                          | 156                  | 86                 | 7              |                      | 10                    | 1                  | 15           | 21         | 20         |                             | 1            |                       |
| <a href="#">Barnet CAMHS West</a>  | 76                          | 154                  | 50                 | 13             | 3                    | 8                     | 2                  | 8            | 42         | 31         |                             | 21           |                       |
| <a href="#">Barnet Learning Difficulties Neurodevelopmental Team - Barnet SCAN</a> | 20                          | 22                   | 23                 | 3              | 2                    | 5                     |                    | 3            | 44         | 61         |                             | 17           |                       |
| <a href="#">Barnet Looked After Children &amp; Adoption service</a>                | 4                           | 41                   | 4                  | 1              |                      |                       | 2                  |              | 2          | 7          |                             | 1            |                       |
| <a href="#">Barnet Paediatric Liaison Team</a>                                     | 2                           | 5                    |                    |                |                      |                       |                    |              |            |            |                             | 5            |                       |
| <a href="#">Barnet Primary Project</a>   | 2                           | 68                   | 12                 |                |                      |                       |                    | 3            |            |            |                             |              |                       |
| <b>TOTAL</b>   | <b>178</b>                  | <b>526</b>           | <b>187</b>         | <b>28</b>      | <b>15</b>            | <b>53</b>             | <b>21</b>          | <b>29</b>    | <b>112</b> | <b>122</b> | <b>0</b>                    | <b>47</b>    |                       |
| <b>Percentage</b>  | <b>14%</b>                  | <b>40%</b>           | <b>14%</b>         | <b>2%</b>      | <b>1%</b>            | <b>4%</b>             | <b>2%</b>          | <b>2%</b>    | <b>8%</b>  | <b>9%</b>  | <b>0%</b>                   | <b>4%</b>    | <b>0%</b>             |
| <a href="#">Behaviour Improvement Project (Enfield)</a>                            | 1                           | 9                    | 1                  |                |                      |                       |                    |              |            |            |                             |              |                       |
| <a href="#">Behaviour Support Service (Enfield)</a>                                |                             | 4                    | 7                  |                |                      |                       |                    |              | 1          |            |                             |              |                       |
| <a href="#">CAMHS &amp; EPS Childrens' Centres Team</a>                            |                             | 6                    | 4                  |                |                      |                       |                    |              |            |            |                             | 1            |                       |
| <a href="#">Child Development Team (Enfield)</a>                                   | 1                           | 2                    |                    | 1              |                      |                       |                    |              | 19         | 3          |                             | 8            |                       |
| <a href="#">Enfield CAMHS North Team</a>   | 22                          | 128                  | 48                 | 6              | 2                    | 7                     | 1                  | 4            | 15         | 7          |                             | 36           |                       |
| <a href="#">Enfield CAMHS South Team</a>   | 25                          | 165                  | 65                 | 9              | 4                    | 7                     | 2                  | 11           | 15         | 16         |                             | 23           |                       |
| <a href="#">Health &amp; Education Access and Resources Team/LAC (Enfield)</a>     | 3                           | 28                   | 8                  |                |                      | 1                     |                    | 1            | 1          | 5          |                             | 1            |                       |
| <a href="#">Hospital Paediatrics (Enfield)</a>                                     |                             |                      |                    |                |                      |                       |                    | 1            |            |            |                             | 1            |                       |

CAMHS Partnership Facilitation: Workforce Planning

|  |           |            |            |           |            |            |            |           |           |           |           |            |           |
|--|-----------|------------|------------|-----------|------------|------------|------------|-----------|-----------|-----------|-----------|------------|-----------|
| <a href="#">SCAN - Service for Children &amp; Families with neurodevelopmental disorders, En</a> | 1         | 9          |            |           | 3          | 1          |            |           | 13        | 1         |           | 14         |           |
| <a href="#">Service for Adolescents and Families in Enfield</a>                                  | 1         | 113        | 9          | 8         | 11         | 59         | 7          | 6         | 3         | 1         |           | 15         |           |
| <a href="#">Teenage Parents Project (Listening 2 U), Edmonton</a>                                |           | 1          |            |           |            | 1          |            |           |           |           |           | 1          |           |
| <a href="#">Youth Offending Service (Edmonton)</a>   | 4         | 6          | 5          |           | 1          | 2          | 2          |           |           |           |           |            |           |
| <b>TOTAL</b>   | <b>58</b> | <b>471</b> | <b>147</b> | <b>24</b> | <b>21</b>  | <b>78</b>  | <b>12</b>  | <b>23</b> | <b>67</b> | <b>33</b> | <b>0</b>  | <b>100</b> |           |
| <b>Percentage</b>  | <b>6%</b> | <b>46%</b> | <b>14%</b> | <b>2%</b> | <b>2%</b>  | <b>8%</b>  | <b>1%</b>  | <b>2%</b> | <b>6%</b> | <b>3%</b> | <b>0%</b> | <b>10%</b> | <b>0%</b> |
| <a href="#">Haringey Adolescent Outreach Team</a>  | 1         | 40         | 8          | 4         | 21         | 17         | 5          | 2         | 1         |           |           |            |           |
| <a href="#">Haringey CAMHS</a>   | 25        | 143        | 39         | 4         | 2          | 3          | 2          | 15        | 21        | 27        |           | 12         |           |
| <a href="#">Haringey SCAN Team</a>   | 6         | 3          | 9          | 2         |            |            |            | 7         | 7         | 11        |           |            |           |
| <b>TOTAL</b>   | <b>32</b> | <b>186</b> | <b>56</b>  | <b>10</b> | <b>23</b>  | <b>20</b>  | <b>7</b>   | <b>24</b> | <b>29</b> | <b>38</b> | <b>0</b>  | <b>12</b>  |           |
| <b>Percentage</b>  | <b>7%</b> | <b>43%</b> | <b>13%</b> | <b>2%</b> | <b>5%</b>  | <b>5%</b>  | <b>2%</b>  | <b>5%</b> | <b>7%</b> | <b>9%</b> | <b>0%</b> | <b>3%</b>  | <b>0%</b> |
| <b>TIER 4 SERVICES</b>   |           |            |            |           |            |            |            |           |           |           |           |            |           |
| <a href="#">New Beginning</a>  | 1         | 26         | 18         | 7         | 17         | 29         | 9          |           | 2         | 2         |           | 2          |           |
| <a href="#">Northgate Clinic</a>   | 1         | 17         | 6          | 1         | 1          | 5          | 7          | 1         |           |           |           |            |           |
| <b>TIER 4 TOTAL</b>  | <b>2</b>  | <b>43</b>  | <b>24</b>  | <b>8</b>  | <b>18</b>  | <b>34</b>  | <b>16</b>  | <b>1</b>  | <b>2</b>  | <b>2</b>  | <b>0</b>  | <b>2</b>   |           |
| <b>Percentage</b>  | <b>1%</b> | <b>28%</b> | <b>16%</b> | <b>5%</b> | <b>12%</b> | <b>22%</b> | <b>11%</b> | <b>1%</b> | <b>1%</b> | <b>1%</b> | <b>0%</b> | <b>1%</b>  | <b>0%</b> |
| <b>Total</b>   | 270       | 1226       | 414        | 70        | 77         | 185        | 56         | 77        | 210       | 195       | 0         | 161        | 0         |
| <b>Percentage</b>  | <b>9%</b> | <b>42%</b> | <b>14%</b> | <b>2%</b> | <b>3%</b>  | <b>6%</b>  | <b>2%</b>  | <b>3%</b> | <b>7%</b> | <b>7%</b> | <b>0%</b> | <b>5%</b>  | <b>0%</b> |

Source: CAMHS Mapping website (2007/08 unvalidated data, collected 19/5/08)

### Appendix 4 Case mix to skill mix translation matrix

| Presentation   | Behaviour therapy | Interdisciplinary work | Nutrition | Parenting | Prescribing and medical | CBT | Family therapy | IPT | 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  | ✓                 |                        | ✓         |           |                         | ✓   |                |     |                                  |                    |                        |             |             |                     | ✓                 | ✓        | ✓                            | ✓                      | ✓                        |
| Relative priority interventions for current caseload |                   |                        |           |           |                         |     |                |     |                                  |                    |                        |             |             |                     | .                 | .        | .                            | .                      | .                        |

✓ Indicates interventions listed in *Drawing on the Evidence* in relation to primary presentations

## CAMHS Partnership Facilitation: Workforce Planning

This worksheet of source data is based on Wolpert et al (2006) *Drawing on the Evidence* 2nd edition. Its purpose is to identify the skills that most closely match the evidence of effective interventions in CAMHS, in order to assist workforce planning. **Caution: this worksheet is not a substitution for the original document named above.** Much of the contextual and explanatory text in *Drawing on the Evidence* is not reproduced here, where only evidence for practice based on category A and B evidence has been used. Go

to: [http://www.acamh.org.uk/site/upload/document/Drawing\\_on\\_the\\_Evidence\\_-\\_text.pdf](http://www.acamh.org.uk/site/upload/document/Drawing_on_the_Evidence_-_text.pdf)

### DISORDERS OF CONDUCT

| Level of evidence   | A  |  |                                   |  | B  |  |
|---|--|--|-----------------------------------|--|--|--|
|   | <b>Under 12</b>  |  |                                   | <b>Adolescent</b>  |  |  |
| <b>Best practice drawn from the evidence</b>                            | Parent training for children <10                         | Parent training with individual child skills programme for children 8-12                               | Multi systemic therapy            | Specialist foster placement  | Reducing opportunities for delinquent behaviour and increasing skills such as problem solving or coping. | Use of novel antipsychotics with combined dopaminergic and serotonergic action, such as risperidone, may be cautiously considered for children and young people who have not been responsive to a comprehensive trial of psychosocial treatments |
| <b>Workforce implications ie skill sets/expertise/ disciplinary mix</b> | Ability to run individual and group parenting programmes | Ability to run individual and group parenting programmes<br>Expertise in skills training with children | Trained multi systemic therapists | Inter-disciplinary approach and strong links with social care - SW in T3 team? | Inter-disciplinary approach and strong links with schools, YOS, substance misuse services, youth work.   | Prescribing, medical monitoring - Psychiatry?  |
| <b>Tier</b>   | 2  | 3  | 3                                 | 3  | 3  | 3 and 4  |

CAMHS Partnership Facilitation: Workforce Planning

| DISTURBANCES OF ATTENTION   |  |   |   |   |  |   |
|---|--|---|---|---|--|---|
| Level of evidence   | A  |   |   | B   |  |   |
| <b>Best practice drawn from the evidence</b>                            | If diagnostic criteria for ADHD are met following a comprehensive assessment by a suitably qualified professional, and other reasons for the behaviour have been excluded, then a trial of medication is indicated as the first line of intervention. Effective monitoring of children given medication is needed to minimise adverse side effects and optimise treatment benefits. Discontinuous medication (i.e. holiday breaks) may reduce the risk of mild growth suppression. | Children should be started on a short acting preparation of methylphenidate or on dexamphetamine. Atomoxetine is probably the evidence based second line treatment, but although there is relevant RCT evidence to support effectiveness this is a new drug and reports of side effects need to be monitored. | As it is not possible to predict which dose will be effective, dosage should be increased within safe limits until an effect is achieved. If there is insufficient resolution of symptoms with stimulants or atomoxetine, then other medication should be considered. The alternatives include: clonidine, selective serotonin reuptake inhibitors, tricyclic anti-depressants and selective monoamine oxidase inhibitors | If there is insufficient response to medication, then parent training and individual behavioural therapy with the child should be added. Where individual behavioural interventions are used, these need to be provided in the child's school as well as within the home as they do not generalise across settings. | There is some evidence to support the use of omega 3 and 6 dietary supplementation | Behavioural intervention in addition to medication can also be offered as a way of achieving similar outcomes to medication alone but with reduced levels of medication |
| <b>Workforce implications ie skill sets/expertise/ disciplinary mix</b> | Prescribing, medical monitoring - Psychiatry? with GPs?  |   | Shared care   | Ability to run individual and group parenting programmes. Expertise in behavioural therapy  | Input of expertise on nutrition  | Inter-disciplinary and multi-agency working, specifically with schools. Expertise in behavioural therapy  |
| <b>Tier</b>   |  |   | <b>3</b>  |   |  | <b>3</b>  |

## CAMHS Partnership Facilitation: Workforce Planning

### ANXIETY DISORDERS

| Level of evidence  | A  |  | B  |   |   |
|--|--|--|--|---|---|
| <b>Best practice drawn from the evidence</b>                             | Behaviour therapy and cognitive behavioural therapy (in group or individual format) first-line treatment for children with specific phobias and children with generalised anxiety. | Behaviour therapy and cognitive behavioural therapy should be considered for children with OCD | Clomipramine and selective serotonin reuptake inhibitors should be considered in the treatment of OCD when cognitive behavioural therapy alone has proved ineffective. | Selective serotonin reuptake inhibitors should be considered in the treatment of social anxieties when cognitive behavioural therapy alone has proved ineffective | 'Educational support' should be considered in the management of children with anxiety problems. |
| <b>Workforce implications ie skill sets /expertise/ disciplinary mix</b> | Expertise in behavioural therapy and in CBT  |  | Prescribing, medical monitoring - Psychiatry?  | Inter-disciplinary and multi-agency working, specifically with schools  |   |
| <b>Tier</b>  | 2 and 3  |  | 3  | 3   |   |

### POST TRAUMATIC STRESS DISORDER

| Level of evidence   | A   | B  |
|---|---|--|
| <b>Best practice drawn from the evidence</b>                            | Debriefing should not be offered routinely immediately following a trauma | Children and young people with PTSD, including those who have experienced traumatic events other than sexual abuse, should be offered a course of trauma focused CBT adapted to suit their age circumstances and level of development. |
| <b>Workforce implications ie skill sets/expertise/ disciplinary mix</b> | Access to expertise in PTSD   | Expertise in trauma focused CBT  |
| <b>Tier</b>   | 3   | 3  |

CAMHS Partnership Facilitation: Workforce Planning

**DEPRESSIVE DISORDERS**

| Level of evidence  | B   | A  | B   |
|--|---|--|---|
| <b>Best practice drawn from the evidence</b>                           | Given the high rate of remission in control groups, initial psychological treatment (either CBT, family therapy or Inter-Personal Therapy) for up to three months should be offered as the first line of treatment. | If psychological treatment does not produce improvement in symptoms by six weeks, anti-depressant medication should be offered for adolescents (and cautiously considered for younger children) in combination with longer term psychological treatment using either CBT, psychotherapy or family therapy. | Depression is a condition which is liable to recur. Clinical follow-up and 'booster sessions' may be helpful in reducing relapse. |
| <b>Workforce implications ie skill sets/expertise/disciplinary mix</b> | Range of therapies: family therapy, CBT, IPT.   | Range of therapies plus Prescribing, medical monitoring - Psychiatry?  |   |
| <b>Tier</b>  | <b>3</b>  | <b>3 and 4</b>   |   |

CAMHS Partnership Facilitation: Workforce Planning

**PSYCHOTIC DISORDERS**

| Level of evidence  | A   |  | B   |  |
|--|---|--|---|--|
| <b>Best practice drawn from the evidence</b>                           | Neuroleptics are the treatment of choice for the acute phase of schizophrenia | Clozapine should be cautiously considered in cases of treatment resistant schizophrenia, in line with the nationally agreed protocol | Because of the side effects of traditional neuroleptics atypical neuroleptics should normally be used, although caution should be exercised as these too have side effects. | Lithium should be considered in the first instance in the acute phase of manic/bipolar disorder. |
| <b>Workforce implications ie skill sets/expertise/disciplinary mix</b> | Prescribing, medical monitoring - Psychiatry?                                 |  |   |  |
| <b>Tier</b>  | 3 and 4   |  |   |  |

**EATING DISORDERS**

| Level of evidence  | A  | B  |
|--|--|--|
| <b>Best practice drawn from the evidence</b>                           | Family therapy (behavioural/structural) is recommended as the treatment of choice for anorexia nervosa, either as an outpatient or after in-patient treatment. | Behavioural treatment should be considered in hospital in order to increase weight |
| <b>Workforce implications ie skill sets/expertise/disciplinary mix</b> | Expertise in family therapy  | Expertise in behavioural therapy   |
| <b>Tier</b>  | 3 and 4  | 3 and 4  |

## CAMHS Partnership Facilitation: Workforce Planning

### DELIBERATE SELF HARM

| Level of evidence   | A  | B   |   |
|---|--|---|---|
| <b>Best practice drawn from the evidence</b>                            | When instituting schools based interventions, selection of material should be made with reference to existing evaluated programmes | Following a suicide attempt by a child or young person, brief interventions involving families should be considered | For young people who have self-harmed several times, consideration should be given to the addition of group psychotherapy |
| <b>Workforce implications ie skill sets/expertise/ disciplinary mix</b> | Consultancy and support to schools   | Expertise in family work  | Expertise in group psychotherapy  |
| <b>Tier</b>   | 2 and 3  | 3 and 4   | 3 and 4   |

### SUBSTANCE MISUSE

| Level of evidence   | A  | B   |
|---|--|---|
| <b>Best practice drawn from the evidence</b>                            | Family therapy should be considered the first line treatment of substance misuse | Multi-systemic therapy should be considered where substance misuse is part of a wider pattern of problems |
| <b>Workforce implications ie skill sets/expertise/ disciplinary mix</b> | Expertise in family therapy  | Trained multi systemic therapists   |
| <b>Tier</b>   | 3  | 3 and 4   |

**PERVASIVE DEVELOPMENTAL DISORDERS**

**Level of evidence** **B**

|  |  |  |
|--|--|--|
| <b>Best practice drawn from the evidence</b> | Intensive behavioural interventions, either individual or group, should be considered to help improve the adaptive behaviour of children with autism | Medication is not indicated for the treatment of core symptoms of autism but may be used to reduce specific behaviours associated with autism in children. |
|--|--|--|

|  |                                  |   |
|--|----------------------------------|---|
| <b>Workforce implications ie skill sets/expertise/disciplinary mix</b> | Expertise in behavioural therapy | Prescribing, medical monitoring - Psychiatry? |
|--|----------------------------------|---|

|             |                |                |
|-------------|----------------|----------------|
| <b>Tier</b> | <b>3 and 4</b> | <b>3 and 4</b> |
|-------------|----------------|----------------|

**TOURETTES SYNDROME**

**Level of evidence** **A** **B**

|  |   |   |   |
|--|---|---|---|
| <b>Best practice drawn from the evidence</b> | Neuroleptics and clonidine should be considered as first choice treatments for Tourette's syndrome. Since the evidence for effectiveness does not differentiate between them, the decision as to which medication to use may be based on the clinician's and family's view of the different side effects. The atypical neuroleptics usually have fewer side effects | The presence of tics is not a contraindication to the use of methylphenidate in the treatment of ADHD | Selective serotonin reuptake inhibitors should be considered in Tourette's syndrome with co-morbid OCD, but the response may be less favourable than in OCD without co-morbidity. |
|--|---|---|---|

|  |   |
|--|---|
| <b>Workforce implications ie skill sets/expertise/disciplinary mix</b> | Prescribing, medical monitoring - Psychiatry? |
|--|---|

|             |          |
|-------------|----------|
| <b>Tier</b> | <b>3</b> |
|-------------|----------|

**PHYSICAL SYMPTOMS NO KNOWN CAUSE**

**Level of evidence**

**Best practice drawn from the evidence**

Cognitive behavioural therapy should be considered for recurrent abdominal pain

If attention to diet has not already been considered, trial of a high fibre diet is indicated for recurrent abdominal pain.

**Workforce implications ie skill sets/expertise/disciplinary mix**

|                  |                                 |
|------------------|---------------------------------|
| Expertise in CBT | Input of expertise on nutrition |
|------------------|---------------------------------|

Tier

2 and 3

2 and 3

**COPING WITH PAINFUL PROCEDURES**

**Level of evidence**

**Best practice drawn from the evidence**

|   |
|---|
| <b>A</b>  |
| Cognitive behavioural therapy, behaviour therapy and hypnosis should be used to counter the stress associated with painful procedures and selected according to the particular types or stages of procedure as well as the developmental stage of the individual child. |

**Workforce implications ie skill sets/expertise/disciplinary mix**

|   |
|---|
| Expertise in child development, behaviour therapy and hypnosis. |
|---|

Tier

2

**COPING WITH CHRONIC ILLNESS AND DISEASE**

Level of evidence

**Best practice drawn from the evidence**

| <b>A</b>   | <b>B</b>  |  |   |
|--|---|--|---|
| Cognitive behavioural therapy and behaviour therapy, tailored to specific illnesses, should be considered for children with hard to control physical symptoms. | Psychoanalytic psychotherapy should be considered for the treatment of hard to control diabetes | Systemic family therapy should be considered for the treatment of asthma | Provision of specialist nurse support to families of children newly diagnosed with chronic illness should be considered as a means of improving later physical and psychological outcomes |

**Workforce implications ie skill sets/expertise/disciplinary mix**

|   |   |                                     |                          |
|---|---|-------------------------------------|--------------------------|
| Expertise in behavioural therapy and in CBT | Expertise in psychoanalytic psychotherapy | Expertise in systemic psychotherapy | Specialist nurse support |
|---|---|-------------------------------------|--------------------------|

**Tier**

**2**

**3**

**3**

**2 and 3**

CAMHS Partnership Facilitation: Workforce Planning

**SKILLS SUMMARY**

|  |   |  |   |  |
|--|---|--|---|--|
| <b>DISORDERS OF CONDUCT</b>  | <b>DISTURBANCES OF ATTENTION</b>  | <b>ANXIETY DISORDERS</b>   | <b>POST TRAUMATIC STRESS DISORDER</b>   | <b>DEPRESSIVE DISORDERS</b>                          |
| parenting<br>multi systemic<br>therapy social<br>work input<br>interdisciplinary<br>work prescribing,<br>medical | prescribing, medical<br>parenting<br>behaviour therapy<br>interdisciplinary work<br>nutrition input | behaviour therapy<br>prescribing, medical<br>CBT<br>interdisciplinary work | PTSD<br>knowledge/therapeutic<br>skill<br>trauma focused CBT  | family therapy<br>IPT<br>CBT<br>prescribing, medical |
| <b>PSYCHOTIC DISORDERS</b>   | <b>EATING DISORDERS</b>   | <b>DELIBERATE SELF HARM</b>  | <b>SUBSTANCE MISUSE</b>   | <b>PERVASIVE DEVELOPMENTAL DISORDERS</b>             |
| prescribing,<br>medical  | family therapy<br>behaviour therapy   | family work<br>group psychotherapy   | family therapy<br>multi-systemic therapy  | behaviour therapy<br>prescribing, medical            |
| <b>TOURETTES SYNDROME</b>  | <b>PHYSICAL SYMPTOMS NO KNOWN CAUSE</b>   | <b>COPING WITH PAINFUL PROCEDURES</b>                                      | <b>COPING WITH CHRONIC ILLNESS AND DISEASE</b>  |  |
| prescribing,<br>medical  | CBT<br>nutrition advice   | child development<br>behaviour therapy<br>hypnosis                         | behaviour therapy<br>CBT<br>psychoanalytic<br>psychotherapy<br>systemic<br>psychotherapy<br>specialist nurse<br>support |  |

This worksheet shows how the categories of mental disorder may be matched, between those used in the National CAMHS mapping and those in *Drawing on the Evidence*

**NATIONAL  
CAMHS  
MAPPING  
CATEGORIES**  
Hyperkinetic  
disorders

**DRAWING ON  
THE EVIDENCE  
CATEGORIES  
DISTURBANCES  
OF ATTENTION**

prescribing, medical  
parenting  
behaviour therapy  
interdisciplinary  
work nutrition  
input

**Emotional  
disorders**

**DEPRESSIVE  
DISORDERS**

family therapy  
IPT  
CBT  
prescribing, medical

**ANXIETY  
DISORDER**

behaviour therapy  
prescribing,  
medical  
CBT  
interdisciplinary  
work

**PTSD**

PTSD knowledge  
/therapeutic skill  
trauma focused  
CBT

**Conduct  
disorders**

**DISORDERS OF  
CONDUCT**

parenting  
multi systemic  
therapy social  
work input  
interdisciplinary  
work prescribing,  
medical

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|                                    |   |   |   |
|------------------------------------|---|---|---|
| <b>Eating disorders</b>            | <b>EATING DISORDERS</b><br>family therapy<br>behaviour therapy                        |   |   |
| <b>Psychotic disorders</b>         | <b>PSYCHOTIC DISORDERS</b><br>prescribing, medical                                    |   |   |
| <b>Deliberate self harm</b>        | <b>DELIBERATE SELF HARM</b> family work<br>group psychotherapy                        |   |   |
| <b>Substance abuse</b>             | <b>SUBSTANCE MISUSE</b> family<br>therapy<br>multi-systemic therapy                   |   |   |
| <b>Habit disorders</b>             | <b>TOURETTES SYNDROME</b><br>prescribing, medical                                     |   |   |
| <b>Autistic spectrum disorders</b> | <b>PERVASIVE DEVELOPMENTAL DISORDERS</b><br>behaviour therapy<br>prescribing, medical |   |   |
| <b>Developmental disorders</b>     |   |   |   |
| <b>Not possible to define</b>      |   |   |   |
| <b>Other</b>                       | <b>PHYSICAL SYMPTOMS NO KNOWN CAUSE</b><br><br>CBT<br>nutrition advice                | <b>COPING WITH PAINFUL PROCEDURES</b><br><br>child development<br>behaviour therapy<br>hypnosis | <b>COPING WITH CHRONIC ILLNESS AND DISEASE</b><br><br>behaviour therapy<br>CBT<br>psychoanalytic<br>psychotherapy<br>systemic<br>psychotherapy<br>specialist nurse<br>support |