

National Workforce Programme
Child and Adolescent Mental Health

Workforce Plan for
The Child and Family Services Division
Lincolnshire Partnership NHS Foundation Trust

LPT Child and Family Services Workforce Plan

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Workforce Plan for The Child and Family Services Division Lincolnshire Partnership NHS Foundation Trust

FOREWORD

This plan was drawn up by the workforce planning team of the Child and Family Services Division (CFS) of Lincolnshire Partnership Foundation Trust (LPT), with support from the Health and Social Care Advisory Service (HASCAS). In 2006-7 the national child and adolescent mental health services (CAMHS) workforce programme, under Barry Nixon, offered each region the opportunity to put forward an early implementor site for workforce planning. LPT volunteered and was one of the very first sites to start work.

This workforce plan should be viewed as a working document. It should not be regarded as a policy or strategy, but as a committed plan of action with underpinning evidence. There is however a strategic foundation for this piece of work, in the planning group's in-depth understanding of the current workforce position and the implicit vision for the future, with clear intent as to how the vision is to be realised.

All commitments and actions contained within or deriving from this plan and the processes behind compiling it are supported by evidence. The nature of this evidence is threefold:

1. **Value base.** The plan reflects the values of LPT and makes explicit reference to key Trust documents. It is also underpinned by national policy, notably the National Service Framework for Children, Young People and Maternity Services and Every Child Matters.
2. **Benchmarking.** Using national databases, principally the CAMHS Mapping and Office of National Statistics, it has been possible to compare the LPT CFS workforce with a series of benchmarks. The presentation of numerical data as charts, graphs and tables has enabled the workforce planning group to have a clear overview of existing services.
3. **Audit/evaluation/research.** In addition to the use of national research, two important pieces of local work were carried out in compiling this plan. The first involved a comprehensive consultation with staff across the Trust to secure their engagement with the work and to capture their valuable views. Additionally this project audited the clinical staff competencies. The second project was a full review of administrative support to CFS. Both were indispensable in creating a plan that is widely owned and, crucially, has already led to action and change.

The plan addresses workforce issues for specialist CAMHS staff and is intended to be integrated with broader children's services workforce planning for the County, as well as with wider LPT plans, with which it is compatible. At its core are the six principles of workforce planning adopted by the National Mental Health Workforce Strategy (2004)¹, which are to:

- improve *workforce design and planning* so as to root it in local service planning and delivery;
- identify and use creative means to *recruit and retain* people;
- facilitate *new ways of working* across professional boundaries;
- *create new roles* to tap into a new recruitment pool and so complement existing staff types;
- develop the workforce through revised *education and training* at both pre and post qualification levels;
- develop *leadership and change management* skills.

ACKNOWLEDGEMENTS

The plan is the result of hard work and commitment from all the members of the workforce planning group. Special thanks are due to Paul Jackman, who volunteered LPT as an early implementor site, chaired the planning group and drove the project; Saeed Nazir, who had unbounded enthusiasm and support for the enterprise from beginning to end, Gill Walker, who worked hard in order to secure the engagement of all CFS staff and Chris Mardon, who supplied a great deal of helpful information, not least the comprehensive review of administrative support and staffing.

Yvonne Anderson
HASCAS CAMHS Lead
October 2007

¹ National Mental Health Workforce Strategy
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4087362.pdf

Workforce Plan for The Child and Family Services Division Lincolnshire Partnership NHS Foundation Trust

PART I **About this workforce plan**

1.1 Workforce team

This workforce plan has been drawn up by the workforce team, drawn from the Lincolnshire CAMHS Workforce Development and Staff Care Board, which has as its aims:

- To ensure there is a multi-disciplinary CFS workforce sufficiently skilled, and with manageable workloads, to provide the full range of effective treatments and therapies of a Comprehensive CAMHS.
- To fulfil the Trust's duty of care towards its staff, with particular emphasis on supporting staff through the changes to implement service improvements across child and family services division.

A list of the core members of the workforce team is provided in Appendix 1. Co-opted membership includes Trust staff with a remit for:

- performance
- finance
- HR

as well as commissioner input from both Primary Care Trust (PCT) and Local Authority (LA).

The workforce planning team emphasise that this is a working document. It should not be regarded as a policy or strategy, but as a committed plan of action with underpinning evidence.

1.2 Positioning of this plan

The aim is for the completed plan to become subsumed within the work of the CAMHS commissioning group, so that it will be a sub section of the CAMHS strategy, but will also feed into the Trust Workforce Plan. The CAMHS Commissioning group will undertake devolved commissioning activity on behalf of the Children and Young People's Strategic Partnership (CYPSYP).

CAMHS workforce planning will thus be an integral part of delivering the local CAMHS Strategy and will also be linked into the wider children's services workforce strategy.

1.3 Timeline

The plan covers the period 2007-10, for the geographical area serviced by Lincolnshire Partnership NHS Trust (LPT), covering the county of Lincolnshire, which is administered in three divisions, East, West and South West, shown below. The Trust geographical area is co-terminous with the boundaries for the county council and the primary care trust.¹

Figure 1 Geographical area served by Lincolnshire Partnership NHS Trust



1.4 Workforce covered by the plan

1.4.1 Whilst it is recognised that comprehensive CAMHS encompasses a range of levels and a variety of providers, this plan addresses the recruitment and retention of staff in LPT's specialist child and family services. LPT has a child and family services division (CFS) comprising specialist CAMHS and joint working arrangements with child psychological therapies.

¹ Lincolnshire Teaching PCT (LTPCT) was formed in October 2006, bringing together the former East Lincolnshire PCT, West Lincolnshire PCT and South West Lincolnshire Teaching PCT.

1.4.2 The plan also covers the education and training, as it relates to people working with children and young people's emotional and psychological well being, across all universal, targeted and specialist services. Training for universal services has already been commissioned as part of the primary mental health worker (PMHW) role.

1.5. Strategic overview

The following statement is drawn from LPT's 2006-07 service development priorities for child & adolescent mental health services and provides the strategic context for this document.

LPT provides a specialist CAMH service comprising a single staff group, budget and business process that provides the maximum range possible of comprehensive CAMH services defined in Standard 9 of the National Service Framework.

LPT's commitments are:

- A single service to flexibly provide the full range of treatments and therapies to meet children's mental health needs.
- Clear leadership with authority and capacity to lead and support service improvement
- Clear arrangements for effective participation in service improvement.
- Responsiveness to the emerging CAMHS needs assessment, the new school and practice clusters, the development of extended schools and children's centres, and opportunities for the development of new services eg learning disability.
- CAMHS workforce development, supported by CSIP.
- Capacity to support all those involved in the change programmes, and in providing effective and safe services.
- To ensure all service developments and care plans are fully informed by users' and carers' views.
- To meet children's needs as close to home as possible, reducing the use of out of area placements and reinvest in local services.
- Agreed local priority for children's services.
- Sustainable demand & capacity management (including consideration of Choice & Partnership Approach, and service thresholds). Priority risk areas identified regarding deliberate self-harm, urgent mental health needs and 16 & 17 year olds.
- Responsiveness to a changing population profile.
- Collecting and using evidence of the impact of service.

1.6 Key documents underpinning this plan

1.6.1 National policy and guidance

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

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.

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

Specifically, meeting the requirements set out under *Local Target Setting*, the workforce planning group will ensure 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.*³

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 - clear role definition, staff working according to their expertise/specialism, roles designed around skills required.

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

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

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

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

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

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

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

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

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;
 - and
 - strengthen leadership, management and supervision. (Page 17)

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

1.6.2 Local policy and strategy

Best Value Review of Child and Adolescent Mental Health, Final update September 2006. Implementation Plan			
BVR Recommendation	Next Steps	Work Programme(s)	Lead
Single CAMHS information system, compatible with health & social care systems	Social Care and Education staff full access rights Full implementation of CAMHS National Dataset	Information & Communication Improvement	Chris Mardon, Business Support and Project Team Manager
Community Team location, size & premises:	Complete community reconfiguration West Lindsey Team phased relocation to Gainsborough Relocation of Lincoln Team from DX Moore House Spalding Team relocation to PFI premises (2007-08) Foundation Trust Long-Term Financial Model includes plan to increase staffing by 38% as indicated by NSF Standard 9	Service & Practice Improvement Business Administration	Chris Mardon, Business Support & Project Team Manager
Co-terminosity with LA Teams	As above, and note alignment to Scholl Clusters and Practice Based Commissioning Clusters	As above	As above
Improved quality & capacity of premises	Priorities in Trust capital programme: <ul style="list-style-type: none"> ▪ Moore House ▪ Boston ▪ Ash Villa > Continue phased move to Morton centre	Business Administration	Chris Mardon, Business Support & Project Team Manager
Initiatives to reduce waiting times	-CAPA single care pathway aiming to remove waiting list -Planned trajectories: Oct 31 st 06 – Revised Threshold Criteria Apr 2 nd 07 – CAPA goes live with pathway guidance and thresholds criteria to referrers Oct 31 st 07 – Single care pathway with Community Paediatrics (tbc)	Service & Practice Improvement	Paul Jackman, Director Amanda Newman, Team Leader

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

LPT CFS workforce plan

Eligibility Criteria	-CAMHS & Child Psychological Therapies Threshold Criteria -Develop LPT C&F services criteria including other community health care services (especially community Paediatrics)	Service & Practice Improvement	Shelagh Nash, CAMHS Manager
Full range timely interventions, including consultation, training, outreach & co-work Tiers 1 & 2	-Complete workforce profile / skills audit -Expand primary mental health as resources allow -Increase community team capacity as resources allow -Develop range highly specialist provision as per Commissioning Group Brief	Workforce Development & Staff Care Service & Practice Improvement	Paul Jackman, Director
Address under-staffing	-Commence phased increase community team capacity -Workforce Development Strategy supported & facilitated by CSIP (national pilot site)	Service & Practice Improvement Workforce Development & Staff Care	Paul Jackman, Director
Position of Psychology:			
<ul style="list-style-type: none"> ▪ What contribution to CAMHS? 	-Define core CAMHS and 'non-CAMHS' services	Service & Practice Improvement	Paul Jackman, Director Libby Dower, Head of Speciality
<ul style="list-style-type: none"> ▪ Extent of separate funding / management 	-Review effectiveness of separate management & funding arrangements -Review effectiveness of Integrated Team Working under CAPA	Service & Practice Improvement	Paul Jackman, Director Libby Dower, Head of Speciality
Staff training / development strategy	-Develop and Implement Workforce Strategy, including NWW -Multi-disciplinary line management & professional supervision model	Workforce Development & Staff Care	Paul Jackman, Director Shelagh Nash, CAMHS Manager
Comprehensive Needs Assessment	-See CAMHS Commissioning Arrangements above	CAMHS Commissioning	PCT & LA lead commissioners
Develop & expand prevention, early intervention & family support (including disabled children)	-PMHT expansion as resources allow -Lead role in Raising Aspirations & Self-Belief programme with LCC, including 'Feeling Good Week' -Significant improvements in planning & providing services for children with disabilities	Service & Practice Improvement	Elisse Moody, Primary Mental Health Co-ordinator Shelagh Nash, CAMHS Manager
Enhance & increase training & support to staff in agencies working with vulnerable children	-Expand PMHT size & training / support activities as resources allow -Scope community team and highly specialist CAMHS support -Education outreach from Ash Villa school	Workforce Development & Staff Care	Elisse Moody, Primary Mental Health Co-ordinator

Joint area review of Lincolnshire Children's Services Authority Area 2007 **From the findings:**

A full range of specialist mental health services is, however, not available across the whole county and there is no specialist team for those children and young people with learning difficulties and/or disabilities.

Recommendations:

Ensure that strategies, procedures and services are in place which meet the diverse needs of all children and their families, including those who are part of transient and migrant populations.

Develop systems to ensure effective coordination between health services and education to enable all children to be identified and their whereabouts known.

Improve health promotion services and ill health prevention both in schools and in the community, particularly in the east of the county, and improve access to NHS dental services for children and young people.

Improve services and transition arrangements for children and young people with learning difficulties and /or disabilities, particularly those with complex needs, and ensure they are effectively coordinated to better meet their physical and mental health needs.

For action in the longer term:

Ensure that the involvement of all children and young people genuinely shapes services, and routinely provide feedback to them on the outcomes of consultations.

Lincolnshire Teaching Primary Care Trust` Local Delivery Plan (LDP) ⁶

The LDP main areas for investment are:

- Achievement of the 18 week RTT
- Choosing Health priorities including obesity, mental health, sensible drinking, tobacco control and sexual health
- **Children's Services**
- Prescribing
- Pump priming 'invest to save' initiatives e.g. unscheduled care
- Community Diversions
- Non Payment by Results, especially critical care

(Also £177,000 has been committed for a new CAMHS community team and proposals have been submitted for the use of the remaining CFISSA monies of approximately £215,000 all on expanding the workforce.) ⁷

The key risks within the LDP are

- Non-elective/ emergency activity above planned levels (1% equals £2.5m)
- GP referral and elective activity above planned levels (1% equals £2.5m)
- Continued growth in high cost/ specialised named patient care activity (1 case equals £50-200k)
- The introduction of risk sharing in relation to the section 31 agreement for learning disabilities (see later section for details)
- Failure to improve cost effectiveness of prescribing (up to£3.5m)
- Failure to achieve provider services CREG (up to £1.5m)
- **No delivery of targets, particularly 18 week RTT**
- Continued overspending in areas such as home oxygen and prison services (up to £1m)
- Continued recovery of patient charges income in dental and pharmaceutical services (£4-5m)
- **Not recruiting to key posts to deliver service changes required**
- Failure to ensure that good systems and processes exist for resource utilisation and reporting
- **Failing to engage clinicians, patients and the public in re-designing services and pathways to improve access and choice**
- Coding drift in secondary care (1-1.5% approximately £6m)

⁶ Lincolnshire PCT Local Delivery Plan 2007/08 SHA submission 23 February 2007 Chief Executive's Commentary

⁷ The Central Funded Initiatives and Services and Special Allocations programme provides central revenue funding to implement the NHS Plan and other initiatives.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/Browsable/DH_5340867

Lincolnshire Partnership Trust. *With People in Mind – A Workforce Strategy – core principles*

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

PART 2
1. The six principles of CAMHS workforce planning
2. Local population profile and mental health need of children and young people
3. The current specialist CAMHS, service description and staffing

IMPORTANT NOTES:

- THE FOLLOWING TWO SECTIONS CONTAIN GRAPHS THAT NEED TO BE VIEWED IN COLOUR AND IF A COLOUR PAPER COPY IS NOT AVAILABLE IT WILL BE ADVISABLE TO VIEW ON A COMPUTER SCREEN. ALL GRAPHS AND CHARTS ARE ALSO PROVIDED IN A LARGER SCALE AT THE END OF THE DOCUMENT, FOR EASE OF VIEWING.
- THE SELF ASSESSMENT MATRIX AND THE NATIONAL CAMHS MAPPING ARE THE TWO PRIMARY SOURCES OF NUMERICAL INFORMATION WHEN BENCHMARKING SERVICES. BOTH DATASETS ARE GROWING IN RELIABILITY BUT CARE SHOULD BE TAKEN IN DRAWING FIRM CONCLUSIONS FROM THE DATA.

2.1. The six principles of CAMHS workforce planning.⁸

2.1.1 Workforce design and planning

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

2.1.2 Recruitment and retention

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

2.1.3 New ways of working

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

⁸ Nixon, B., (2005) *Delivering workforce capacity, capability and sustainability in Child and Adolescent Mental Health Services*. National Mental Health Workforce Strategy
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4087362.pdf

2.1.4 New roles

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

2.1.5 Leadership

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

2.1.6 Education, training and other learning opportunities

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

2.1.7 LPT is committed to staff care and support and these underpin all six themes.

2.2. Local population profile and mental health need of children and young people

2.2.1 There are high levels of deprivation on the East Coast and in Lincoln.

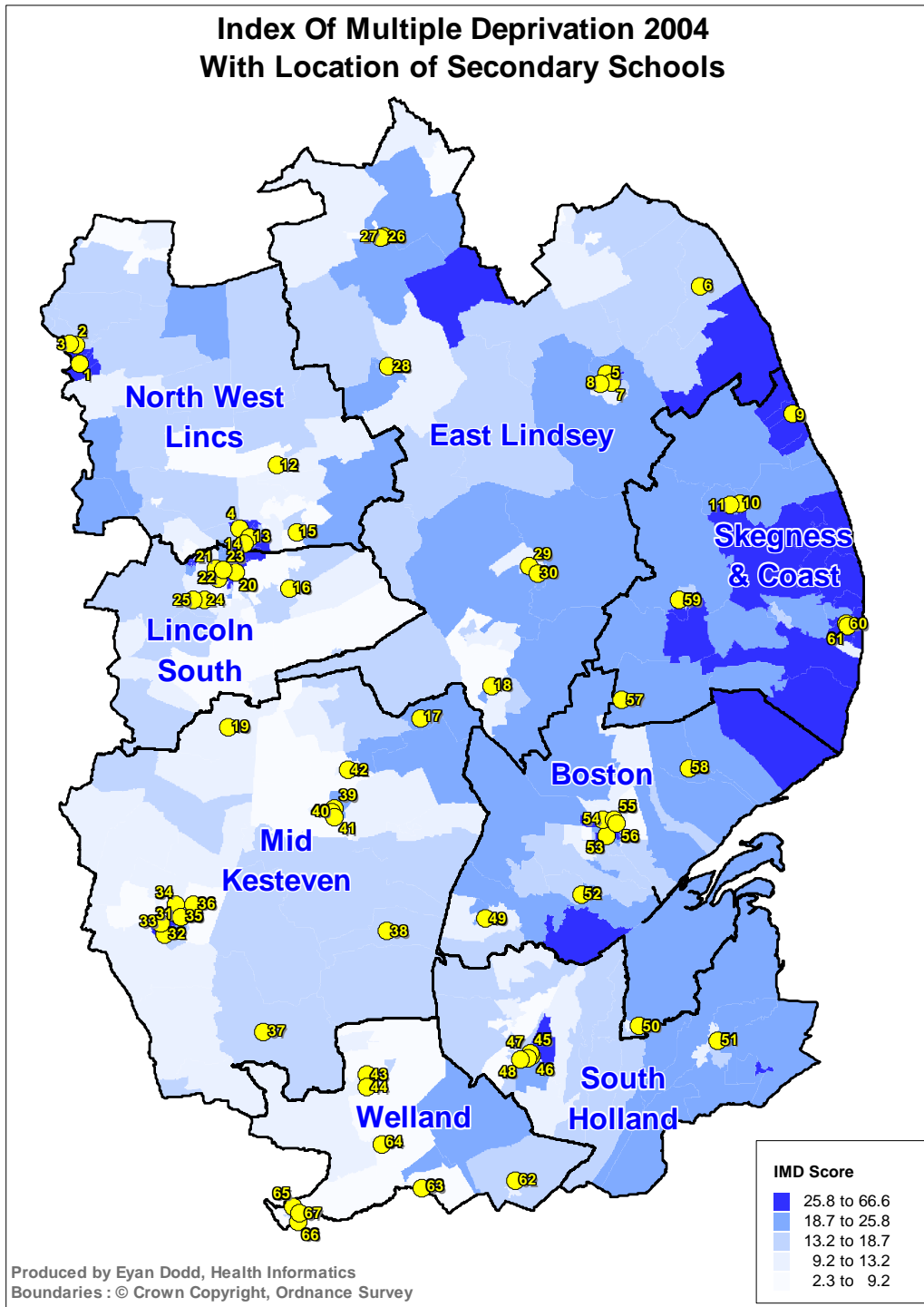
Over 40% of those living in the Skegness and Coast GP Cluster live in areas among the 20% most deprived in the country. In North West Lincolnshire, including the North of Lincoln and Gainsborough the figure is 24.3%. East Lindsey (0.1%), South Holland (0.1%) and Welland (0%) have no deprivation to speak of when compared nationally.

2.2.2. Many areas of Lincoln have high levels of deprivation and Lincoln has been designated a spearhead area. Spearhead areas are given extra monies to invest in health programmes to tackle health inequalities. Grantham has one particular area with high levels of deprivation which adversely affect the health and social well being of it population, the Earlesfield Estate. Boston has some areas of deprivation but not on the same scale as the East Coast and Lincoln.⁹

The map in Figure 1 below shows the distribution of deprived areas across the counties, as well as the location of secondary schools.

⁹ Eyan Dodd Senior Information Analyst (Public Health) eyan.dodd@lss.nhs.uk

Figure 1. Multiple indicators of deprivation across Lincolnshire



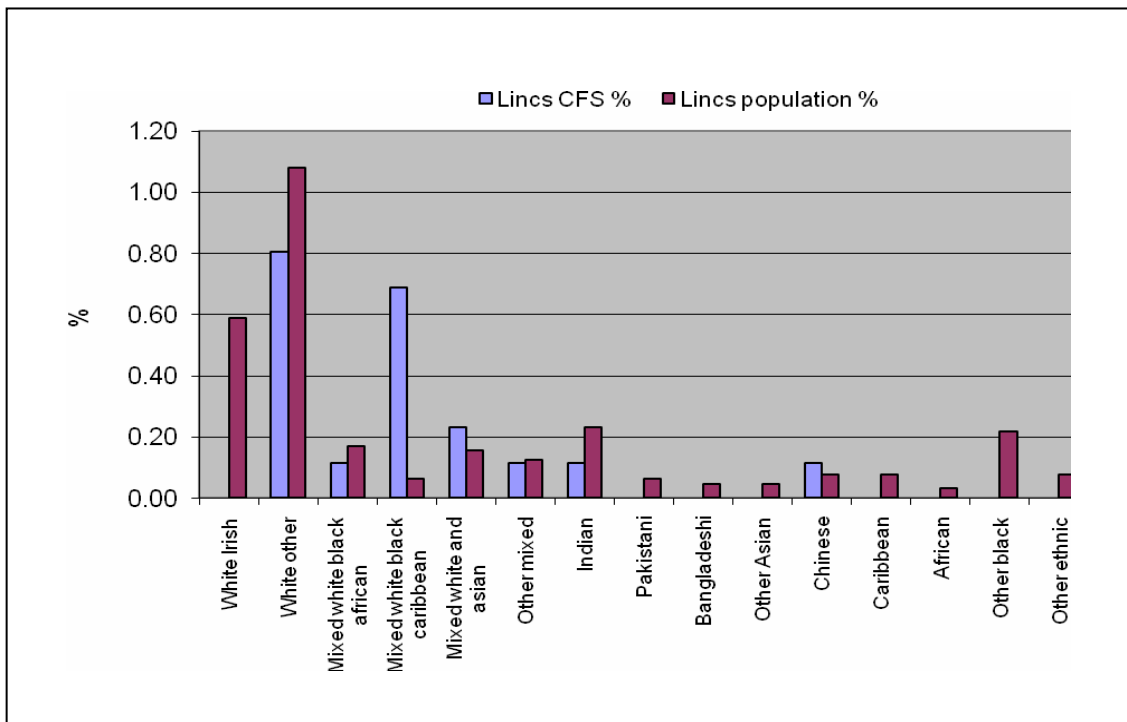
2.2.3 The ethnicity of the county can be compared to the ethnic mix in CFS caseloads. Figure 2 below shows the percentage of each ethnic group within the total Lincolnshire CFS caseload¹⁰ compared with the percentage of each group as represented in the Lincolnshire population.¹¹ All figures comparing ethnic mix have omitted the “White British” category, as these are so high they skew the scaling of the graph. (White groups form 99.2% of the county population and 98.6% of the CFS caseload.) To see the full data sets, including White British, see Appendix 2.

White Irish and White Other account for the largest proportions of ethnic groups shown on the graph. White Other includes new migrants, many from the enlarged European Union.

The actual numbers behind the percentages are in some cases very low, for example only one person of Chinese ethnicity and one of mixed Asian and white heritage were seen across the whole patch. The bar that apparently shows far more Mixed white and black Caribbean children being seen, actually represents only six children. It is very difficult to make accurate interpretations of the ethnicity of the caseload when such small numbers are involved.

Figure 2. Ethnicity of the CFS caseload compared with the local population

Enlargement on page 36

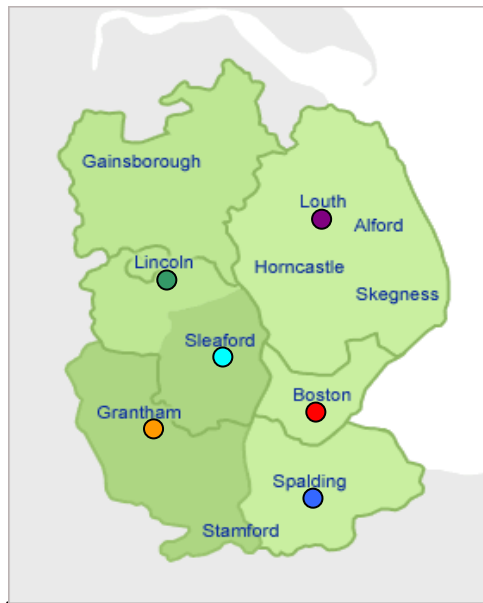


¹⁰ Source: National CAMHS Mapping 2006

¹¹ Source: Office of National Statistics

<http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14238>

2.3 The existing specialist CAMHS, service description and staffing¹²



2.3.1 There are six constituents for commissioning CAMHS, which are inpatient, LAC, YOS, community (totalling eight teams), secure and primary mental health teams. This translates into six generic multidisciplinary teams, two targeted, one dedicated service and one tier 4 for the county, these are shown on the Lincolnshire map above with more detail in Table 1: When compared with Figure .. it is noteworthy that the deprived coastal area including Skegness does not look well served. There is disparity between teams on caseload per WTE, in which Spalding has almost 36 cases per WTE, compared with Lincoln and West Lindsey with 11.76.

Table1. Lincolnshire CAMHS configuration (from CAMHS mapping)

Name	Team type	Population served	WTE (est.)	WTE actual	
Boston Locality Team	●	Generic MDT	Boston	9.63	9.57
Grantham Locality Team	●	Generic MDT	South Kestevon	13.9	12.03
Lincoln & *West Lindsey Team	●	Generic MDT	Lincoln and West Lindsey	25.94	25.51
Louth Locality Team	●	Generic MDT	East Lindsey	7.34	7.28
Spalding Locality Team	●	Generic MDT	South Holland	4.01	4.01
*Sleaford Area Team	●	Generic MDT	North Kestevon		
Nurse Specialists in YOS	Targeted	County	3	3	
LAC Workers Foster Care	Targeted	County	3	3	
Lincolnshire Secure Unit	Dedicated	County	2.84	1.84	
Ash Villa	Tier 4	County	29.31	25.59	
Total			98.97	91.83	

*New teams. Sleaford data is not yet included in the CAMHS mapping, from which the source data for Table 1 was obtained.

¹² Based on 2006 CAMHS mapping return, not reflective of in-year changes. Will need updating following the 2007 return in February 2008

2.3.2. The current staffing of the services within CFS is given in Figure 3 below. Medical staff numbers include 2.4 WTE training posts (Senior House Officer, SHO and/or Specialist Registrar, SpR) .

Figure 3. Current staffing of CFS, across the teams (Based on local staffing figures) Enlargement on page 37.

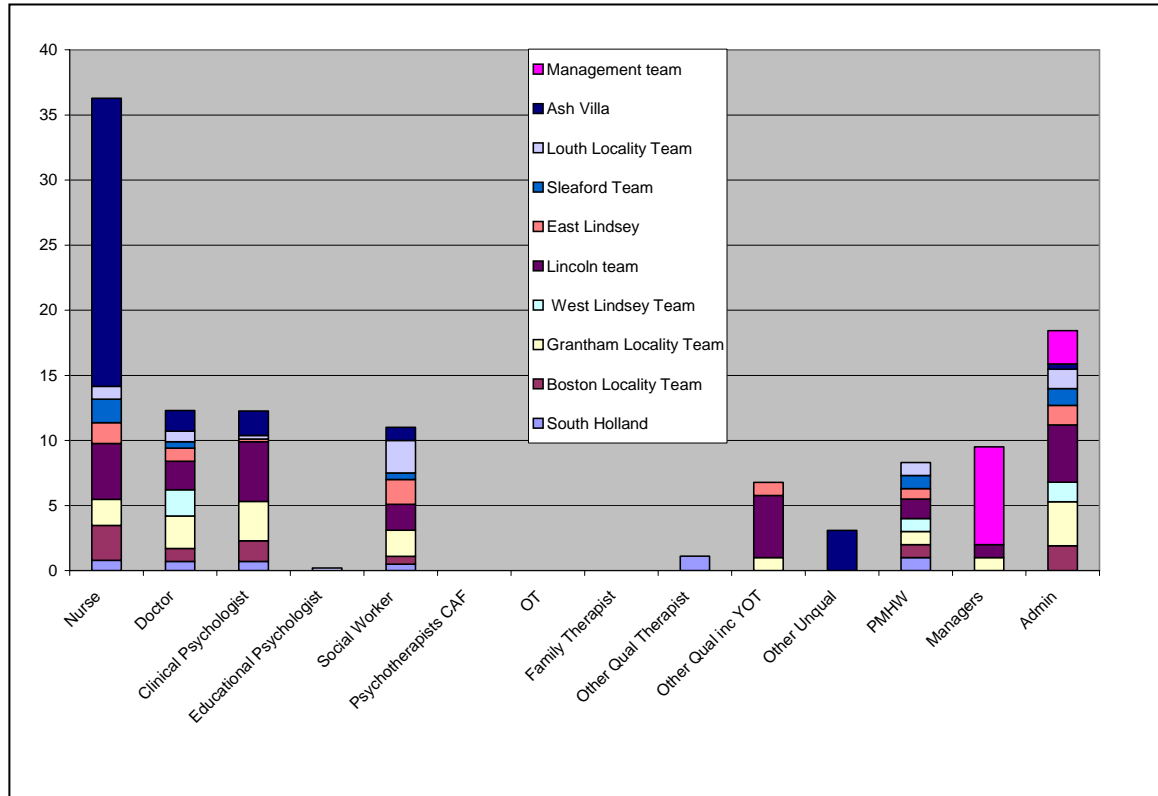
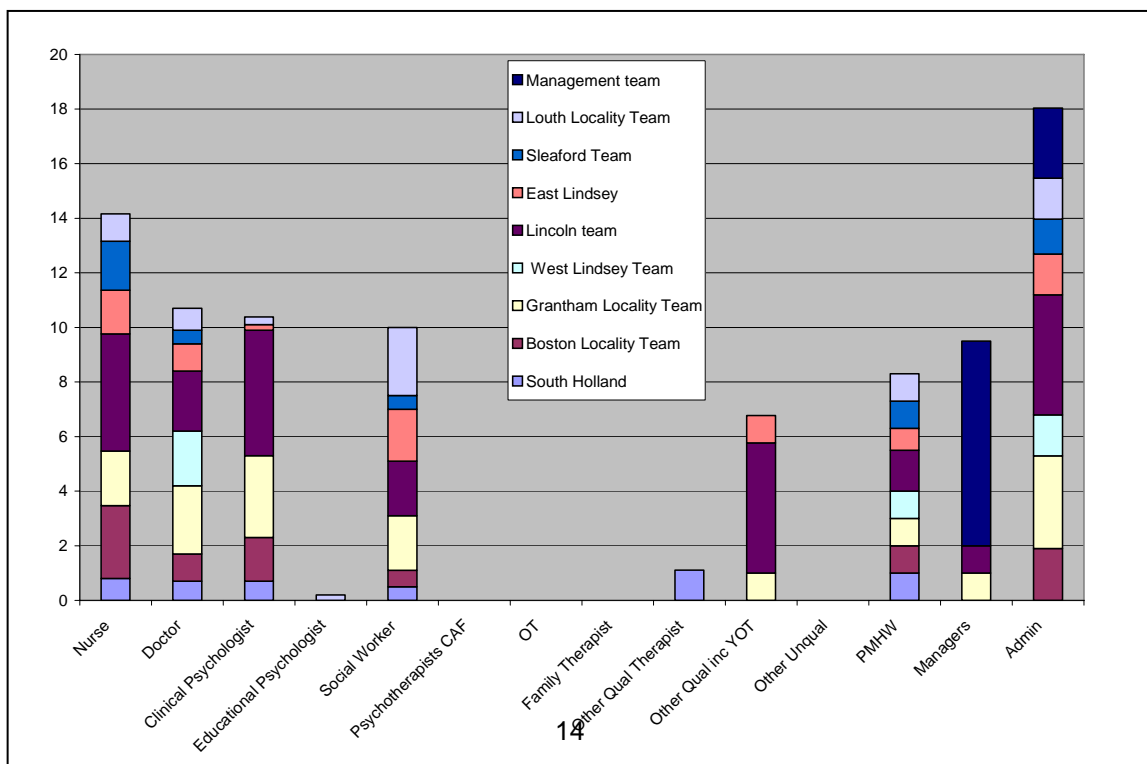


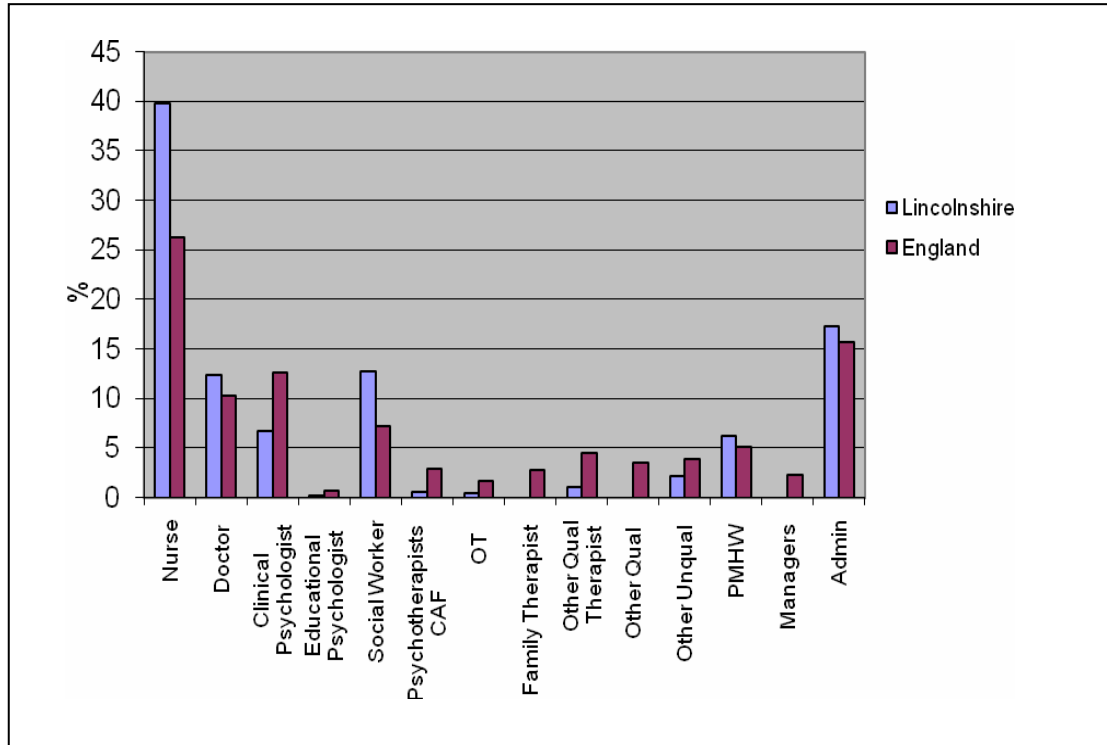
Figure 4 shows the staffing mix when Ash Villa is excluded, as the Tier 4 provision skews the overall nursing numbers.

Figure 4. Current staffing excluding Tier 4 Enlargement on page 38.



As Figure 4 shows, Lincolnshire has proportionately more nurses, social workers and doctors than the national average, and fewer clinical psychologists, psychotherapists, family therapists, occupational therapists (OT) and other (un)qualified staff.

Figure 5. Staffing mix in Lincolnshire CFS compared with England (includes Tier 4) Enlargement on page 39.

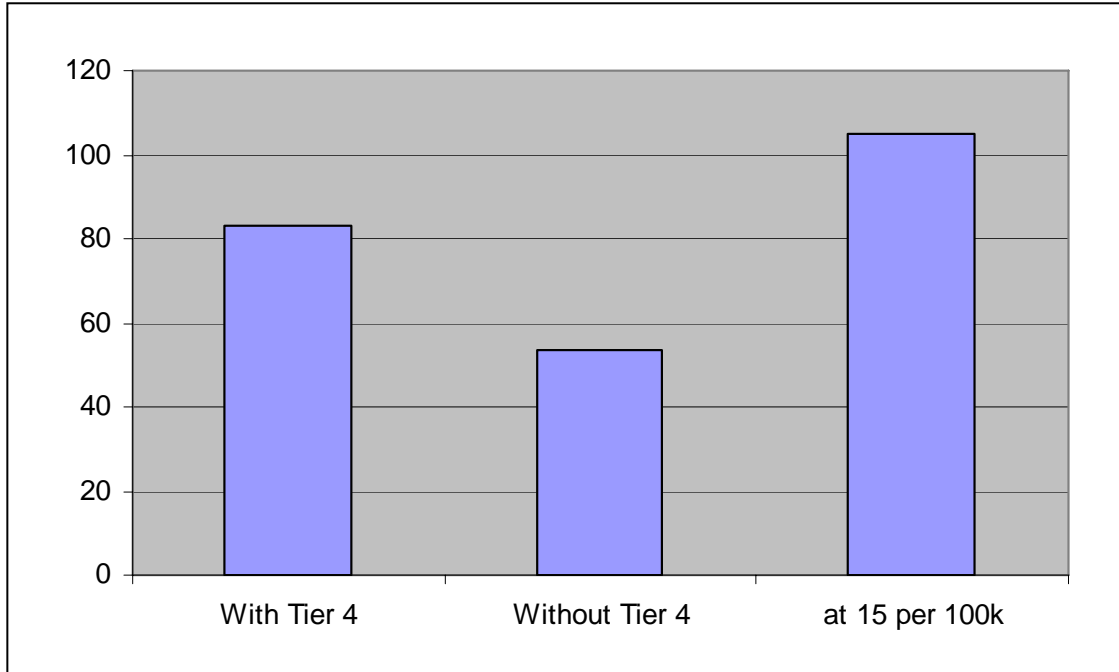


2.3.3 The emphasis of the CAMHS workforce plan is on using existing resources more effectively. The NSF however has recommended that numbers of specialist CAMHS practitioners should be 15 WTE per 100,000 population and it is worth noting how the workforce for Lincolnshire CFS measures up to that recommendation.

Figure 6 shows the existing WTE for Lincolnshire as it compares with the figure of 15 per 100,000. Appendix 3 has the source data for these findings, in which staffing totals from the CAMHS mapping have been set against the latest available population numbers. The total WTE of clinical staff across Lincolnshire is 82.99, with Tier 4 excluded, it becomes 53.68, whereas the recommended level for its total population of 670,000 would be 105.

Figure 6. Comparison of Lincolnshire CFS WTE with NSF recommendations

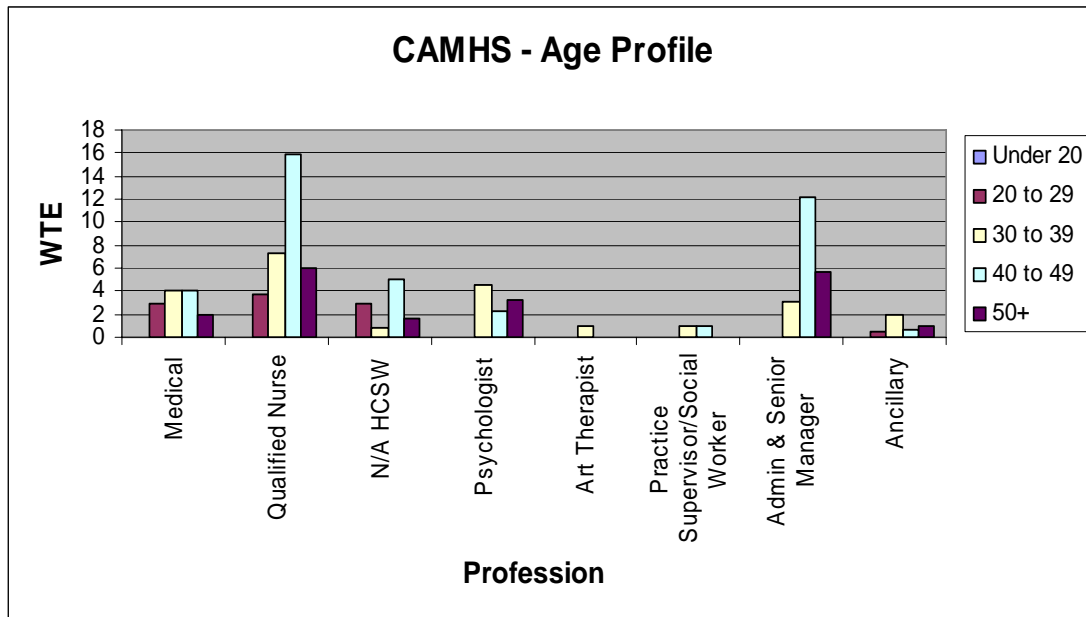
Enlargement on page 40.



2.3.4 The use of agency and bank staff is a significant issue for LPT and needs a long term strategy to address it.

2.3.5 CFS has an ageing workforce,¹³ in particular in the nursing and managerial areas, with the highest number in the range 40-49, but a smaller number in the 50+ age bracket. This creates potential for recruiting and developing a younger workforce, although the principle of career pathways would need to be introduced or improved across the piece, especially for staff who want to progress, but are not interested in management. Figure 7 shows the age distribution of existing staff.

¹³ Source: Paul Jackman

Figure 7. Age profile of staff Enlargement on page 41.

2.3.6 The case mix for each service is an approximate indicator of demand. Additionally, employing the best available evidence it is possible to use case mix as a proxy indicator of the skill mix needed in each service, in order to offer the most effective interventions. The tables given in Appendix 4 show the proportion of each presenting problem seen in each team. The skills required to deliver the most effective interventions have then been mapped on to these proportions, to indicate the relative amount of each skill that would be needed in the service. The charts show a range of skills and do not specify which professions or disciplines may or may not be competent in those areas.

Figure 8 shows the case mix across Lincolnshire CFS; overall it can be seen that in the majority of cases (83%) the primary presentations fall into four categories: *Emotional Disorder, Conduct Disorder, Hyperkinetic Disorder and Autistic Spectrum Disorder*. There is sound evidence of effectiveness for interventions in all three of these groups and Figure 9 displays the skills as they map on to the disorders.

Cautionary note

This section is based on Wolpert, M., *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. The contextual and explanatory text in *Drawing on the Evidence* cannot be reproduced here, and readers are advised to read the whole source document. ¹⁴

To view the spreadsheet showing how the evidence and skills were summarised for use in this report, please email Yvonne Anderson, details in Appendix 1 – this document has not been included as it can only be viewed electronically and is not amenable to printing.

¹⁴ http://www.acamh.org.uk/site/upload/document/Drawing_on_the_Evidence_-_text.pdf

Figure 8. Case mix across Lincolnshire CFS (primary presentation)

Enlargement on page 42.

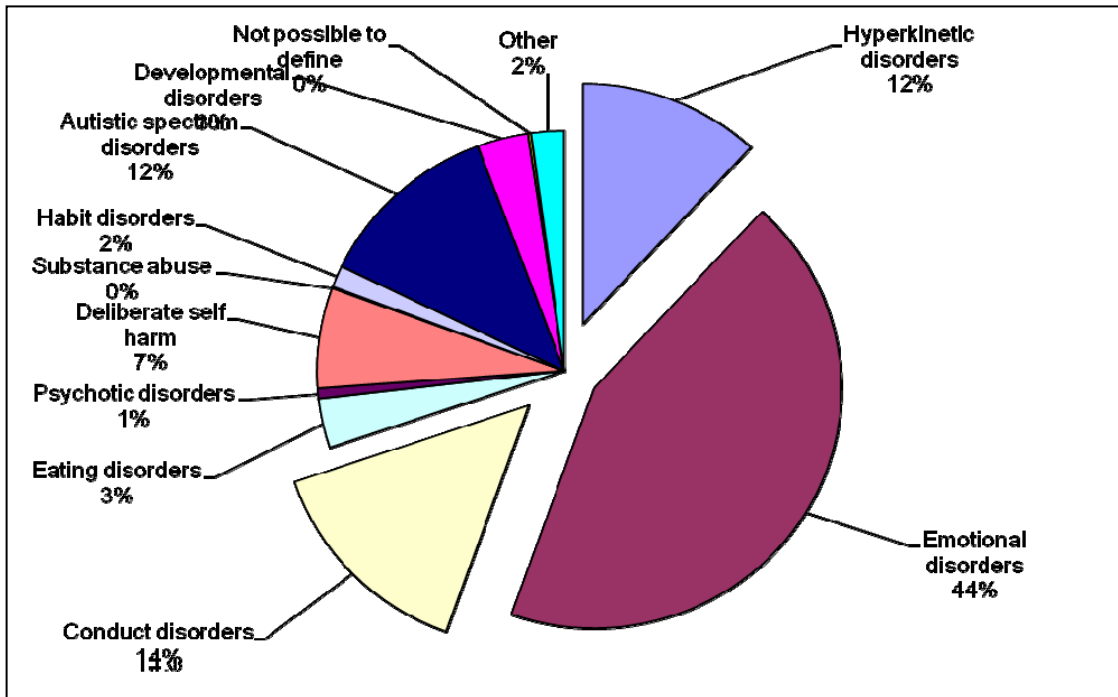


Figure 9. Indicative skill mix across Lincolnshire CFS Enlargement on page 43.

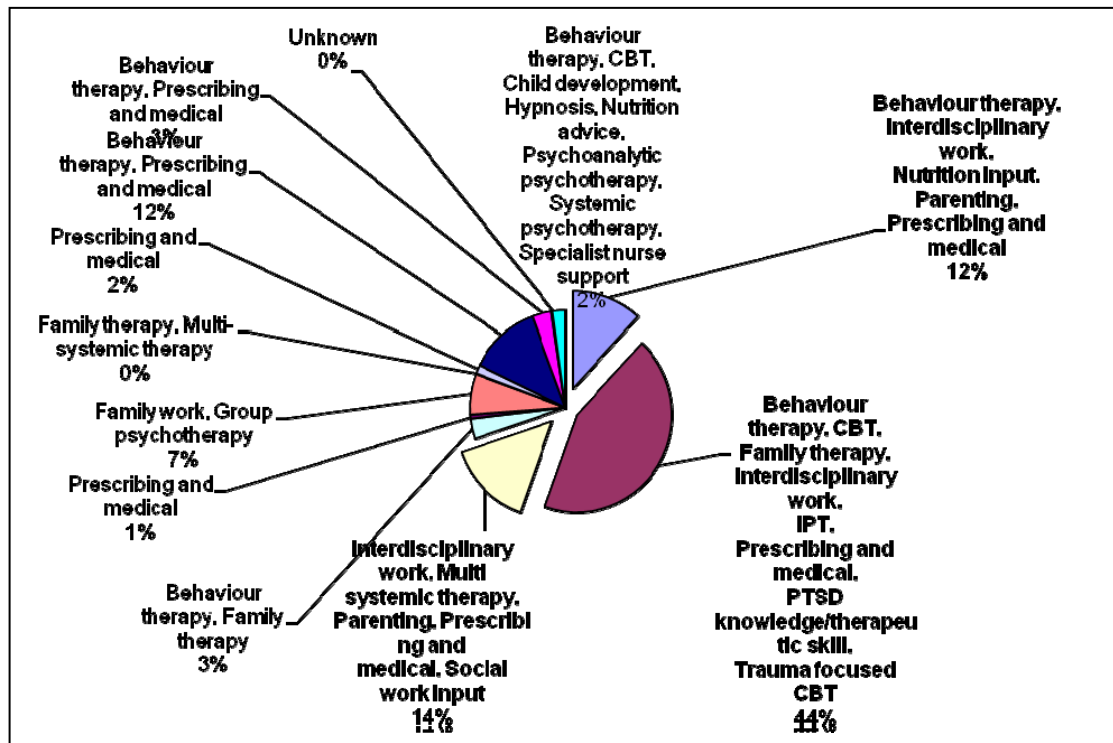


Figure 10. Available disciplinary mix across Lincolnshire CFS, including Tier 4
 Enlargement on page 44.

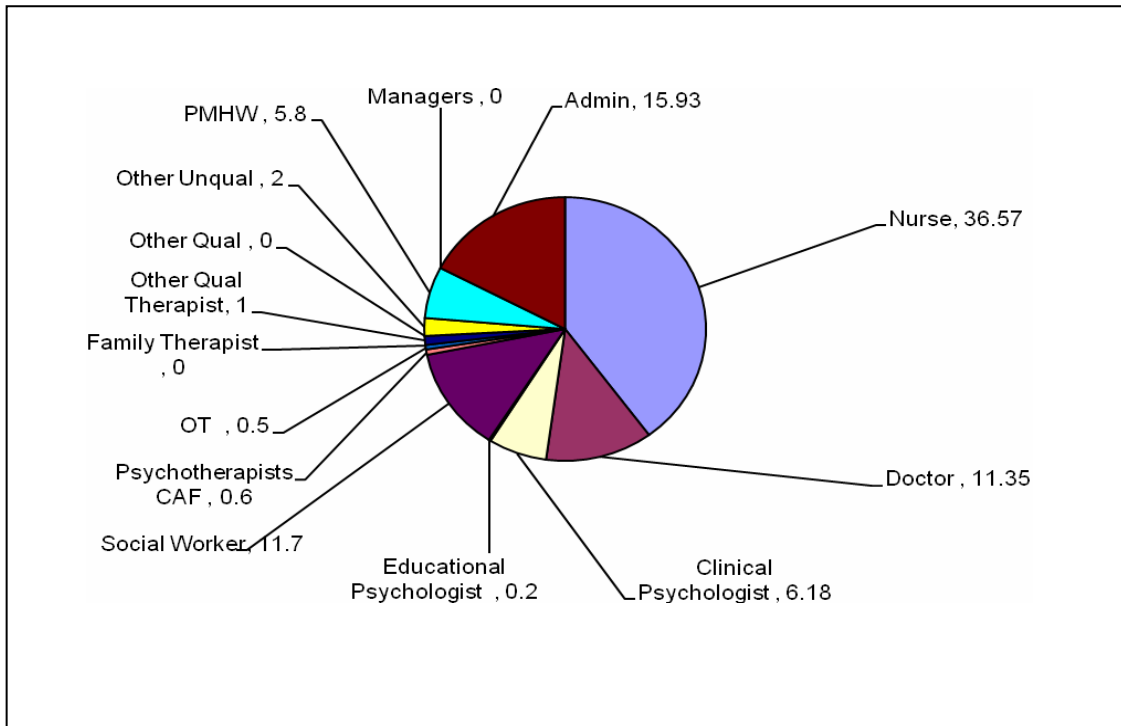
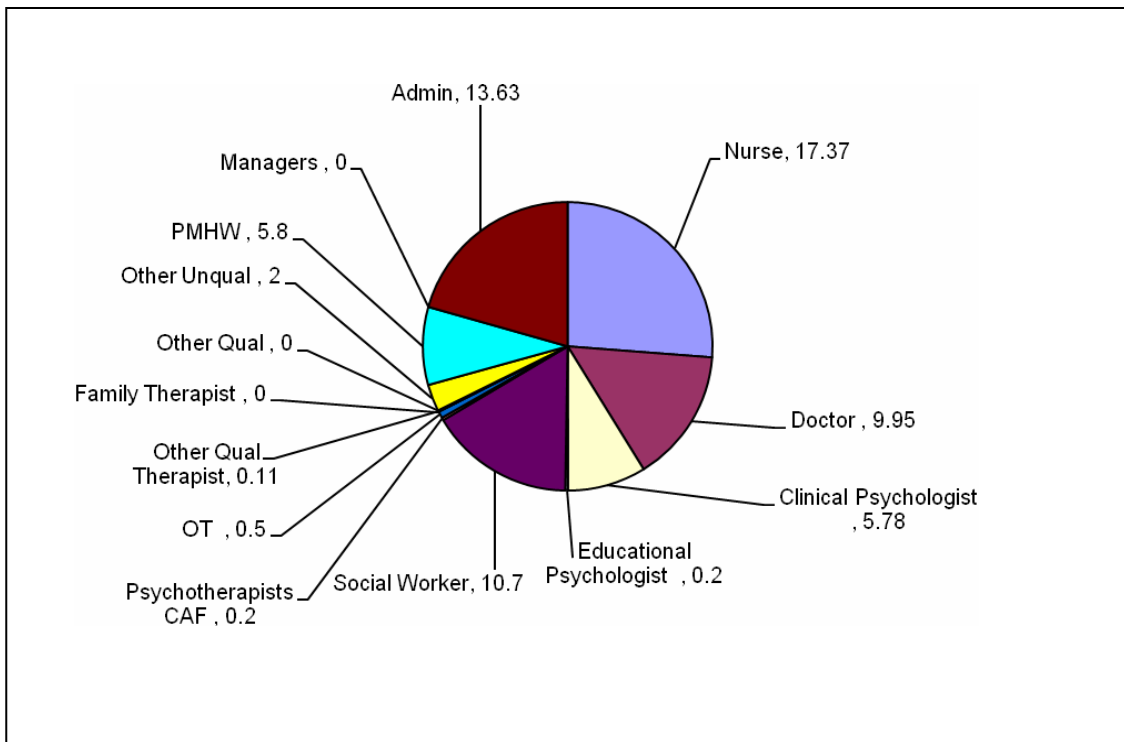


Figure 11. Available disciplinary mix across Lincolnshire CFS, excluding Tier 4
 Enlargement on page 45.



For a rough framework in assessing skill mix, the following formula is a guide, with the caveat expressed in the footnote.

For every 1 WTE person for prescription and monitoring, there should be:

- 1 WTE systemic/multimodal therapist;
- 1.5 parent management trainers; and
- 3 WTE behavioural, cognitive and interpersonal therapists.

This is assuming that each WTE is providing just one category of intervention – people who deliver more than one type of treatment would be calculated as part time equivalents for each.¹⁵

2.3.7 Staff skills audit

During the process of compiling this workforce plan a staff skills audit was undertaken. Each team was asked to assess the team strengths and potential risks in:

- a) dealing with specific disorders/need
- b) offering particular interventions

Four of the five community teams sampled (Sleaford was still being established) supplied their self assessment. Tables 2 and 3 below show the areas in which all teams judged themselves confident and those in which there was less confidence.

Table 2. Intervention/skill

Strength across all 4 teams	Potential risk, across 2 or more teams
Advice giving	Data collection
Attachment Therapy	Data input
CBT	Dialectic Behaviour Therapy
Consultation	DISCO
Counselling	EMDR
Dealing with aggression	Medication monitoring
Dealing with professional enquiries	Medication prescribing
Family Therapy	Psychometric testing
Family Work	Psychotherapy
Group work	Training specialist professionals
Parent Training	
Solution Focussed	
Training staff in targeted services	
Training staff in universal services	

¹⁵ Based on **work in progress** by Robert Goodman and Tamsin Ford. It should not be quoted elsewhere or used in any other document. Contact Yvonne Anderson for update.

Table 3. Disorder/need

Strength across all 4 teams	Potential risk, across 2 or more teams
Anxiety	Alcohol/drug misuse
Attachment	Chronic Illness
Attention deficit Hyperactivity Disorder	Conduct
Autistic Spectrum Disorder	Emerging borderline personality disorder
Complex/co-morbid	Epilepsy
Depression	Feeding difficulties
Early Psychosis	Forensic/Offending
Eating disorders	Learning difficulty
Grief and loss	Neuro-development disorder
Obsessive Compulsive Disorder	Severe Learning Disability
Parental Mental Health Problems	
Physical Abuse	
Self harm	Mixed response
Sexual Abuse	Tourettes/Tics
Trauma	Trauma

Both tables show that the potential risks are outweighed by considerable strengths across the Trust. The risk areas have implications for:

- a) training and development (eg severe/learning difficulty)
- b) partnership working (eg alcohol/drug misuse, conduct, forensic)
- c) recruitment (potentially any category)
- d) re-allocation of specialist skill across teams (eg prescribing and medical monitoring)
- e) management and leadership (eg data recording and data input).

The review was conducted by Gill Walker. For more detail see Appendix 5.

2.3.8 Review of CAMHS administrative services

This review, which also took place during the production of this overall workforce plan, highlighted a number of gaps in the existing administrative arrangements. The actions planned to close these gaps are:

- Recruiting to specific vacancies in a limited fashion to make sure that workload problems are kept to a minimum that is fixed term cover for maternity cover, bank cover or use of current part time staff until new teams are agreed and moves to new premises are agreed.
- Discuss with teams at their team meetings as to how best to move forward, in an attempt to get a shared agreement as to the admin requirement.
- Member of management team to attend team meetings to feedback any issues highlighted by the teams in order to assist them in a proactive and timely manner.
- Provide ongoing training and support for the various IT systems.

Areas needing to be addressed in the longer term were identified as:

- Identified workload issues – e.g. reception cover, which are specific to Moore House and will be resolved by a move to new premises
- IT issues – which are to do with connectivity not access to equipment, will be addressed via the move to more suitable premises in some incidences and by the Trust IT Strategy.
- Monitoring the admin workload and other changes as a result of CAPA and CORC – Gill Walker, CAPA lead and CSIP support has approached other Trusts who use this approach to establish the possible increase in workload for admin staff and what new tasks need to be carried out as a result of CAPA and what tasks are reduced.
- To request all staff complete the EKSF staff profile on line as required by the Trust and use the results for the framework of a skills audit to identify skills, capacity and training needs, as opposed to developing yet another questionnaire for the staff to complete.
- The CFS Workforce Board has therefore decided to carry out the CAMHS admin review over a longer time-scale to make sure that all of these issues are addressed.
- CFS Service developments: eg CORC, performance monitoring.

All the findings of the administration review need to be taken into account whenever broader workforce changes are made as a result of actions deriving from this plan. The full report, by Chris Mardon, can be found at Appendix 6.

PART 3

- 1. The local labour market**
- 2. Regional, national and international labour markets**
- 3 Attracting people to work in the NHS**

3.1 The local labour market.

3.1.1 Lincolnshire is one of the largest and most sparsely populated counties in England. It has approximately 700,000 residents, of whom 22% are under 18 years old, which is about the same as the national average. Around half the population live in the city of Lincoln and the main towns of Boston and Grantham. The remainder are scattered throughout the county in small towns, villages or isolated communities.

Although 97% of the population is white British, there has been a significant increase in the number of people from other European countries, particularly from Poland and Portugal. Many have settled in the south and east of the county to work in the large agricultural sector, but many also work in seasonal employment in the rural areas and in the eastern coastal region, which has a high influx of tourists in the summer. Migrant workers are not a new phenomenon in South Lincolnshire - in the eighteenth century early settlers from Holland drained the land and introduced the growing of bulbs and flowers in the area.

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

The movement of British people to South Lincolnshire has involved an increasingly older population (South Holland -19.2 %) many of whom are over retirement age, and not looking for the temporary and non-qualified jobs which are currently filled by the migrant workforce. There is also a difference between the current local average working age of 41 years, against 25-34 years for migrant workers. Migrant workers are proving to be younger and more competitive in the labour market than the local population. 2001 Census data for Lincolnshire shows that there have been significant increases in the number of people in the 40-59 and 75+ age groups and a noticeable fall in the number of the 25-39 age group. This trend could have a negative impact on the county's economy should it continue.

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

Unemployment is below the national average but wage levels are also low. Almost one third of adults have no qualifications; in the east of the county this rises to 40%.

Twenty-five wards are in the 20% most deprived areas nationally. Crime levels are lower than both regional and national averages.

Lincolnshire has one of the fastest growing populations in the country and this is projected to continue;

- The population is growing fastest in the more rural areas and more slowly in the City of Lincoln;
- The population is ageing, by 2010 a quarter of the combined population of East Lindsey and South Holland is projected to be aged 65 and over;
- As the dependency ratio shifts there will be less people of working age compared to the older age groups;
- The school age population is slowly falling which could impact on future requirements for school places as well as reducing the number of new entrants to the labour market in years to come;
- The make-up of the workforce and of communities in some areas has changed rapidly due to migrating workers and expanding EU membership.

Source: LRO¹⁶

Research shows that migrant workers experience a range of problems associated with working in the UK. Many are connected to low paid casual or sessional work, that is not a consideration for this workforce plan. But there is also a lack of recognition of migrant workers' existing qualifications and many highly qualified migrant workers, such as engineers, teachers, doctors are working in pack houses.¹⁷

3.1.2 The implications for CFS:

- The areas of most need` are likely to be where CFS will need to recruit, but potential staff are not liable to be living in those areas.
- Inducements will need to include good career pathways and training/development prospects.
- CFS managers may consider joining with other health and social care providers in recruitment drives, graduate fairs and in making the NHS locally an attractive career choice for young adults who may otherwise move away.
- As the workforce ages, CFS, in agreement with the Trust, may consider more flexible arrangements for those staff approaching retirement and incentives to keep them longer, to allow for succession planning and smooth transition.

3.2. The regional, national and international labour markets.

3.2.1 Regional labour markets

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

¹⁶ The Lincolnshire Research Observatory (LRO) has also produced interactive maps of Lincolnshire, which are highly recommended for a more detailed analysis of population trends.

<http://www.research-lincs.org.uk/lro/toolkits/imd2004/swf/imd2004-toolkit.asp>

¹⁷ Zaronaitė, D., & Tirzite, A., (2006) *The Dynamics of Migrant Labour in South Lincolnshire* [http://www.migrantworker.co.uk/docs/The%20Dynamics%20of%20Migrant%20Labour%20in%20South%20Lincolnshire%20\(2\).pdf](http://www.migrantworker.co.uk/docs/The%20Dynamics%20of%20Migrant%20Labour%20in%20South%20Lincolnshire%20(2).pdf)

Lincolnshire and Nottinghamshire have the highest percentages of people in part-time work (25.8% Lincolnshire, 25.6% Nottinghamshire).

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

Derbyshire the highest proportion of people aged 25-49 working part time (24%). Lincolnshire (36.6%), Northamptonshire (35.3%) and Nottinghamshire (35.1%) have the highest proportions of employed people aged 50+ working part time.

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

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

Lincolnshire has the lowest proportion of 30-39 year olds qualified to NVQ4+ (18.7%) and the lowest percentage of those aged 20-24 (23.9%) with NVQ3.¹⁸

3.2.2 National and international labour markets.

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses, although across Lincolnshire CFS the numbers for these staff groups are higher than the national average (see Figure 4). Many of the issues raised around recruitment and retention of doctors and nurses apply equally to other professions, however.

Psychiatrists

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

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

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

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

¹⁸ Jones, J., (2004) *East Midlands Regional Skills for Productivity Partnership: Informing Regional Priorities.*

<http://www.esppartnership.org.uk/measuring-impact/research--evidence-papers>

Nurses

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

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

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

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

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

3.3 Attracting people to work in the NHS

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

They conclude that:

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

The report recommends the following:

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

PART 4

- 1. Strategic vision for future services**
- 2. Workforce capacity required for future services**
- 3. Ways of increasing the capacity of specialist CAMHS**

4.1 Strategic vision for future services

4.1.1 The key LPT themes are reproduced below, with their implications for the CFS workforce (italicised).

▪ **Equality and Equity**

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

The CFS workforce should be sufficient in number to serve all geographical areas and competent to deliver a comprehensive service as outlined in the NS.

▪ **Improving Quality of Life for Service Users & Carers**

Medical and Social Care interventions, which improve outcomes and enable service users to live as independently as possible

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

▪ **Improving Efficiency and Productivity**

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

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

▪ **Enhancing Service Users' Experience**

A key focus area for Health Care Commission

Four Domains:

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

The service should move towards service user participation. Young people and their families should have choice about the timing and location of their appointments. Staff may need training and support in developing new service models in partnership with service users.

▪ **Social Inclusion**

Service Users are supported to break the cycle of social exclusion – unemployment, debt, homelessness and worsening health

Fulfilling people's aspirations through work and social networks

Staff need to be competent in partnership working and managing/participating in the network of services around a child and family.

4.1.2 The key LPT themes underpin the strategic priorities for CFS 2006-7, which are:

- Develop an integrated CAMHS, comprising a single workforce, budget and business Process
- Meet the mental health needs of young adults (including 16 & 17 year olds)
- Meet the mental health needs of children with disabilities, including learning disabilities
- Respond to urgent mental health needs, providing 24/7 cover
- Develop a specialist CAMHS Care Pathway (Choice & Partnership Approach)
- Configure community teams to align with local children's service developments
- Develop a range of highly specialist (Tier 4) CAMHS
- Make improvements to complex care, including forensic services and Out of Area placements (OATs), meeting the needs of children and young people with complex, severe and persistent behavioural and mental health needs through a multi-agency approach.

4.1.3 This plan is a first step in building upon the existing workforce to develop capable and competent teams that will deliver these goals. The workforce planning group will develop a competence-based skill mix for CFS teams, based on analysis of the evidence for effective practice. Evidence will cover three domains, in keeping with CAMHS Outcomes Research Consortium (CORC) principles:¹⁹

- **Value base.** Local and national policy and guidance, vision and aspirations
- **Benchmarking.** Ongoing use of national databases, principally the CAMHS Mapping and Office of National Statistics, to update and build upon the comparisons and benchmarks used in this report.
- **Audit/evaluation/research.** National and local, published as well as "grey" literature

4.2 Workforce capacity required for future services

4.2.1 The NSF recommends 15 WTE per 100,000 population for a specialist CAMHS that does not offer formal teaching and 20 per 100,000 for one that does. As shown in Figure 5 above, Lincolnshire, like most areas of England, falls short of this number. The total WTE of clinical staff across Lincolnshire is 82.99, with Tier 4 excluded, it becomes 53.68, whereas the recommended level for its total population of 700,000 would be 105.

York and Lamb (2005) suggest that primary mental health workers (PMHW) provide various combinations of consultation, short-term direct work and training, employed within a Tier 2/3 CAMHS or part of a stand-alone team. They state (page 29)

In their description of a four star and five star CAMHS, Davey and Littlewood recommended 5 wte Primary Mental Health Workers per 100,000 total population (Davey & Littlewood, 1996b). We agree with this recommendation.

4.2.2 Closely linked with the physical numbers employed is the productivity of the service, which should be evidence based.

¹⁹ <http://www.corc.uk.net/>

The box below gives a recommendation for an average caseload of 40. Using the figures from Table 1, the average WTE caseload for generic teams in Lincolnshire is 17.36, with a range of 11.76 to 35.91.

York, A., & Lamb, C., (2005) Building And Sustaining Specialist CAMHS Workforce, capacity and functions of tiers 2, 3 and 4 specialist Child and Adolescent Mental Health Services. Royal College of Psychiatrists. Page 7

Capacity calculations based on providing an epidemiologically needs based service for 0 to 16 year olds suggest that current specialist CAMH services are overburdened. Team capacity should be set at 40 new referrals per whole time equivalent (WTE) per year. This will enable specialist CAMHS to respond quickly, flexibly and offer evidenced based treatments for long enough for them to be effective. However, commissioners may prefer to choose to use existing capacity in specific ways such as setting the number of new cases that are seen a year as higher than 40 per WTE but limiting the number of treatment sessions available. If this is done it needs to be recognised that some effective treatments could not be provided. Matching demand and capacity is essential to ensure efficient service provision. Much can be done to ensure the patient journey is smooth and that delays are kept to a minimum. A service that has streamlined operations has a team capacity of 40 new referrals per WTE per year. For a specialist Tier 2/3 CAMHS of 10 WTE this means a team capacity of 400 new referrals a year.

4.3 Increasing the capacity and capability of Child and Family Services

The content of this section was obtained both from the workforce planning group and from the wider consultation of all frontline staff carried out by Gill Walker. There was a wealth of ideas and thoughts put forward that together demonstrate the level of engagement and interest in workforce planning across the whole of CFS.

The input from the workforce planning group and the wider staff group is given below under the headings that reflect the six principles of workforce planning. Each section is sub-divided into three categories:

- underpinning values/principles
- aims for the future workforce
- outcomes to be achieved

4.3.1 Workforce design and planning

- Collate information on courses available
- Grow your own staff
- Share training/experience in CFS teams locally/nationally
- CFS staff training in education establishments and more in-house training
- CFS training budget needs the board to co-ordinate and facilitate
- Allow and encourage staff to develop special interests – provided these are congruent with overall service objectives and model
- Identify core competencies for continued development
- Develop/commission modular training with saleable credit systems
- Link in with local training providers
- This needs to be based on a needs analysis

4.3.2 Recruitment and retention

Underpinning values/principles

- Attract high quality staff to the area and provide sufficient support and career potential to retain them.
- Build all plans on an understanding of key demographic themes for this area such as isolation (virtual, or perceived and real) and deprivation.
- A good way of recruiting generally is to have input into child development courses, forensic courses, research project into secure unit, and student placements for clinical psychologists.
- Any new workers employed should have added on costs attached to include adequate training and Personal Development.
- It would help us to know by a needs assessment and demand/capacity analysis if we have the right proportionate amount of staff and input by professions in relation to child population.
- Retention- it is important for staff within universal and specialist services to understand their role, peer support, management support, and wider agency knowledge of the service.

Aims

- Understand the age profile and skill range of the current workforce
- Use targeted advertising
- Analyse and manage the impact of Agenda for Change.
- Develop *grow our own* schemes
- Address professional isolation in many areas of this large county with its relatively low population
- Devise ways of showing staff they are valued
- Clarify, extend and promote supervision as a key theme
- Use vacancies creatively to make workforce changes depending on skill mix needed
- Would like to develop LAC service to include recruitment of foster carers, looked after children and care leavers.
- Better training opportunities for nursing staff, more courses/teaching sessions.
- Opportunities for career progression.

Outcomes

- Tap into and develop local initiatives, eg job fairs, recruitment events for new graduates
- Link with HEIs and their potential recruitment pool(s)
- Develop recruitment packs and induction programmes
- Construct career pathways/progression routes, including development and training
- Provide support and management to support staff
- Develop new roles such as Graduate Workers and para professional roles – where there is a demonstrated need
- Provide a training post for newly qualified staff.
- Offer secondment opportunities to give a taster to YOS (CFS).
- Improve the image of YOS (CFS).
- Mentoring system could be put in place for less experienced staff.
- Offer workshops in 6th form or in colleges.
- An Ash Villa (CFS) open day.

4.3.3 New ways of working

Underpinning values/principles

- Build on and recognise good practice
- Work to a vision that is owner-articulated, involving front line staff and particularly users and carers
- Ethos and direction to work across boundaries needs to come from top, Service level/Director level.

Aims

- Find ways to work across NWW → professional & organisation boundaries, linking to regional initiatives
- Develop training that is supported by the children's agenda (Every Child Matters)
- Recognise what is and is not working – outcomes focus
- Utilise maximum amount of people's skills but ensure people work within competencies.
- Need to understand other services more, who they are, what they do.
- Needs to be part of Inductions to shadow other professionals.
- Pathways needed, referral pathways inside service and also knowledge of universal services pathways.

Outcomes

- Link into national pilots, such as CAPA and Tier 4 scoping, run joint training on CAF – CAPA – CPA, county/local (tapping into national drivers)
- Investigate specialist clinics
- Develop a single model of line management
- Develop integrated process/protocol across services in CAMHS/AMH
- Link with associated professionals eg. Paediatrics, specifically liaising with Primary Mental Health on promotion and prevention
- Mentoring, shadowing and clinical supervision
- Flexible working hours, eg three long days as one option.

4.3.4 New roles

Underpinning values/principles

- Promote a flexible workforce
- Be clear why new roles are required (and those not required) - not a means to reduced expenditure
- Need to move from CAMHS service to a community based centre, integration with other agencies, genuinely embedded in the community.

Aims

- Learn from experience
- Imaginatively use unqualified staff

Outcomes

- Link and learn from with Adult Mental Health, where new roles have already been developed
- Link with New Ways of Working
- Looking at existing staff and how their roles might be extended
- Support and develop unqualified staff who may wish to and are eligible to progress, promoting the element of continuity through transferability, governance and regulation.
- Move the mental health nurse consultation post to residential children's homes into the LAC team.

- Change the term 'worker' at the end of PMHW – this has prompted discussions in the past about people using the service not understanding the worker is a trained professional.
- Provide training for current nurses on ward so they can become specialists as part of development, hence less of a divide between band 5 to a management level on the banding scale.

4.3.5 Leadership

Underpinning values/principles

- Recognise that we have very talented people at all levels and that leadership extends to all levels and includes clinical roles.
- Leadership should not be confused with management (eg clinical supervision is not the same as line management, etc)
- Cultural change is critical to develop new ways of working – it needs change management, which in turn needs leadership and managing. Specialist CAMHS are ready and able to change the culture, but recognising the challenges
- Recognise that our natural leaders are not always in management positions and not all managers are “leaders”
- All staff are managers and/or leaders, at various times and different levels
- Foundation Trust status will impact upon leadership roles
- Need to know what and where service will be in Year 1, Year 2 Year 3 etc

Aims

- Create opportunity for training that demonstrates we value all staff
- Address issues arising out of Agenda for Change, which has been divisive
- De-mystify “management”, using plain English and no jargon.
- Promote CFS as well placed, being a “young” service, to initiate cultural change– keeping fresh, keeping up with rapid change.
- Would be helpful to employ an organizational psychologist to explore change in our system and get someone to do a study and evaluate change- a PhD project.

Outcomes

- LM and supervision framework already being developed
- Use Agenda for Change creatively to support management development, not afraid to change job descriptions to reflect existing skills and roles
- Ways of developing leadership will be creative and include
 - Mentors
 - Shadowing
 - Cross boundary/professional working to increase understanding
 - Links between in-house and external/accredited training
 - Secondments
 - External placements e.g. voluntary sector
 - Leadership course
 - Awards programmes e.g. positive practice awards

4.3.6 Education, training and other learning opportunities

Underpinning values/principles

- Staff are our most important resource
- Budgetary constraints should not be a threat to training and education, which should be valued and protected
- Recognition for training and development already completed
- There should be more responsibility for 'on the job' training, core competencies, develop and maintain workforce, richer experience for working.

- Training budgets should be part of the advert and this is not always the case.
- Needs to be closely aligned with performance management and then with salary. Ongoing education training and development would arise from this. Individual responsibility for passing on knowledge on a variety of levels and disseminate knowledge, education and training of others.

Aims

- Provide and/or commission modular training
- Initiate relationships with FE colleges
- Build on strengths in psychology training
- Could the training offered by PMHW to other professional/communities be given University/H.E accreditation.

Outcomes

- Develop links with HEIs, (Nottingham University, nursing, Trent, social work, Lincoln University, in house training, open learning and nurse training)
- Work towards joint training/pooled budgets (“local exchange training scheme” LETS)
- Offer more in-house training, investigate course validation (training committee to organise events, eh CAMHS conference)
- Contribute to curriculum development
- Develop local and/or tap into national core competencies
- Map existing training courses and co-ordinate what is available, involving staff to promote ownership Encourage foster carers, looked after children and care leavers to deliver training
- Always have three medical trainees

PART 5

- 1. Agreed actions**
- 2. Goals and milestones**
- 3. Monitoring and review**

5.1 Agreed actions

The following actions were agreed as a starting point by the planning group. The full implementation plan can be viewed as a separate document and resides with the Workforce Development and Staff Care Board, where it is monitored.

- Disseminate this plan to all CFS staff and wider Trust.
- Share this plan with CAMHS Partnership/commissioners and start to integrate with wider children's services workforce planning.
- Investigate the impact/benefits of aiming for a WTE caseload of 40 and the methods for achieving it (link with CAPA).²⁰
- Build on the staff skills audit by devising a training programme and recruitment plan.
- Identify teaching and training expertise and experience from within the service. Look at their potential to train internally as well as the feasibility of income generation.
- With HR and Finance, investigate possibilities for flexible working and how to incorporate into existing roles and/or build into new posts.
- Plan and implement a series of PR/recruitment events for the service, linking in with HEIs and piggybacking on other local activities.
- Develop a CFS induction pack and process.
- Set up small pilots, one per team, to evaluate the potential for shadowing, mentoring and secondment as CPD opportunities.

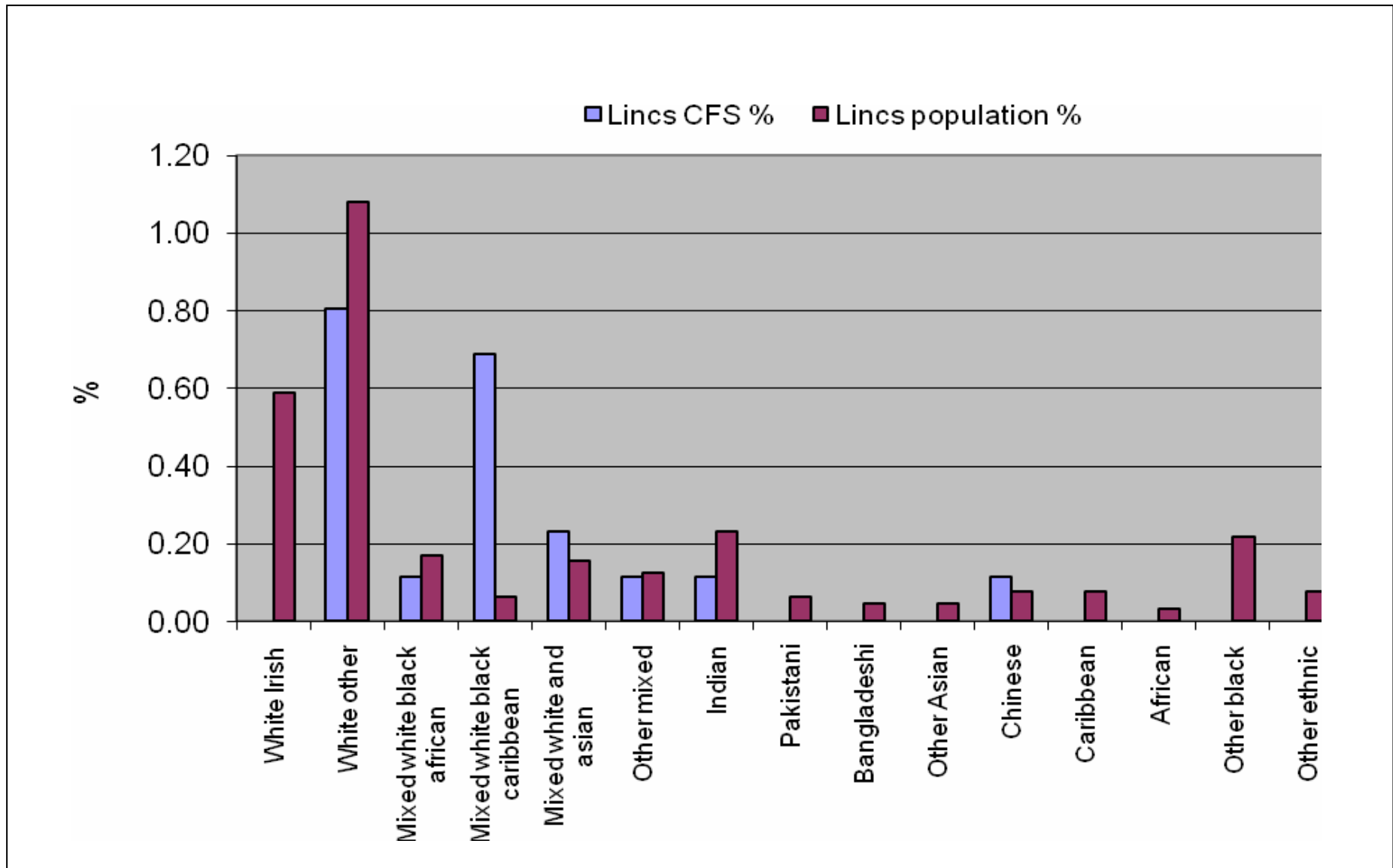
5.2 Goals and milestones

- Achievements will include:
 - Plan for achieving WTE caseload of 40
 - In-house training programme on specific skills/conditions, as identified in staff audit
 - Proposal for flexible working practices
 - Planned series of PR/recruitment events
 - CFS induction pack and process
 - Evaluation of potential for shadowing, mentoring and secondment

5.3 Monitoring and review

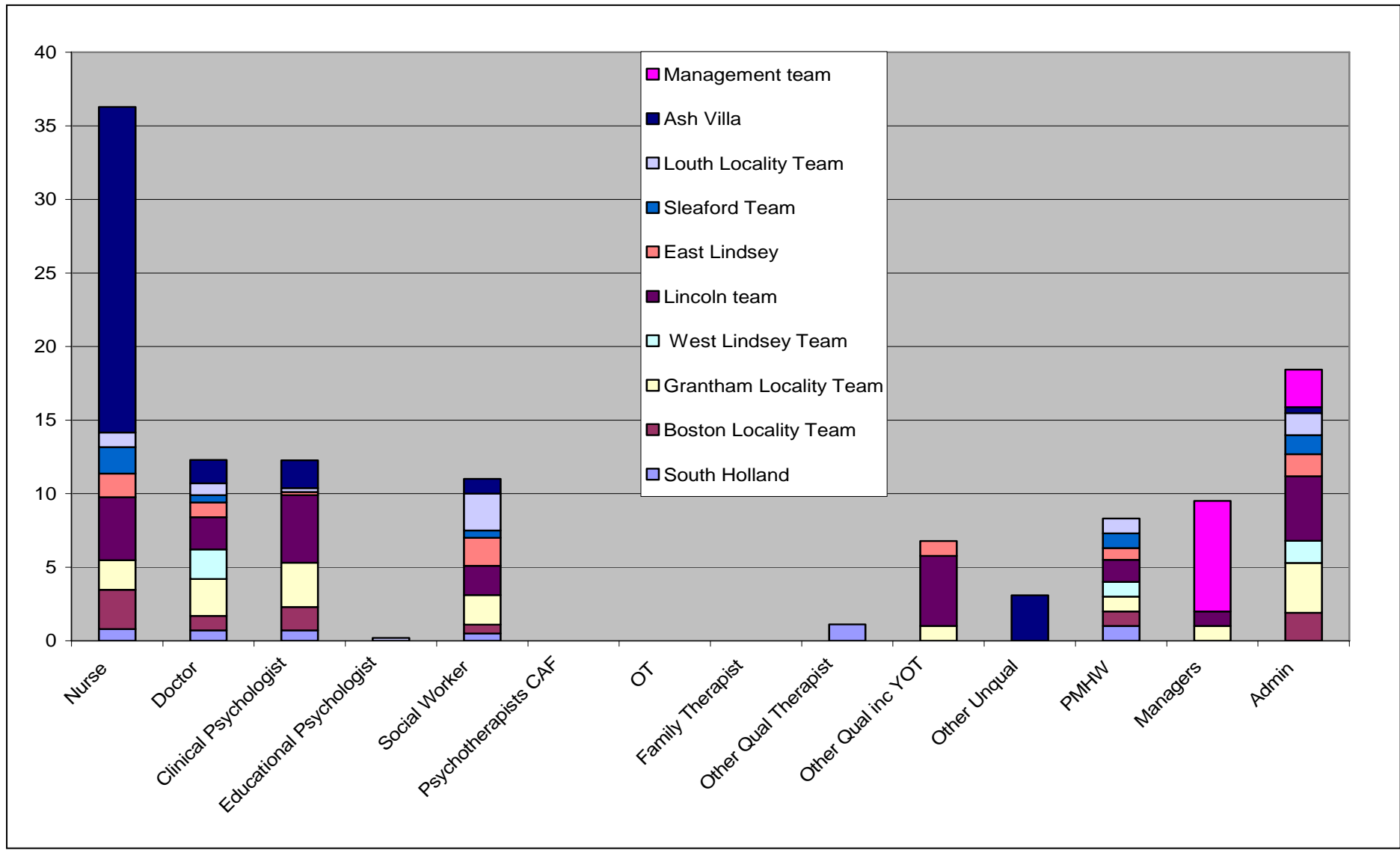
- Three months after starting the action plan the progress meeting will be held
- Six months after starting the action plan the final reports will be presented

²⁰ Choice and Partnership Approach
<http://www.camhsnetwork.co.uk/Childlayer1pages/thestorysofar.htm>



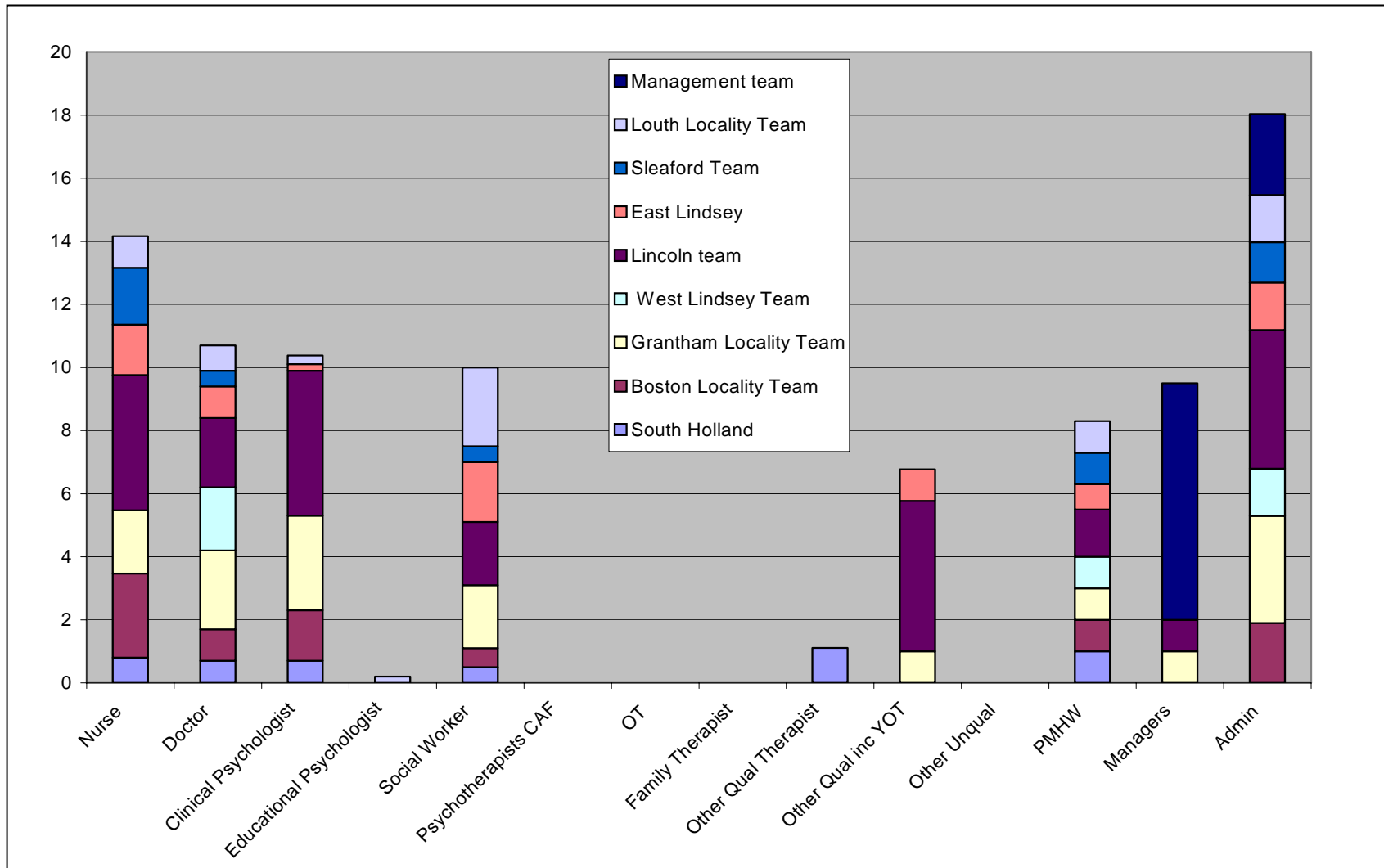
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LPT CFS workforce plan

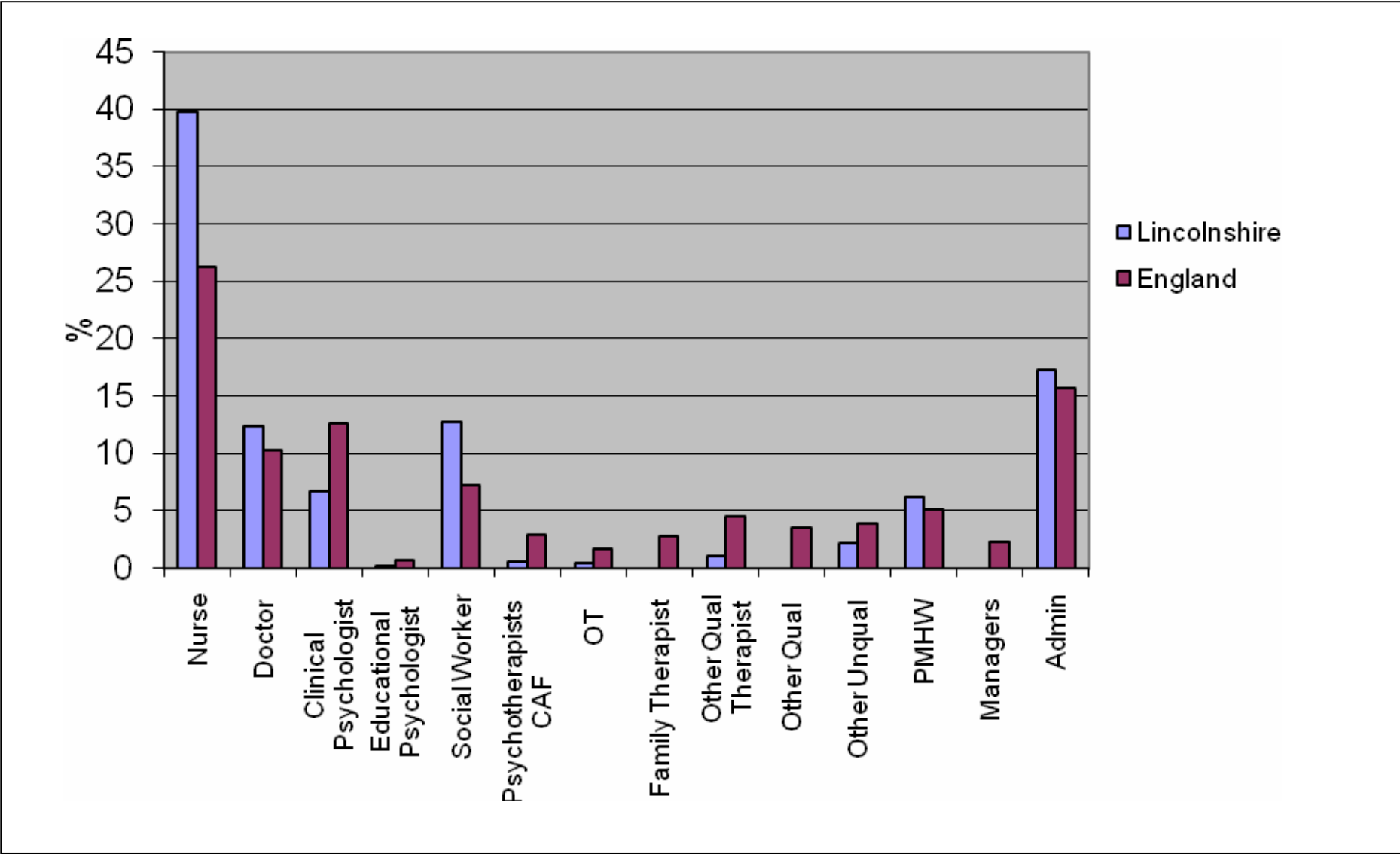


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LPT CFS workforce plan

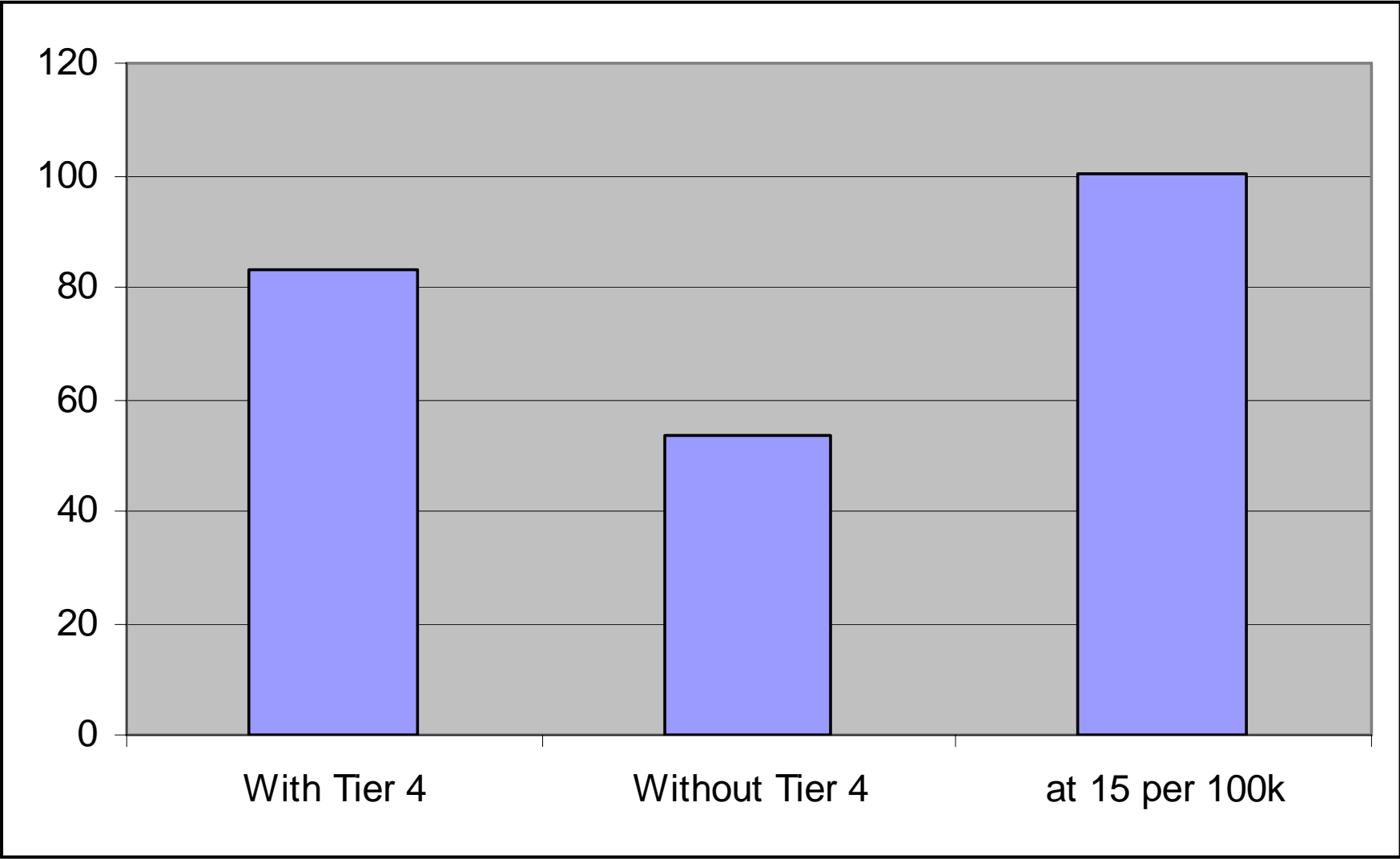


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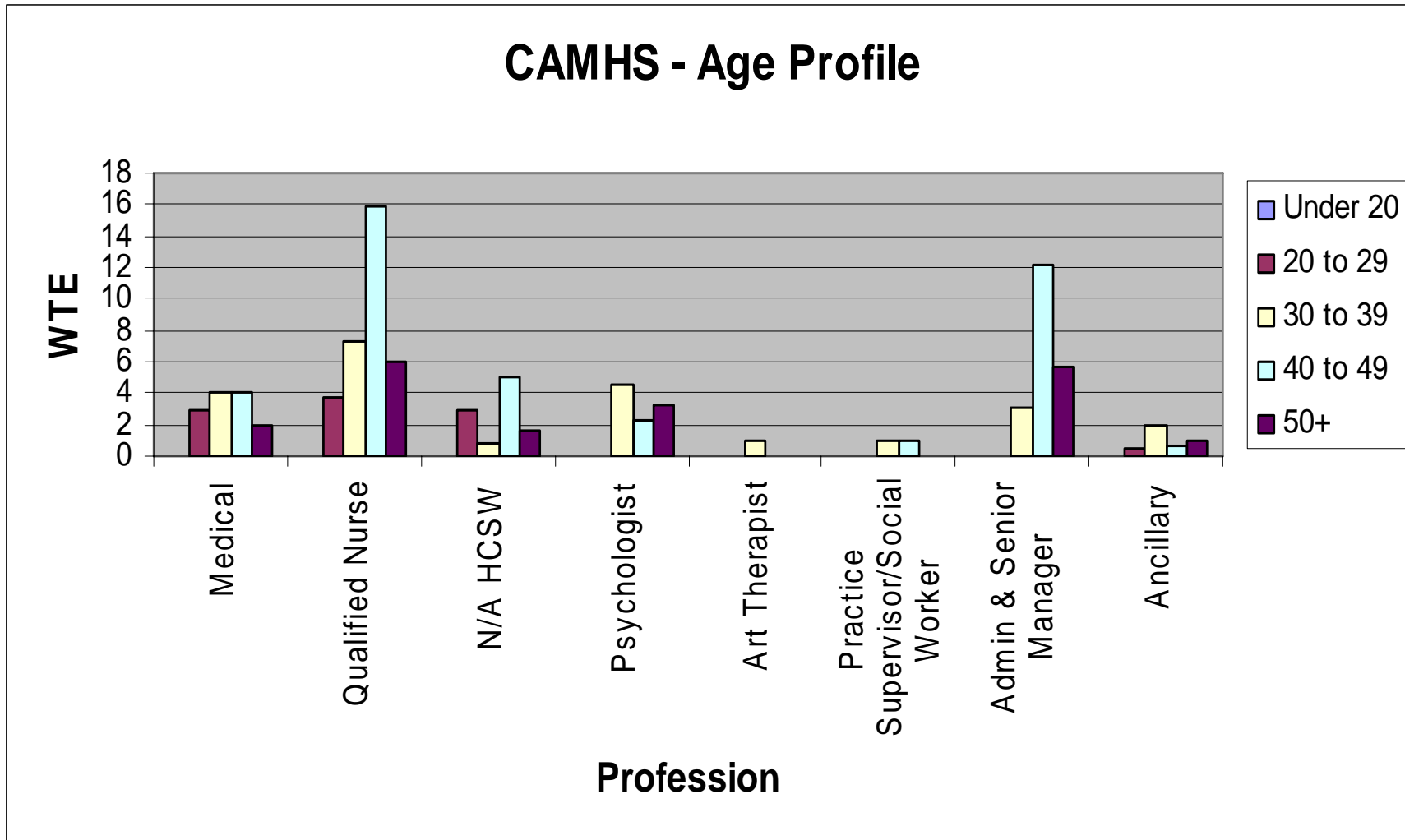


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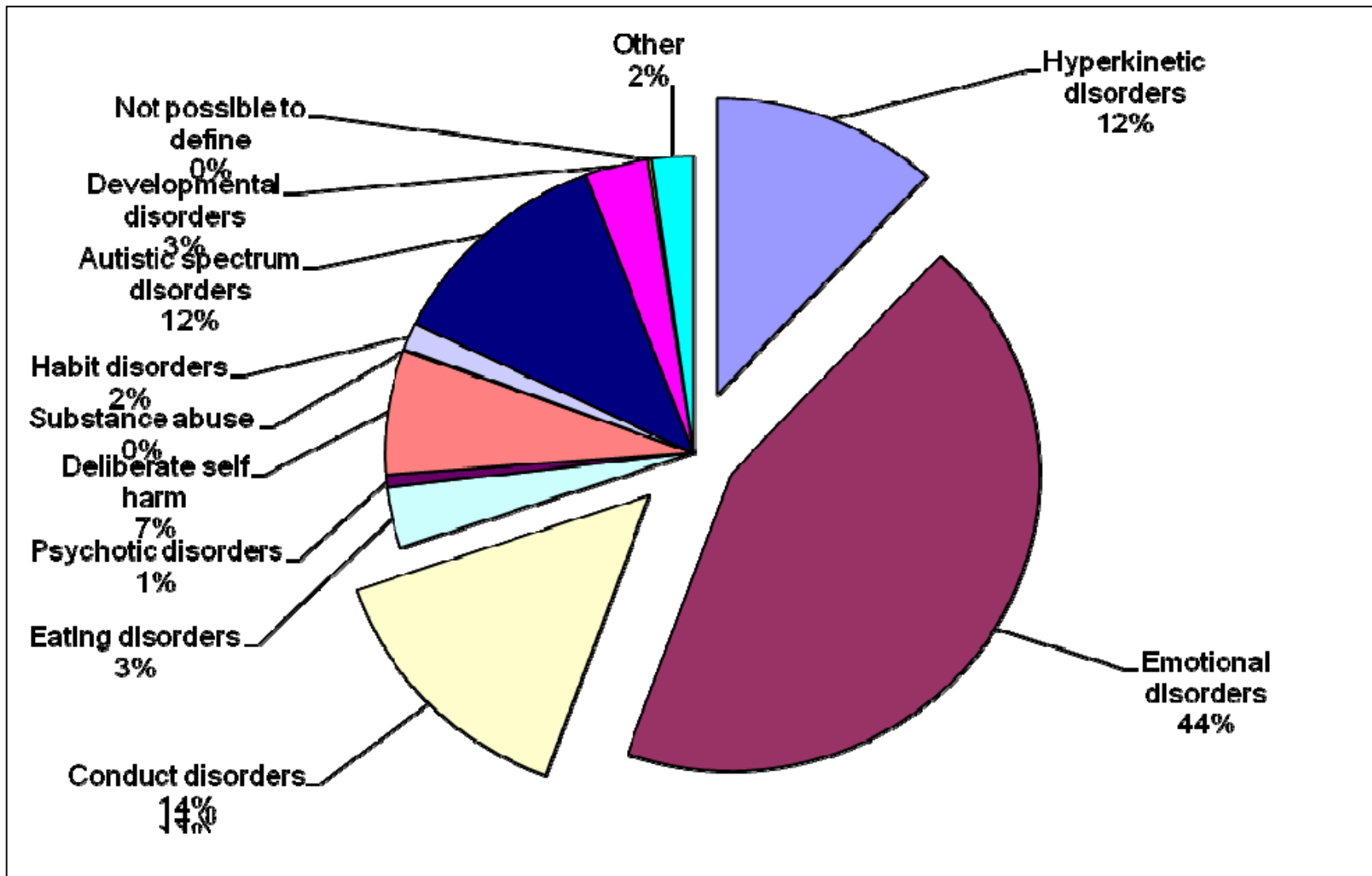
LPT CFS workforce plan



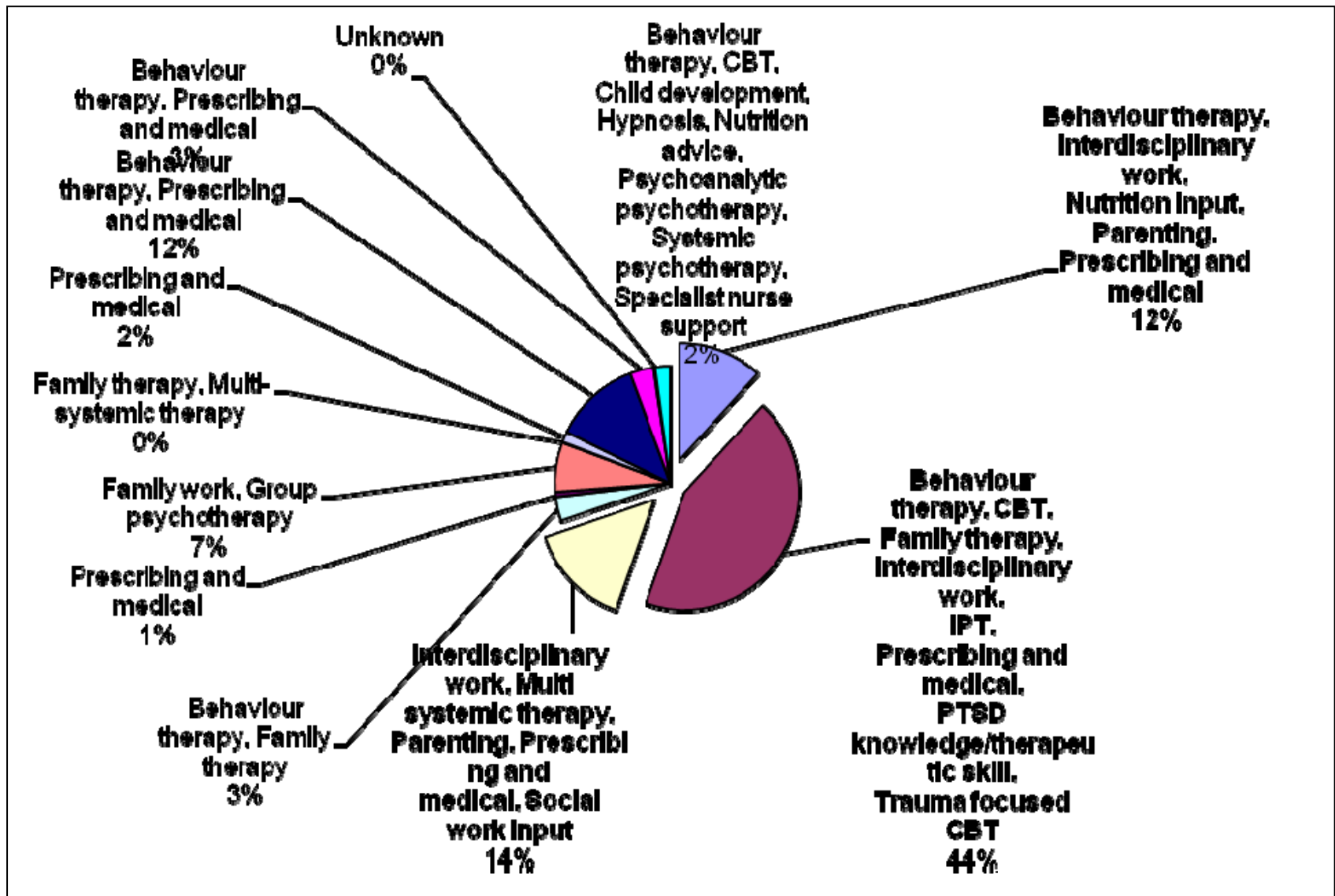
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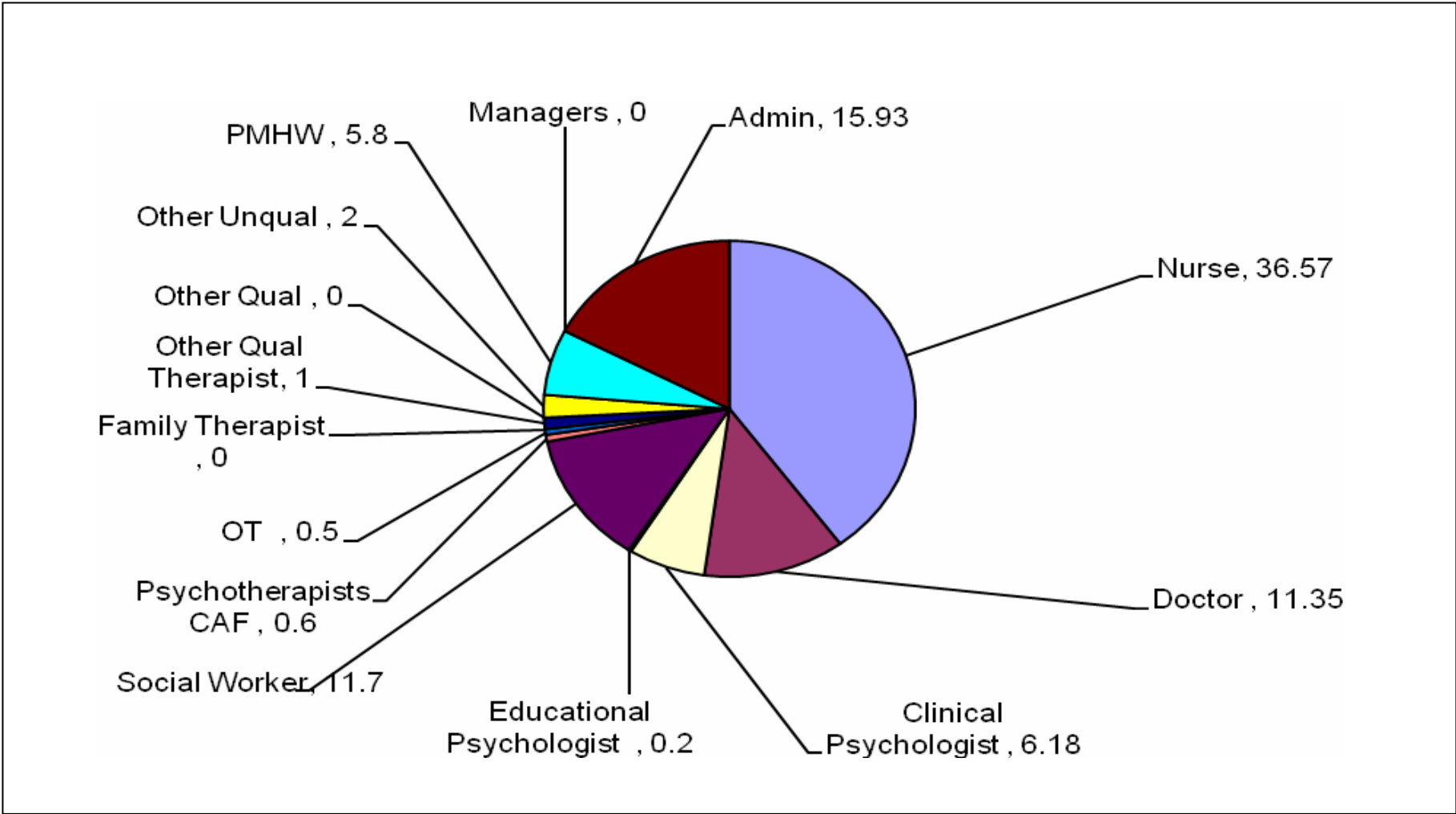
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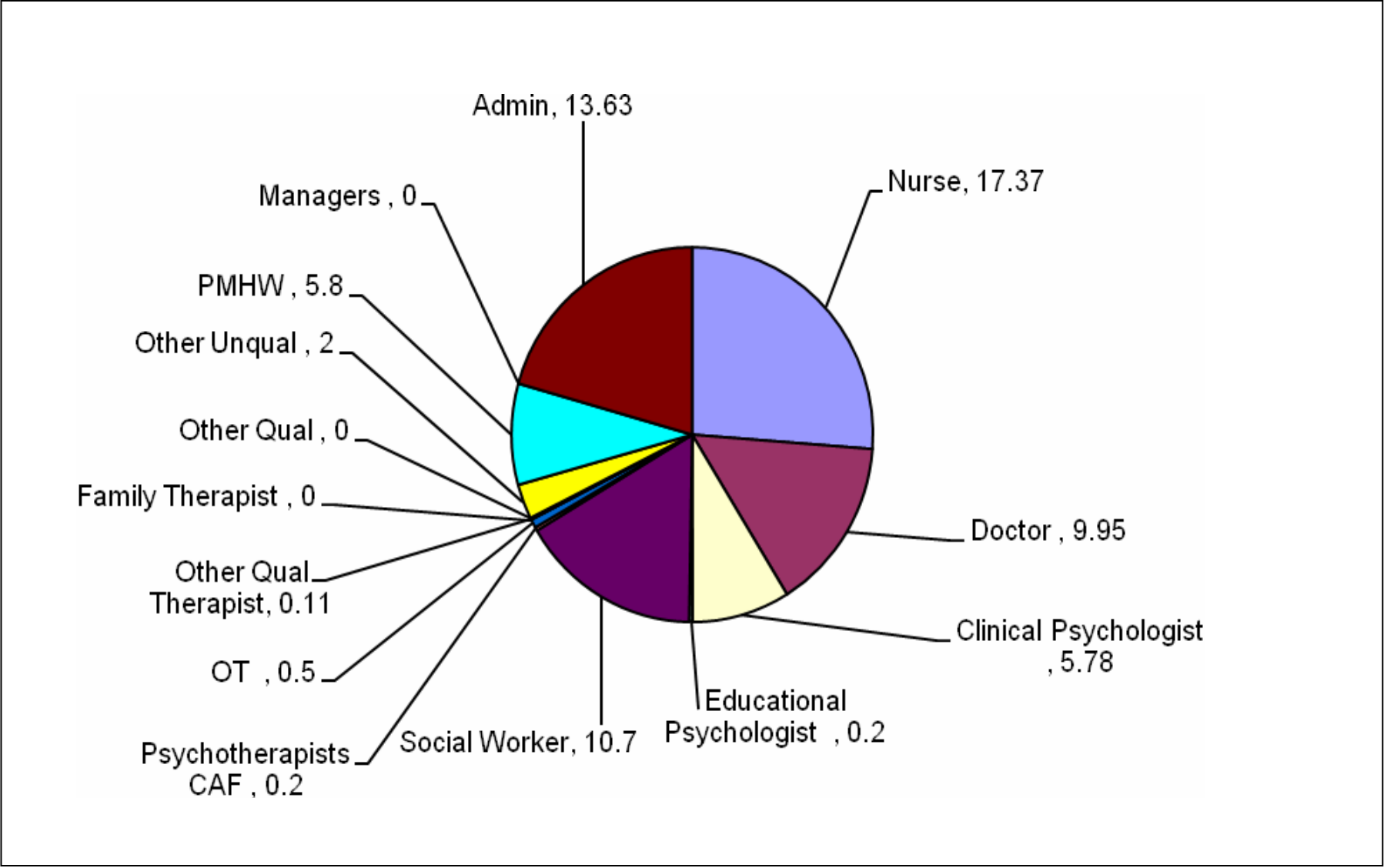


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LPT CFS workforce plan



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APPENDIX 1

WORKFORCE PLANNING GROUP

Appendix 1 Workforce planning group

Caroline Sanders	Social worker, LPT	caroline.sanders@lincolnshire.gov.uk
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APPENDIX 2

ETHNICITY

Appendix 2 Ethnicity

Service	White British	White Irish	White other	Mixed white black african	Mixed white black caribbean	Mixed white and asian	Other mixed	Indian	Pakistani	Bangladeshi	Other Asian	Chinese	Caribbean	African	Other black	Other ethnic	Total
Ash Villa Boston Locality Team	12	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	13
Grantham Locality Team	101	0	2	1	0	0	1	0	0	0	0	0	0	0	0	0	105
Lincoln and West Lindsey Team	194	0	0	0	1	2	0	1	0	0	0	0	0	0	0	0	198
Lincolnshire Secure Unit Louth Locality Team	258	0	2	0	3	0	0	0	0	0	0	0	0	0	0	0	263
Nurse Specialists in YOS Spalding Locality Team	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
Specialist Workers for LAC in Foster Care	157	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	159
Total	47	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47
	43	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	46
	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25
	852	0	7	1	6	2	1	1	0	0	0	1	0	0	0	0	871
	627.9	3.8	7.0	1.1	0.4	1.0	0.8	1.5	0.4	0.3	0.3	0.5	0.5	0.2	1.4	0.5	
	627900	3800	7000	1100	400	1000	800	1500	400	300	300	500	500	200	1400	500	647600
Lincs CFS %	97.82	0.00	0.80	0.11	0.69	0.23	0.11	0.11	0.00	0.00	0.00	0.11	0.00	0.00	0.00	0.00	100.00
Lincs populatio	96.96	0.59	1.08	0.17	0.06	0.15	0.12	0.23	0.06	0.05	0.05	0.08	0.08	0.03	0.22	0.08	100.00

Sources: <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14238>
and 2006 National CAMHS mapping returns

APPENDIX 3

STAFFING

CAMHS staffing numbers - establishment	Grantham and Lincolnshire Localities										% each discipline		% each discipline	total ex tier4
	Ash Villa	Boston Localit y Team	Grantham Localit y Team	Lincoln and West Lindsey	Lincolnshire Secure Unit	Louth Localit y Team	Nurse Specialists in	Spalding Localit y	Specialist Workers for	Lincolnshire Total	England total	Lincolnshire		
Nurse	19.2	2.67	2	5.9	0	1	3	0.8	2	36.57	2599.5	39.82	26.32	17.37
Doctor	1.4	1	2	5.4	0.05	0.8	0	0.7	0	11.35	1018.8	12.36	10.32	9.95
Clinical Psychologist	0.4	1.4	3	0.3	0.8	0.28	0	0	0	6.18	1252.6	6.73	12.68	5.78
Educational Psychologist	0	0	0	0	0	0.2	0	0	0	0.2	67	0.22	0.68	0.2
Social Worker	1	1.6	2.5	3.6	0	2.5	0	0.5	0	11.7	722.07	12.74	7.31	10.7
Psychotherapists														
CAF	0.4	0.2	0	0	0	0	0	0	0	0.6	288.99	0.65	2.93	0.2
OT	0	0	0	0	0.5	0	0	0	0	0.5	175.51	0.54	1.78	0.5
Family Therapist	0	0	0	0	0	0	0	0	0	0	274.38	0.00	2.78	0
Other Qual Therapist	0.89	0	0	0	0	0	0	0.11	0	1	446.74	1.09	4.52	0.11
Other Qual	0	0	0	0	0	0	0	0	0	0	351.52	0.00	3.56	0
Other Unqual	0	0	0	2	0	0	0	0	0	2	393.78	2.18	3.99	2
PMHW	0	0.8	1	2	0	1	0	1	0	5.8	505.77	6.32	5.12	5.8
Managers	0	0	0	0	0	0	0	0	0	0	227.33	0.00	2.30	0
Admin	2.3	1.9	1.53	6.31	0.49	1.5	0	0.9	1	15.93	1551.7	17.35	15.71	13.63
Total	25.59	9.57	12.03	25.51	1.84	7.28	3	4.01	3	91.83	9875.7	100.00	100.00	66.24

lincs est clin wte
With Tier 4 82.99
Without Tier 4 53.68
at 15 per 100k 100.5

CFS staffing numbers - in post sept 2007	South Holland	Boston Locality Team	Grantha m Locality Team	West Lindsey Team	Lincoln team	East Lindsey	Sleaford Team	Louth Locality Team	Ash Villa	Management team	Lincolnshire Total	England total	% each discipline Lincoln	% each discipline England
Nurse	0.8	2.67	2	0	4.29	1.6	1.8	1	22.12	0	36.28	2599.51	30.42	26.32
Doctor	0.7	1	2.5	2	2.2	1	0.5	0.8	1.6	0	12.3	1018.80	10.31	10.32
Clinical Psychologist	0.7	1.6	3	0	4.6	0.2	0	0.28	1.89	0	12.27	1252.63	10.29	12.68
Educational Psychologist		0	0	0	0	0	0	0.2	0	0	0.2	67.00	0.17	0.68
Social Worker	0.5	0.6	2	0	2	1.9	0.5	2.5	1	0	11	722.07	9.22	7.31
Psychotherapists														
CAF	0	0	0	0	0	0	0	0	0	0	0	288.99	0.00	2.93
OT	0	0	0	0	0	0	0	0	0	0	0	175.51	0.00	1.78
Family Therapist	0	0	0	0	0	0	0	0	0	0	0	274.38	0.00	2.78
Other Qual Therapist	1.11	0	0	0	0	0	0	0	0	0	1.11	446.74	0.93	4.52
Other Qual inc YOT	0	0	1	0	4.77	1	0	0	0	0	6.77	351.52	5.68	3.56
Other Unqual	0	0	0	0	0	0	0	0	3.09	0	3.09	393.78	2.59	3.99
PMHW	1	1	1	1	1.5	0.8	1	1	0	0	8.3	505.77	6.96	5.12
Managers	0	0	1	0	1	0	0	0	0	7.5	9.5	227.33	7.97	2.30
Admin	0	1.9	3.39	1.5	4.4	1.5	1.28	1.5	0.4	2.56	18.43	1551.66	15.45	15.71
Total	4.81	8.77	15.89	4.5	24.76	8	5.08	7.28	30.1	10.06	119.3	9875.69	100.00	100.00

APPENDIX 4

CASE AND SKILL MIX

Appendix 4 case mix and indicative skill mix

Primary presenting problem	Ash Villa	Boston Locality Team	Lincoln			Louth Localities Team	Nurse Specialists in YOS	Spalding Localities Team	Specialist Worker for LAC in Foster Care	Total	Skills
			Grantham Localities Team	West Lindsey Team	Lincolnshire Secure Unit						
Hyperkinetic disorders											Behaviour therapy, Interdisciplinary work, Nutrition input, Parenting, Prescribing and medical
Emotional disorders	0	48	25	32	0	14	0	2	0	121	Behaviour therapy, CBT, Family therapy, Interdisciplinary work, IPT, Prescribing and medical, PTSD knowledge/therapeutic skill, Trauma focused CBT
Conduct disorders	1	91	67	109	0	87	40	23	27	445	Interdisciplinary work, Multi systemic therapy, Parenting, Prescribing and medical, Social work input
Eating disorders	2	40	43	24	15	12	0	11	0	147	Behaviour therapy, Family therapy
Psychotic disorders	1	1	10	12	0	8	0	2	0	34	Prescribing and medical
Deliberate self harm	1	1	0	1	0	0	3	1	0	7	Family work, Group psychotherapy
Substance abuse	8	18	11	18	0	12	2	0	0	69	Family therapy, Multi-systemic therapy
Habit disorders	0	1	0	0	0	0	0	0	0	1	
Autistic spectrum disorders	0	7	6	1	0	1	0	0	0	15	Prescribing and medical
Developmental disorders	0	2	13	85	0	19	2	3	0	124	Behaviour therapy, Prescribing and medical
Not possible to define	0	3	16	14	0	1	0	0	0	34	
Other	0	0	0	1	0	0	0	1	0	2	Unknown
											Behaviour therapy, CBT, Child development, Hypnosis, Nutrition advice, Psychoanalytic psychotherapy, Systemic psychotherapy, Specialist nurse support
TOTAL	0	0	7	2	0	0	0	13	0	22	
	13	212	198	299	15	154	47	56	27	1021	

APPENDIX 5
SKILLS AUDIT

Team strengths and possible risks - "Interventions" questionnaire

	Boston	Grantham	Lincoln& WLindsey	Louth	Spalding/ Holbeach		
Advice giving							
Attachment Therapy							
CBT							
Consultation							
Counselling							
Data collection							
Data input							
Dealing with aggression							
Dealing with professional enquiries							
Dealing with public enquiries							
Diagnosing							
Dialectic Behaviour Therapy							
DISCO							
EMDR							
Family Therapy							
Family Work							
Group work							
Medication monitoring							
Medication prescribing							
Parent Training							
Psychometric testing							
Psychotherapy							
Solution Focussed							
Training-non professionals							
-Specialist professionals							
-Targetted professionals							
-Universal professionals							

APPENDIX 6

REVIEW OF ADMIN SUPPORT

**Child & Adolescent Mental Health Service (CAMHS)
Admin Review 2006 – 2007**

**Report by
Chris Mardon
CAMHS Business Support & Project Team Manager**

CAMHS Admin Review

Contents	
Introduction	3
Process	3
Overview of findings	4
External factors	4
Gaps – where we are and where we want to be	4
Actions to close the gaps	4/5
Benefits to Service Users	5
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Financial Implications	8
Monitor & Evaluate	8
Summary	9
Conclusion	9
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Introduction

In order to ensure clarity, transparency, accountability, co-ordination and best use of resources, including staff capacity, we are introducing a CAMHS wide approach to initiating and managing all significant staff work-streams and any service changes or developments. This will be applicable to all initiatives, divisional and local team work-streams. This process will ensure that all significant pieces of work support the Child & Family Services (C&FS) principle objectives and reflect the values and principles of the Trust.

With this in mind we initiated a divisional CAMHS administrative (admin) review to be led by Karen Austin, Assistant Director, Workforce Design and Diversity and supported by Chris Mardon, CAMHS Business Support and Project Team Manager.

This paper provides guidance regarding the capacity and provision of admin support within CAMHS, a summary and recommendations. We intend this to be an evolving process to support service development and Trust productivity priorities.

There are 7 community teams, 4 specialist teams (YOS, PMHW, LAC, and Forensic) and an in-patient team supported by 15.68 WTE admin. We acknowledge there are inequities with the admin support across the teams and intend this document to support the re-design of services.

Process

In order to establish the current and future admin needs we carried out individual written and telephone questionnaires with all CAMHS admin and clinical staff*¹ to find out what the key issues are from the point of view of both the administrative staff and clinicians and a group discussion/focus group with the admin team at an away day.

*¹ Excludes staff off on long term sick

An overview of findings and key issues were:

- Workload issues and staff cover (inc leave and reception)
- Lack of shared understanding of admin role and cultural issues in the teams e.g. duplication of effort and 'helping admin team out...'
- Different processes, paperwork and systems in all the teams.
- IT systems – lack of interface between systems and systems designed for acute or adult services that are not compatible but adapted for CAMHS needs.
- Psychological therapies staff although part of the teams having different systems, processes and admin staff.
- Lack of suitable estates that does not allow some clinicians to be based with admin staff or within their designated patch.
- Lack of IT connectivity in some bases due to server issues in some areas of county.

External factors that influence our processes are:

- Other children's services processes such as the CAF, Choose & Book, Social Care and Youth Offending Service more especially the lack of suitable information systems and the need for duplication of input to provide data.
- Department of Health or SHA requirements being different from our own internal needs i.e. lack of clarity with targets and reporting requirements.
- Funding from non-recurrent pots causing problems for long term plans for resources.
- Reliance on external agencies to support our systems. i.e. telephone systems, Shared Services for IT and estates.

The gaps between where we are now and where we want to be:

- Section 75, integration of social care staff and full integration of records and information systems.
- Joint admin and IT processes within all teams to include psychological therapies to be representative of child & family services.
- Staff based within their locality in suitable fit for purpose buildings.
- Admin establishment reflective of team needs.
- Admin staff working as team secretaries in order to provide comprehensive cover for the teams with the correct skill sets for identified roles.
- Introduction of Choice and Partnership (CAPA)
- Introduction of Outcomes Measures (CAMHS Outcomes Research Consortium - CORC)
- Introduction of performance monitoring within teams.

Actions needed to close the gaps.

There are some workforce shortages in the admin team that are causing some specific problems. Therefore, we will be doing the following:

- Recruiting to specific vacancies in a limited fashion to make sure that workload problems are kept to a minimum that is fixed term cover for maternity cover, bank cover or use of current part time staff until new teams are agreed and moves to new premises are agreed.
- Discuss with teams at their team meetings as to how best to move forward, in an attempt to get a shared agreement as to the admin requirement.
- Member of management team to attend team meetings to feedback any issues highlighted by the teams in order to assist them in a proactive and timely manner.
- Provide ongoing training and support for the various IT systems.

Other areas we can address in the short term are:

- Agreeing new processes to ensure the minimum duplication of work and provide training to ensure consistency of application.
- Integration of the social care staff by completion of the S75 agreement.
- Support the move to new team premises.
- Admin representation at the McKesson system User Group.

Areas we need to address in the longer term are:

- Identified workload issues – e.g. reception cover, which are specific to Moore House and will be resolved by a move to new premises
- IT issues – which are to do with connectivity not access to equipment, will be addressed via the move to more suitable premises in some incidences and by the Trust IT Strategy.
- Monitoring the admin workload and other changes as a result of CAPA and CORC – Gill Walker, CAPA lead and CSIP support has approached other Trusts who use this approach to establish the possible increase in workload for admin staff and what new tasks need to be carried out as a result of CAPA and what tasks are reduced.
- To request all staff complete the EKSF staff profile on line as required by the Trust and use the results for the framework of a skills audit to identify skills, capacity and training needs, as opposed to developing yet another questionnaire for the staff to complete.
- As there is a full workforce plan being developed for C&FS with support from HASCAS, it is not realistic to make too many changes to the admin workforce as this may change again as part of the wider workforce review.
- The C&FS Workforce Board has therefore decided to carry out the CAMHS admin review over a longer time-scale to make sure that all of these issues are addressed.
- C&FS Service developments: egg CORC, performance monitoring.

Benefits to the service users by implementing the above changes will be:

- One access point for the service with an integrated workforce.
- Faster access to the treatment.
- More choice of where and when they are seen.
- Build on and recognise good practice in order to develop appropriate skills.
- Systems remain the same should the young person move around the county.
- More appropriate fit for purpose surroundings that fit with children's needs as close to home as possible and that reflect population needs.

Not implementing these measures will lead to:

- Lack of clarity for referrers for access to the service.
- Lack of clarity with services users, where and who to contact for information.
- A risk to patient records with different clinical groups holding files and duplication of records that could lead to inaccuracies.
- Waiting times would remain high.
- Teams not equitably or appropriately resourced with right skill sets.
- Unable to measure clinical outcomes in a meaningful way.
- Unable to support service development in a timely and appropriate way.
- Possible loss of business.

Resources are largely linked to the Trust I.T. and Estates Strategies.

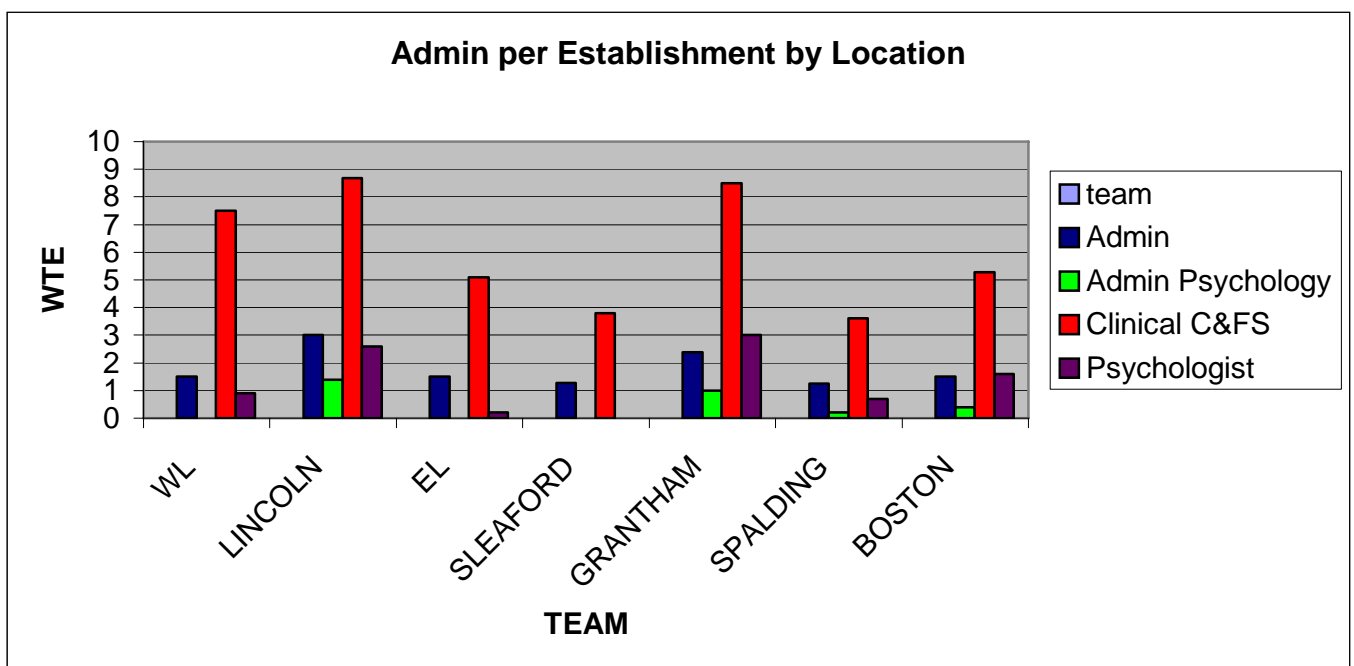
- I.T. systems and issues – which are in 3 teams to do with connectivity not access to equipment, will be addressed via the move to more suitable premises in some incidences and by the Trust IT Strategy for Npfit.
- Other staff are based in non NHS buildings which although meets Every Child Matters (ECM) objectives for joint working does not allow for connectivity to Trust Internet systems and thus McKesson the patient information system and thus easy access to admin support.
- Estates issues will be supported by the Trust Estates Strategy and the current planned new premises programmes coming on-line. This will also address the staff that are currently isolated in non NHS buildings to have access to admin and systems support.

To ensure there is a sufficiently skilled admin workforce administrative posts will continue to be reviewed for skills and redefined according to identified need, via natural wastage, PDP's and service developments. Access to relevant training and secondment opportunities will be required.

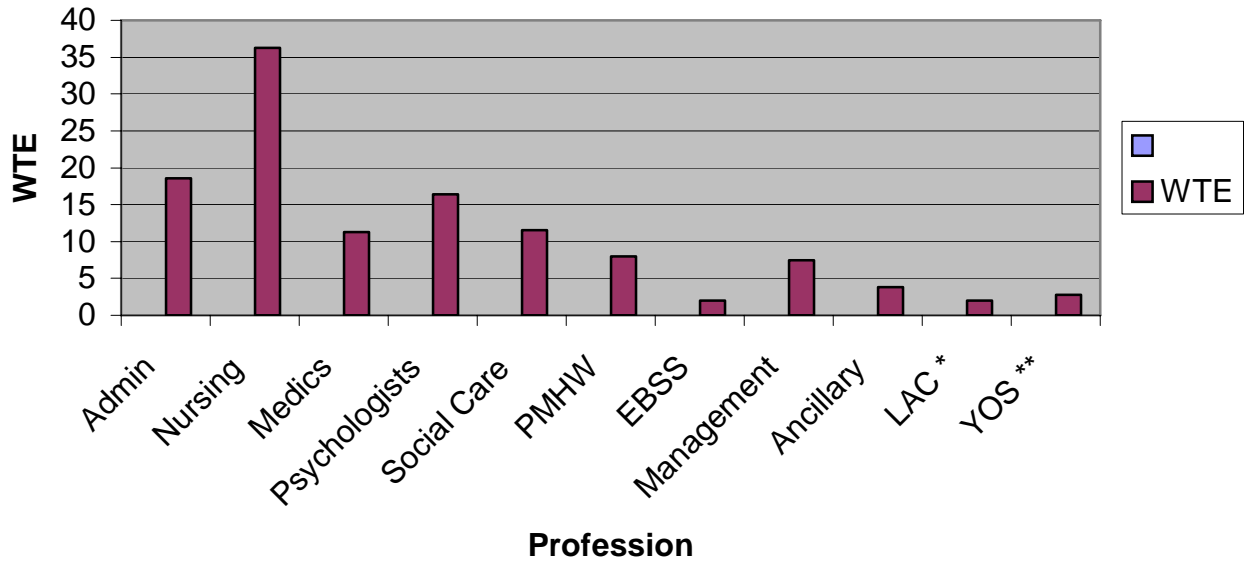
Unlike qualified practitioners where the NSF recommends 15 WTE per 100,000 there are no nationally recognised documents with recommended admin establishment requirements. Although a document by Raphael Kelvin suggests 8.00 WTE per 100,000 population this is not supported within the CAMHS Mapping process, however, should this be applied to child population (153,480) this would be more in line.

Similar services in the National Child Health Service Mapping Exercise 2006/07 indicate percentage of admin to WTE as:

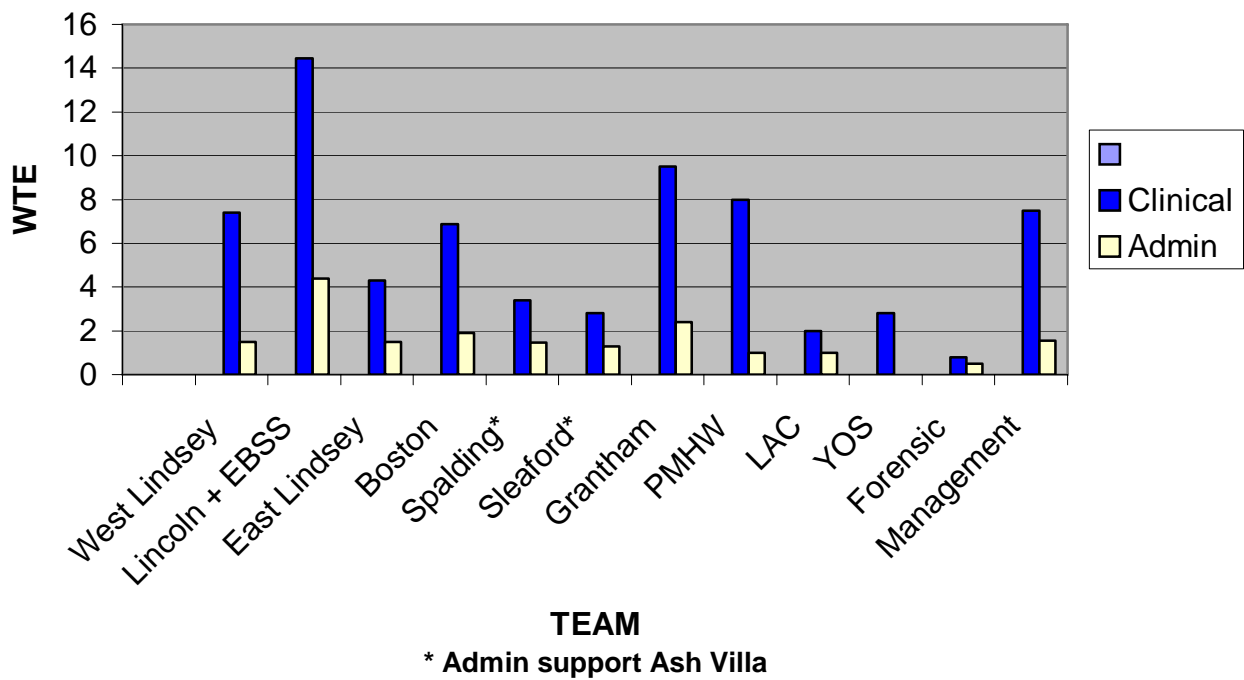
South Essex Partnership Trust	-	18.9%
North Essex Mental Health Partnership Trust	-	15.48%
Susses Partnership Trust	-	18.60%
LPT CAMHS	-	19.46%
LPT C&FS	-	17.08%



Child & Family Services Establishment



Child & Family Service Admin by Team



Implementation

Task	Implementation Date	Status
Recruiting to specific vacancies in a limited fashion to allow for role re-design	Immediate	Implemented & ongoing
Discuss with teams at their team meetings	June 07	Implemented & progressing
Member of management team to attend team meetings to feedback issues highlighted	June 07	Implemented & ongoing
Provide ongoing training and support for the various IT systems	Immediate / induction /	Implemented & ongoing
Agreeing new processes to ensure the minimum duplication of work and provide training to ensure consistency of application.	June to October 07	Rollout commenced
Integration of the social care staff by completion of the S75 agreement	October 07	Off target
Support the move to new team premises: West Lindsey Team Lincoln Team Boston Team Spalding	December 07 Not agreed Not agreed Jan 2009	On target On target
Admin representation at the McKesson system User Group	Jan 2007	Ongoing
Monitor and evaluate via Performance Assessment Reports and supervision.	October 07	Ongoing
To complete KSF profiles	At PDP's	Evolving
To redefine roles to support service developments	Jun 07	Ongoing

Financial Implications

In the short term the service we provide initially needs to be self funding through service re-design and skill mix. In the longer term we need to monitor and evaluate this process to support investment in new service requirements.

Monitor and Evaluate

New processes will be monitored by monthly performance reports to the C&FS Performance Review Group, feedback of external agencies, supervision and Clinical team meetings in line with National, Regional and local targets.

Summary

Karen leaving the Trust has impeded compilation of this report and a consequence lack of access to the information already collected, several management changes with C&FS and the commencement of an overall workforce plan for C&FS have also had an impact.

Despite the delays we have already instigated some changes and achieved some positive actions that is the re-evaluation of vacant posts to meet the needs of the changing processes within teams. This has benefited the teams in providing a wider skill mix within the team, more admin hours available to the teams ensuring more cover when for telephones and reception. Implementation of new processes to ensure consistency of application and cross cover in times of sickness absence or maternity leave.

We need to acknowledge the support and hard work by the admin staff over the past few years of management and system changes and thank them for their contribution to this process that has taken longer than intended. Whilst also acknowledging the achievements in taking on board 4 new I.T. systems during this period.

This is a time of considerable change within C&FS and LPT, Foundation Trust status. PCT changes and Government initiatives are all striving to provide more effective and flexible services to include the input of service users. Within these changes staff need to feel valued and supported while being committed to providing continuous service improvements.

This review is the first step in an evolving process for the admin support for C&FS, psychology admin staff are not included within the review as they are managed directly within psychology however, when a PSA (Professional Service Agreement) is agreed we will need to undertake a further service wide review of admin provision in line with C&FS and the Trust's workforce strategy.

The review will inform the Workforce Plan for Children and Family Services in Lincolnshire currently in progress with Yvonne Anderson from HASCAS with NCSS and the Trust's Productivity Project, phase one of which will be a review of all relevant initiatives that have been undertaken in the area of service.

Conclusion

In order to deliver a high quality support service we need to have the right workforce in the right numbers and with the right skills and that as far as possible reflects the needs of the population they serve.

Child & family Services will function more effectively as part of an integrated single access point with consistent processes throughout.

The admin staff need to be responsive to the changes in service provision and embrace the systems required to do this.

Recommendations

To have all staff using the same processes and systems to provide consistency in service provision.

To provide cover or support for other admin teams in times of absence and where we have difficulty in providing bank cover using consistent systems will assist this process.

To have senior admin roles supervising junior roles thereby developing staff to support succession planning and we should continue to support staff to undertake NVQ's, ECDL and other appropriate relevant training.

To undertake a complete review of C&FS admin requirements in 2008 when the PSA, S75, new processes and new teams are established. The review should incorporate a complete role evaluation and design to ensure the right skills and competencies are available and to provide equity of admin support to all teams. This will require support to staff through role re-design and change and training.

To feed into the C&FS Workforce Plan and the Trust Productivity Strategy.

To include the admin staff in developing new admin processes and systems via workgroups, admin days and attending user groups.

A member of the management team to attend team meetings and to feed back to Core Management Team of any developments or admin issues that may arise.

¹ Based on 'Capacity of Tier 2/3 CAMHS & Service Specification: A Model to Enable Evidence Based Service Development' by Raphael Kelvin 2005

List of Abbreviations

CAMHS	Child and Adolescent Mental Health Services
C&FS	Child & Family Services
CAF	Common Assessment Framework
CAPA	Choice & Partnership Approach
CORC	CAMHS Outcome Research Consortium
CSIP	Care Service Improvement Partnership
ECDL	European Computer Driving Licence
ECM	Every Child Matters
EKSF	Electronic Knowledge & Skills Framework
HASCAS	Health & Social Care Advisory Service
IT	Information Technology
LAC	Looked After Children
LPT	Lincolnshire Partnership Trust
NSF	National Service Framework
NVQ	National Vocational Qualification
PCT	Primary Care Trust
PDP	Personal Develop Plan
PMHW	Primary Mental Health Worker
PSA	Professional Services Agreement
SHA	Strategic Health Authority
WTE	Whole Time Establishment
YOS	Youth Offending Service