CAMHS Joint Workforce Plan for Bury, Oldham, Heywood, Middleton & Rochdale, Stockport and Tameside & Glossop

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Executive summary

The five boroughs that make up Pennine CAMHS form the eastern side of Greater Manchester. The specialist CAMHS is provided by Pennine Care NHS Trust. The populations are ethnically diverse and contain areas of affluence as well as pockets of extreme deprivation.
Proposed action: Review the deployment of staff to ensure adequate coverage of deprived areas.

The Pennine CAMHS workforce is approximately 25% short on the recommended level within the National Service Framework for Children, Young People and Maternity Services. The disciplinary mix shows that numbers of doctors and nurses are slightly lower than the national average, whilst numbers of social workers are significantly higher. Social workers have been shown to offer particularly good value for money.
Proposed action: Review disciplinary mix.

The ethnic mix of the caseload across Pennine CAMHS shows some discrepancies when compared with the ethnic groups represented in the local populations.
Proposed action: Expand on the work begun by the cross-Pennine project "Cottoning on to CAMHS", developing the pool of potential CAMHS trainees.

Across the Pennine footprint the working population has a young profile. The working age population has grown, at least as much as the national average and in some cases more. All five boroughs have numbers of people working part time at below, in some cases notably so, the regional and national averages.
Proposed action: In areas where recruitment is more challenging and where new roles are created, investigate the potential for creating more flexible working.

The case mix across the patch, when mapped on to evidence of best practice, indicates that a significant proportion of specialist CAMHS workers should be able to offer behavioural therapies, including some CBT, skills in interdisciplinary working and expertise in prescribing and medical monitoring.
Proposed action: Audit the skill mix of the teams and produce an analysis of skills gaps to inform a training plan.

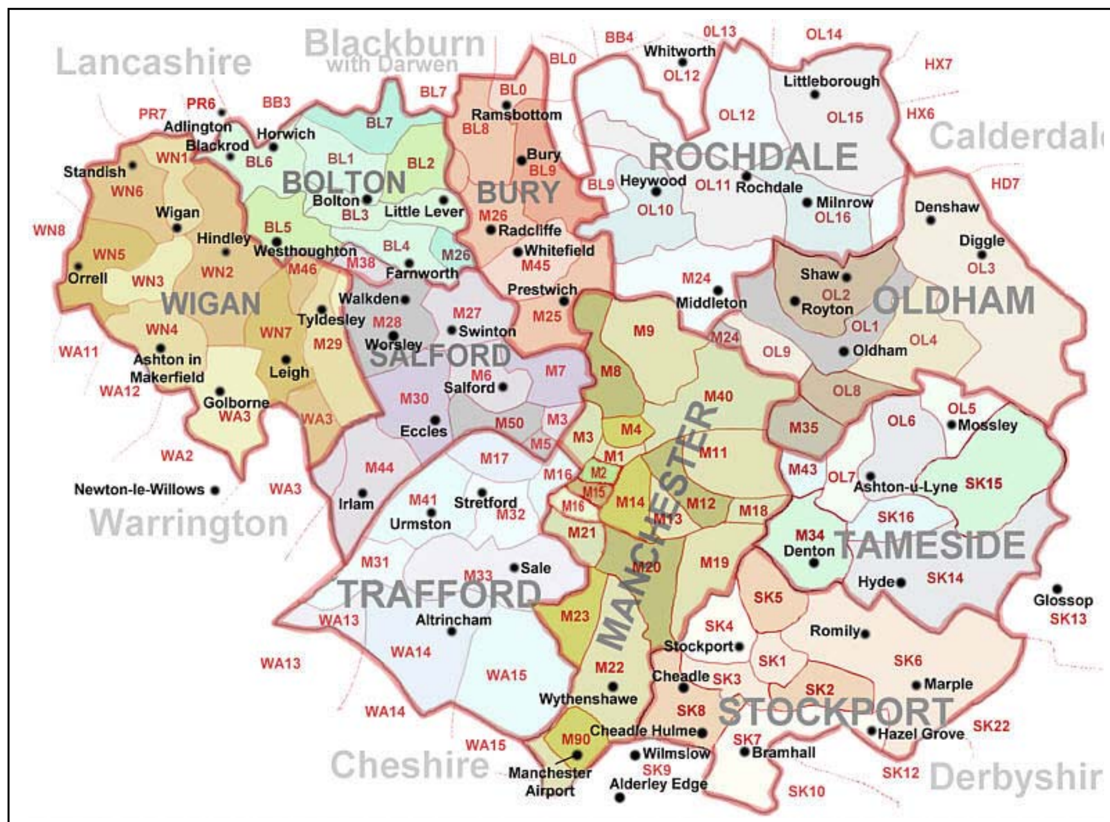
This summary is a very brief overview - there is a wealth of information in the main document, which has informed the decision making process and the implementation plan for 2007-10

PART 1
About this workforce plan

1.1 This workforce plan has been drawn up by the Pennine CAMHS Workforce Team, including providers and commissioners from across the five boroughs. Appendix 1 provides the membership list with contact details.

1.2 The plan covers the period April 2007-2010 for the geographical/ service area covered by the boroughs of Bury, Oldham, Heywood, Middleton & Rochdale, Stockport and Tameside & Glossop. (NB Glossop is in Derbyshire).

Figure 1.Area map of Greater Manchester with postcodes [1]



1.3 Much of the supporting information is presented graphically. It will be necessary to view the graphs in colour. If a colour printed copy is not available, please request an e-version from Chris Scarborough or Yvonne Anderson (email addresses in Appendix 1).

1.4. The following statement is drawn from the strategic aims of each of the five boroughs and provides the context for this document:

[1] http://www.manchester2002-uk.com/maps/postcodes-map.html

The collective vision guiding the CAMHS strategies is underpinned by four key principles, which are that children:

- have the ability to develop psychologically, emotionally, intellectually, culturally and spiritually
- are safe from psychological trauma and abuse
- have their wishes and feelings taken into consideration
- have equal and timely access to appropriate, high quality mental health services.

The vision will be realised by:

- mental health promotion at all levels of service
- early intervention
- consideration of socio-economic and familial factors that impact disproportionately on some young people, with targeted services for those young people.
- inter-agency working with joint protocols and policies
- services provided at appropriate locations and convenient times to suit young people and families
- young people involved and consulted in decision making.

Core specialist services will be offered locally within borough. Additionally some joint provision across the five boroughs would be cost effective, including:

- services to meet needs that are low volume, high severity and complexity
- 24 hour emergency cover, including covering staff leave
- CAMHS training

In summary, children's mental health is everyone's business – all people, all agencies and services in contact with young people have a part to play. The ability of each to contribute effectively depends upon the level of training and support they receive, including that from specialist CAMHS. In turn the ability of CAMH services to respond and meet the needs of the population they serve relies on their capacity and organisational structure to enable them to deliver.

1.5.1 This plan addresses the recruitment and retention of staff in specialist CAMHS, primarily in Tiers 2 and 3/targeted and specialist, but with reference made to Tier 4 where appropriate. There are two jointly commissioned services across Pennine Care – the inreach/outreach team (tier 3-4, or 3+) and the BME project, "Cottoning on to CAMHS". These are likely to attract staff from adult services, which has the added benefit of increasing skill mix and improving communication. There is local evidence of AMH practitioners who were interested in working with adolescents – for the inreach/outreach team, in which five AMH practitioners were trained up for CAMHS.

1.5.2 The plan also covers the education and training, as it relates to CAMHS, of staff working in all universal, targeted and specialist services (Tiers 1, 2, 3, 4). The whole of Greater Manchester is a significant training area, but also a net exporter, especially of psychiatry. Local knowledge is that clinical psychologists tend to stay if there are jobs, although recently both they and speech and language therapists have been finding it difficult to secure jobs, with many junior posts frozen.

Each borough based group will already have a children's services workforce plan that will link directly to their CAMHS plan.

1.6 This workforce plan aims to meet the objectives of the following key documents:

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.

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

[2] http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf
[3] http://www.lincoln.ac.uk/ccawi/publications/NWW%20Psychiatrists.pdf

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

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 the CAMHS workforce plan is fully compatible with the children's services workforce planning and development.

1.6.2 Local policy and strategy by borough

The planning group view is that children are not highlighted sufficiently across the Pennine footprint and this impacts on children's workforce planning. This is a national issue. The structural arrangements of PCTs need to include children – the current situation, which includes not having distinct budgets for children's services, does not always enable children's issues to be aired.

[4] http://www.dh.gov.uk/assetRoot/04/09/05/66/04090566.pdf
[5] http://www.everychildmatters.gov.uk/_files/7D2DD37746721CC8E5F81323AD449DD7.pdf

Arrangements for joint commissioning are becoming more robust in some areas, but this needs to be consistent across Pennine. The cross Pennine commissioning group needs consolidating; it does have an action plan, including workforce issues.

Bury
Local Delivery Plan 2005-6
Relevant areas:

- Assessed deliverable – availability of workforce.
- Financed local initiatives include Workforce, with key targets including practice development and corporate learning.
- Finance local initiatives in service redesign and efficiency include children's services change management.

Oldham
Local Delivery Plan 2005-8
Relevant areas:

- National Service Frameworks: This area was resourced with a reserve of £0.45m, which was uncommitted at the time of publication in 2005. However this amount was subsequently cut as part of cost savings; the *LDP Financial Plan Refresh* (5th cut), dated March 2006 states, "Current investment in the delivery of NSF targets is sufficient."

Rochdale
Local Delivery Plan 2005-8
Relevant areas:

- Further developing integrated services for children across agencies and groups.
- Underpinning Strategies include Workforce, incorporating *Agenda for Change*
- The Children's Local Implementation team have set out how they wish to develop services for Rochdale Children. It appears that children's health services will receive an additional £657,000 to develop over the next 3 years.

Stockport
Local Delivery Plan 2005-8
Relevant areas:
There was no proposal for CAMHS growth last year, however in the current LDP refresh a proposal for £173,795 has been made to support the proxy target for LD and mental health.

Tameside and Glossop
Local Delivery Plan 2005-8
Relevant areas:

- Training and support to front-line professionals – to support tier 1 staff in identifying and supporting families where there is a mental health need.
- Adequately trained and staffed tiers 2 and 3 to meet mental health needs of children and young people with learning disability (LD).

1.7. Additional links to other plans

The five boroughs' CAMHS strategies all refer explicitly to workforce considerations. Additionally senior Pennine Care staff are involved in the CAMHS sub group of the Greater Manchester Workforce Confederation.

Highlight issue – the numbers of CAMHS workforce training places throughout Greater Manchester are few and it is unlikely that a workforce can be recruited that will meet fully the requirements of the developing service.

Bury CAMHS Strategy 2003-2006
Workforce aspects:
- Planned appointment of primary mental health workers (PMHW) and CAMHS graduate workers, senior social work practitioner and CAMHS co-ordinator.
- Working towards appropriate skill mix and staff sufficiently trained to deliver variety of effective treatments.

Oldham CAMHS Strategy and Needs Assessment 2006-2009
Workforce aspects:
- Point 4 under Key Action Plan states "Move towards a staffing level of 15 per 100,000".
- Regarding diversity and capability, 25 WTE, of which four have BME backgrounds. Aiming to strengthen links through the Cottoning On project.

Rochdale Borough's CAMHS Strategy 2003/4-2006/7 (updated 2006)
Workforce aspects:
- Recent appointments of three primary mental health staff, link social workers and link education staff, to support primary and community services.
- Staff have been recruited from nursing and social work backgrounds and CAMHS is providing in house training as well as access to an introductory child and adolescent mental health course run by Central Manchester NHS Trust.
- A child psychiatrist has been recruited and there are training places for SpR, child psychologists, social workers and nursing staff.
- Staff have been undertaking courses in cognitive behaviour therapy (CBT) and infant observation, whilst attempts have been made to obtain parent/child training

Stockport
Workforce aspects not yet available.

Tameside and Glossop CAMHS Strategy 2006-9
Workforce aspects:
- Provide teaching, training and support to tier 1, in mental health awareness, assessment and early identification of mental health problems, front line interventions and access to specialist services
- Item 2 in action plan to address ethnic health strategy is to identify gaps in training need for cultural competence
- Item 3 in action plan to address ethnic health strategy is to achieve an ethnically representative workforce

PART 2
1. The local labour market
2. Regional, national and international labour markets.
3. Local population profile and mental health need of children and young people
4. The current specialist CAMHS, service description and staffing

2.1 The local labour market.

Midas Manchester Investment Agency has produced a series of reports on aspects of workforce for the Greater Manchester area.[6] Each area takes a key town or city as its focus, then calculates all the distances for a forty minute journey to work time, creating a catchment known as the Journey To Work Area (JTWA). The JTWAs for the Pennine area correspond only approximately to the local authority boundaries, but taken together, they provide helpful information on patterns and possibilities in the local workforce. Key findings for each borough are reproduced in Appendix 2

Across the Pennine footprint the working population has a young profile. The working age population has grown, at least as much as the national average and in some cases more. All five boroughs have numbers of people working part time at below, in some cases notably so, the regional and national averages.

The distance people of working age tend to travel to work can have an influence on recruitment and retention and is influenced by environmental factors such as housing, proximity to schools, transport links, etc. The distances travelled to work for each borough are provided in Appendix 3. Figure 2 shows distance travelled to work across the five boroughs, as well as for the region and for England.

2.2.1 The (sub) regional labour market

Manchester Enterprises (2006) has summarised the workforce issues for Greater Manchester in the coming decade. [7] Those that pertain particularly to this workforce plan have been italicised.

Educational issues

- Overall participation and attainment levels are improving but from a baseline below national averages
- Weak performance in English, Maths and Science at Key Stage 4
- Employer concerns about young people being poorly prepared for work, with poor generic or employability skills
- Relatively high numbers of young people Not in Education, Employment and Training, and pockets of high youth unemployment
- *Low levels of progression into traditional higher education in the conurbation core*
- *Scope for greater retention within the sub-region of graduates from local universities*
- Occupational gender stereotyping

[6] www.investinmanchester.com
[7] http://www.manchester-enterprises.com/documents/GMSPS%20final%20version%20240206.pdf

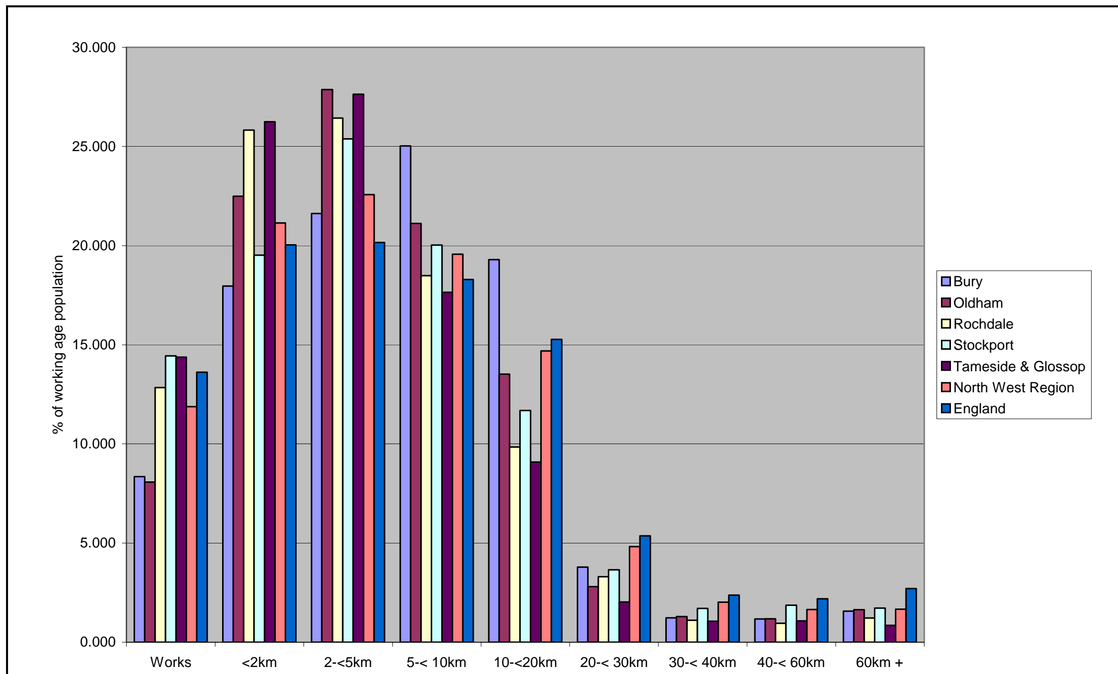
Workforce issues

• *Population profile is ageing*
• Estimated 420,000 residents with poor literacy and numeracy
• Over a fifth of adult population with no qualifications
• High levels of worklessness
• Concentration of low skills and worklessness in particular areas/wards
• *Growing mismatch between the sub-regional qualifications base and the future requirements of the sub-regional economy*
• *Many graduates under-employed in Level 1/2 occupations*
• *Increasing requirements for generic skills such as communication, dealing with numbers, using computers, working in teams, planning etc. at all levels of employment*
• Labour shortages, where increased demand for people in unskilled and semi-skilled occupations cannot be met by the supply of people, e.g. because of lack of generic skills
• *Continued pockets of serious disadvantage, social exclusion, and low activity rates affecting geographical areas and specific groups, including ethnic minorities and the emergence of the underachieving young white male "underclass".*

Occupational issues

• *Very significant overall growth in jobs, at higher and intermediate levels*
• *Continued growth in managerial, professional, associate professional and technical, and personal service occupations*.
• Broad stability of numbers in craft occupations and high replacement demand
• *Over the next five years one in five of future job opportunities will be in managerial roles, 30% will be for professionals, and 19% for administrative/clerical staff.*
• Current skill shortages in a wide range of Level 3 and 4 occupations and some at Level 2
• Over the next five years increased demand from 'higher order' occupations for NVQ level 3 and above will result in around 24,000 jobs requiring Level 3 and above for managers and around 48,000 jobs requiring Level 3 and above for professionals.
• *Occupations projected to grow fastest are those with high proportions of qualified people.*
• *Changes in the occupational structure are likely to drive up further the demand for high-level formal qualifications.*
• *Huge replacement demand in all growth and static occupations*
• The most acute skills shortage is for technical and practical skills- particularly for Professionals and Skilled Trades employees
• Communication skills and customer handling skills lacking in Sales and Customer Services applicants
• Personal Service occupations have a significant level of skills lacking amongst applicants in communication skills, customer handling and team working skills
• Acute and wide-ranging skills shortages for Managers - technical and practical, communication, customer handling, team working and IT skills.
• High levels of literacy and numeracy skills lacking – particularly amongst applicants for Sales and Customer Services vacancies

Figure 2 Distance travelled to work



The estimated replacement demand is given below in Table 1 (selected from a larger table in the document)

Table 1 Replacement Demand by Occupation in Greater Manchester

(Results in 000s)	Expansion Demand	Retirements	Occupational Mobility	Replacement Demand	Net Requirement
Health Professionals	2.6	4.7	1.4	6.1	8.7
Health Assoc Prof	4.1	25.2	0.0	25.3	29.3

Also of particular relevance to this plan, Manchester Enterprises notes there has been no specific provision for adult career changers and the short-term unemployed since the late 1980s. But this group of adults could provide a critical skill supply source for occupations affected by skills shortages. A significant amount of "re-skilling" and "skilling-up" takes place in Further Education but it tends to be hidden and not subject to planning arrangements.

2.2.3 National and international labour markets.

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses and across Pennine CAMHS there is a shortfall in these professions (see Figure 8). Many of the issues raised around recruitment and retention of doctors and nurses apply equally to other professions.

Psychiatrists

Pidd (2003: page 408) [8] offers key messages from senior house officers (SHO) about their training, reporting that they want:

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

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

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

Nurses

In the 1990s one in ten new nurse registrations were from overseas; by 2000-2001 this had risen to over half of all new registrants. The Royal College of Nursing (2005) [9] 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,* [10] 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.

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[8] Pidd, S.A., (2003) Recruiting and retaining psychiatrists. *Advances in Psychiatric Treatment* (2003), vol. 9, 405–413
[9] http://www.rcn.org.uk/publications/pdf/IRN.pdf
[10] http://www2.rcn.org.uk/resources/policy_unit/projects/future_nurse_future_workforce_project

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

Attracting people to work in the NHS

Arnold *et al* (2003) researched the reasons why people join, stay and leave the NHS.[11]

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.

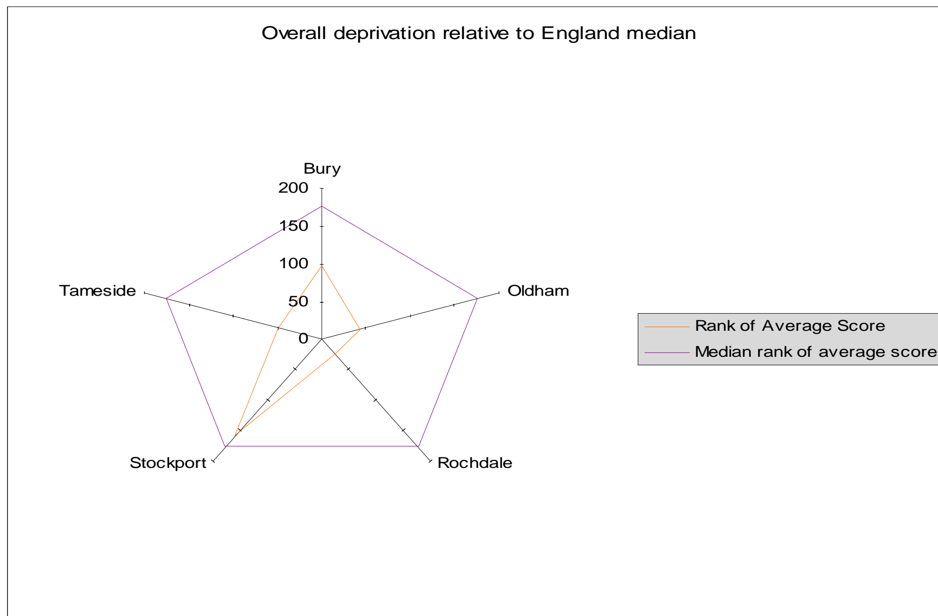
The report recommends the following:

- 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.

2.3.1 The local population needs assessments indicate that whilst there is deprivation in specific areas across the patch, the two boroughs that are the most deprived are Rochdale and Oldham. Figure 3 below shows the deprivation scores relative to the median for England. The closer to the centre, the more deprived the borough.

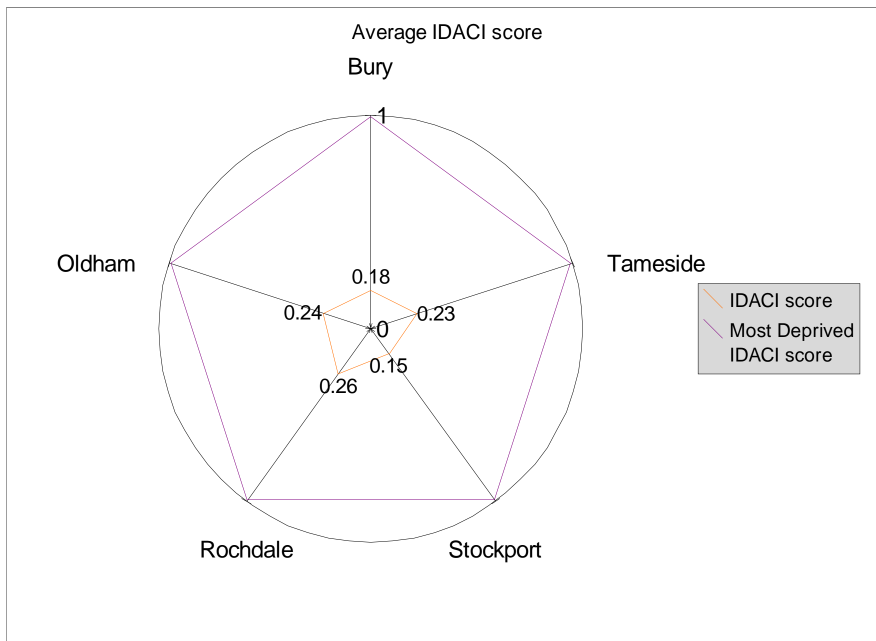
[11] Arnold, J., Loan-Clarke, J., Coombs, C., Park, J., Wilkinson, A., and Preston, D., (2003) Looking Good? The Attractiveness of the NHS as an Employer to Potential Nursing and Allied Health Profession Staff. Loughborough University http://www.lboro.ac.uk/departments/bs/lookinggood/

Figure 3 Overall deprivation in the five boroughs



All the boroughs have areas within them which are amongst the *least* deprived in England. The Income Deprivation Affecting Children Index (IDACI) is a deprivation measure that is a particularly sensitive indicator for children. Figure 4 shows that the average IDACI for all five boroughs is relatively low; which means that in general, income deprivation affecting children is not a significant problem across the Pennine area.

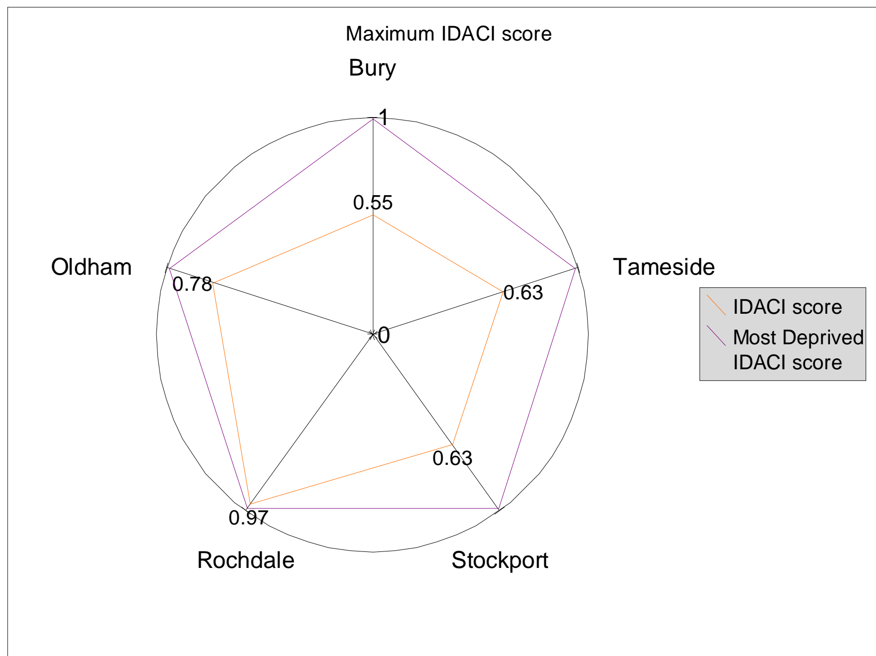
Figure 4 IDACI scores for the five boroughs



If however, the figures are examined by Lower Super Output Area (LSOA) [12], the generally positive picture shown above is offset by IDACI scores indicating that Rochdale has at least one LSOA which scores near the maximum for deprivation, as shown in Figure 5.

In summary, measures of deprivation, which can predict levels of need and demand for mental health services, vary across the patch. Whilst there are pockets both of affluence and deprivation in each borough, the general picture is that the Rochdale area is the most deprived, closely followed by Oldham. Stockport is the least deprived, closely followed by Bury, with Tameside in the middle. More detailed breakdown of LSOAs per borough can be found in Appendices 4 and 5.

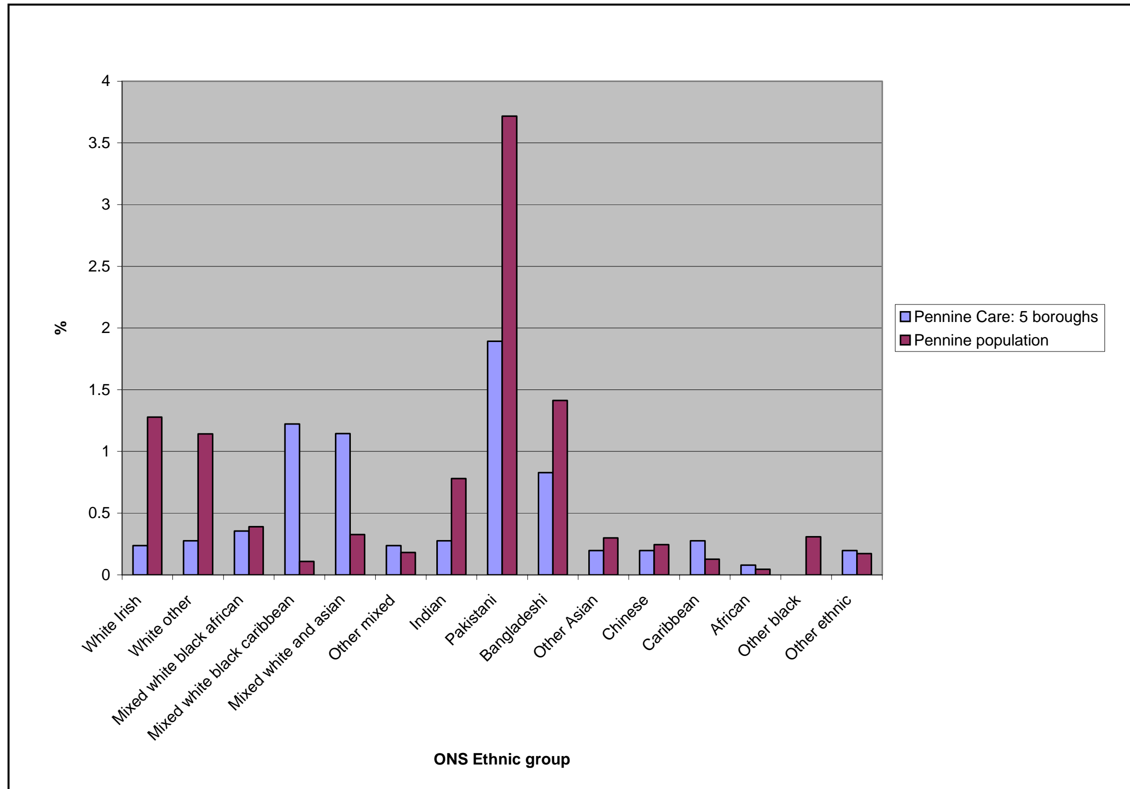
Figure 5 LSOA scores for the five boroughs



2.3.2. The ethnicity of the five boroughs can be compared to the ethnic mix in CAMHS caseloads. Figure 6 below shows the percentage of each ethnic group within the total Pennine CAMHS caseload [13] compared with the percentage of each group as represented in the Pennine population [14]. All figures comparing ethnic mix have omitted the “White British” category, as its inclusion skews the scaling of the graph. To see the full data sets, including White British, see Appendix 6. Further breakdown for each borough is also available in Appendix 6.

[12]Lower Layer Super Output Areas (LSOA) are groupings of Census Output Areas with a minimum population size of 1,000 persons. They nest within Census Ward boundaries.
[13] Source: National CAMHS Mapping 2006
[14] Source: Office of National Statistics
http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14238

Figure 6 Ethnicity of Pennine CAMHS caseload compared with local population



The chart shows that across Pennine CAMHS there is a reasonable match between cases seen and the population, for *Mixed white and black African, Other Asian, Chinese, Caribbean* and *Other ethnic groups.*

Where there are more cases seen than might be expected from the population mix, the groups include *Mixed white and black Caribbean* and *Mixed white and Asian*.

Where there are fewer cases being seen than might be expected from the population mix, the groups include *White Irish, White other, Indian, Pakistani* and *Bangladeshi.*

2.4.1 The current service provision of specialist CAMHS

Table 2 Specialist CAMHS provision across the five boroughs [15]

Bury	Oldham	Rochdale	Stockport	Tameside & Glossop
In Reach / Out Reach Team				
Cottoning On To CAMHS BME project				
Bury CAMHS team	Oldham CAMHS team	Rochdale C&A Unit	Child and Family Team	Tameside CAMHS Team
Bury Home And School Support Project		Behaviour Improvement Team	Education Team (Jigsaw)	Tameside Education team
		Rochdale Excluded Childrens team		
Early Pychosis Team	16 & 17 year old service	16-19 Transition Service	16 & 17 Year Old Service	Young people's mental health team (16-19)
Children In Need Team			Social Care Psychology(LAC)	
LAC Team			The Kite Project	
Early Break		Early Break		
	Disabilities Team	Learning disabilities team		
	Youth Offending Service		YOT	
				Tameside CAMHS Day unit
Peadiatric liason/Access and Crisis		Child Clinical Psychology Team		Tameside Clinical psychology
CAMHS Primary Care Staff	Sure Start		Community Practitioners	
	Zinda Dil	H.Y.Pe Team	Youth Team (Youthful Minds)	Off the Record

2.4.2 The current staffing mix.

The full breakdown of staff between the five boroughs can be seen in Appendix 7. Figure 7 shows the staffing mix across Pennine CAMHS, broken down by service. In Figure 8 the comparison is made between staffing mix in Pennine CAMHS and the figures for England. [16]

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[15] Source: National CAMHS Mapping 2006

[16] Please note that all Pennine figures have been taken from 2006 returns. However, the national atlas for 2006 was not available, so for England 2005 data have been used.

Figure 7 Staffing mix across Pennine CAMHS (WTE)

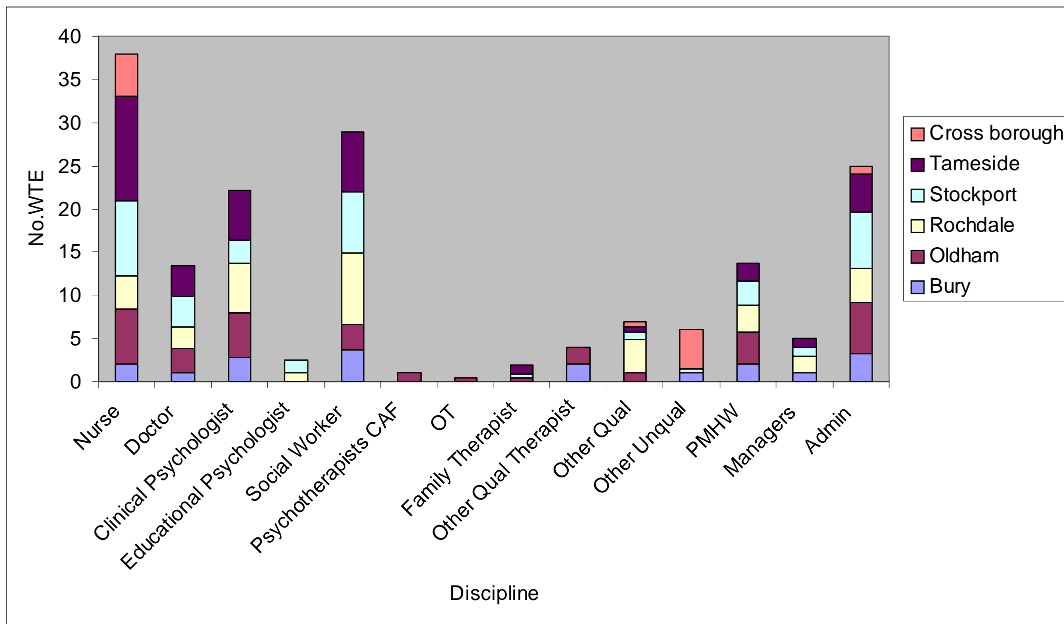
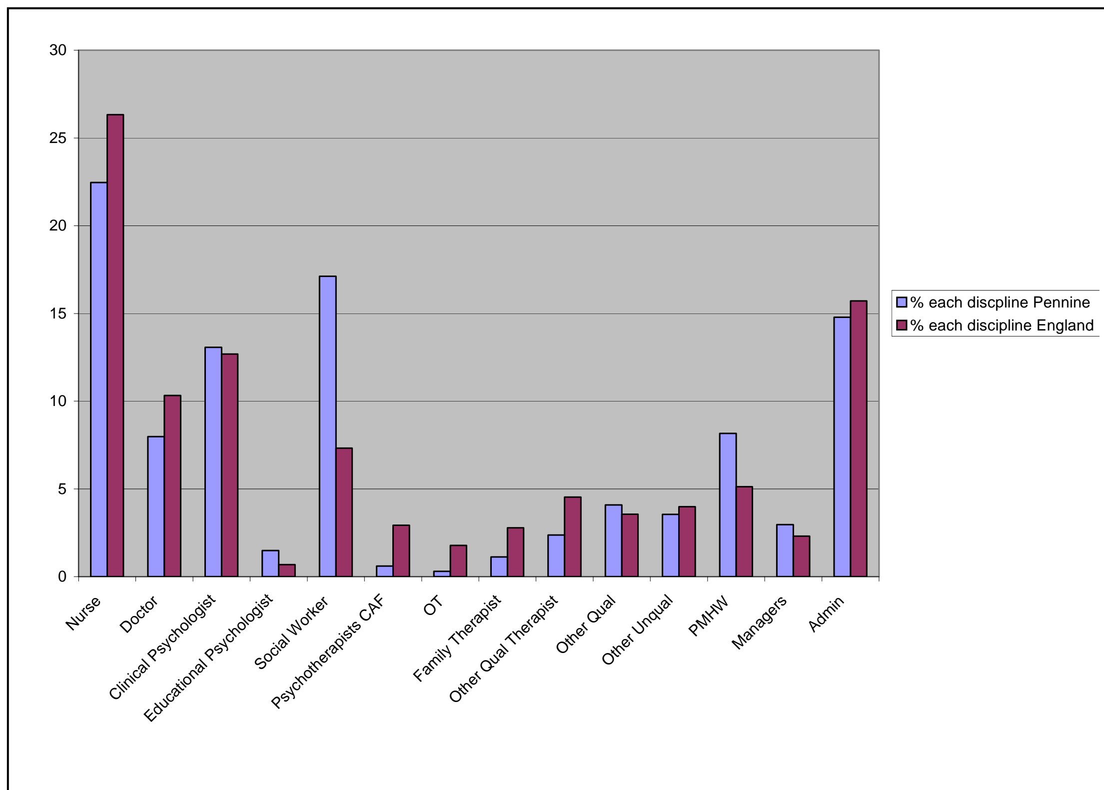


Figure 8 Staffing mix – Pennine CAMHS compared to England



Between Pennine CAMHS and England as a whole there is a reasonable match for clinical psychologists, other qualified and unqualified staff, managers and administrative staff. Pennine CAMHS falls short on nurses, doctors, psychotherapists, occupational therapists and family therapists. Pennine CAMHS has a higher number than England of educational psychologists, primary mental health workers and, notably, social workers. This could reflect cost issues around employing social workers.

Additionally, Pennine CAMHS offers training places to specialist psychiatry registrars (SpR), nurses, psychologists and social workers, as well as one specialist placement for a psychoanalytic psychotherapist. The service tends not to use agencies and hardly uses bank staff, though occasional use of locum psychiatrists does occur.

2.4.3 The case mix for each borough

Case mix is an approximate indicator of demand. Additionally, employing the best available evidence it is possible to use case mix as a proxy indicator of the skill mix needed in each service, in order to offer the most effective interventions. The charts given in Appendix 8 show the proportion of each presenting problem seen in each service. The figures have been taken from the 2006 national CAMHS mapping returns. 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. [17]

Figure 9 shows the case mix across Pennine CAMHS; overall it can be seen that the majority of cases (67%) fall into three categories: *Emotional Disorder, Conduct Disorder* and *Hyperkinetic Disorder*. There is sound evidence of effectiveness for interventions in all three of these groups and Figure 10 displays the skills as they map on to the disorders. It is clear that the primary skills required are in behaviour therapy, interdisciplinary work, prescribing and medical monitoring and family/parenting work. Figure 11 shows the proportion of each discipline available across Pennine CAMHS.

Figure 9 Case mix across Pennine CAMHS

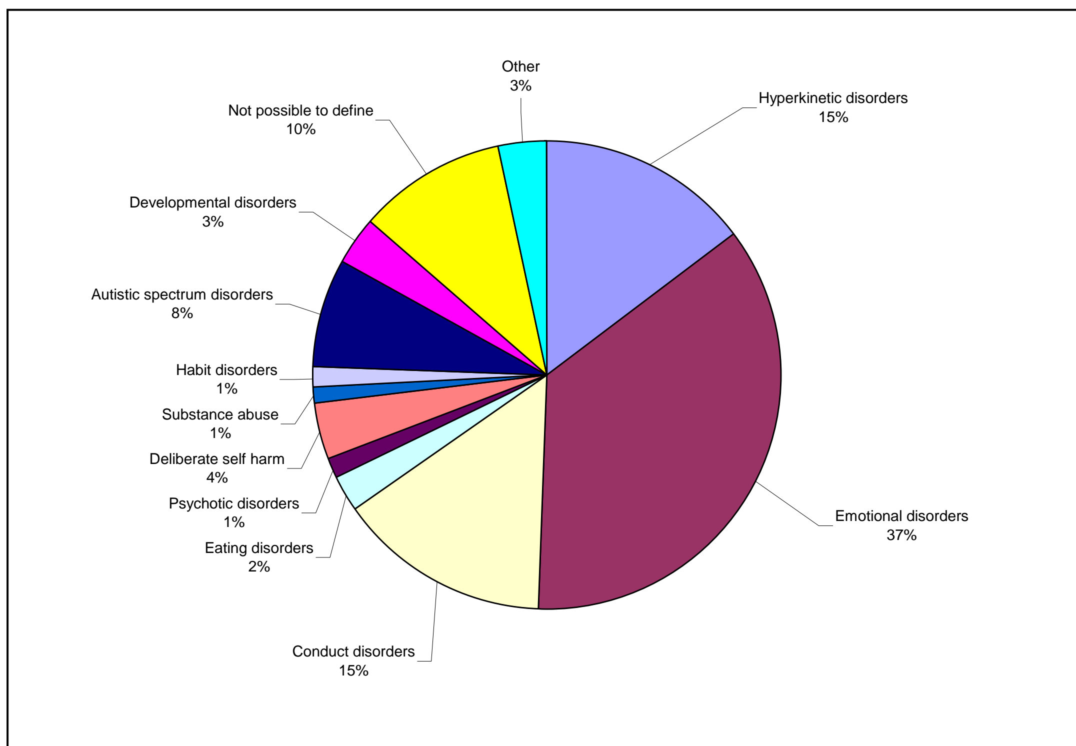


Figure 10 Indicative skill mix across Pennine CAMHS

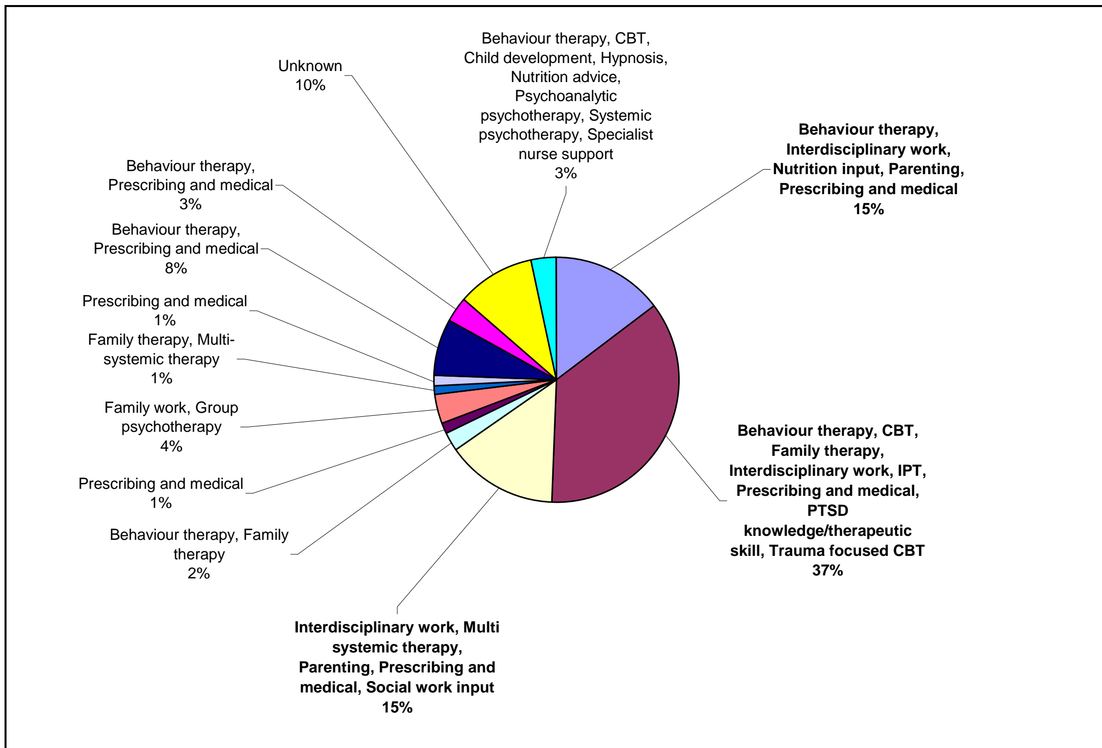
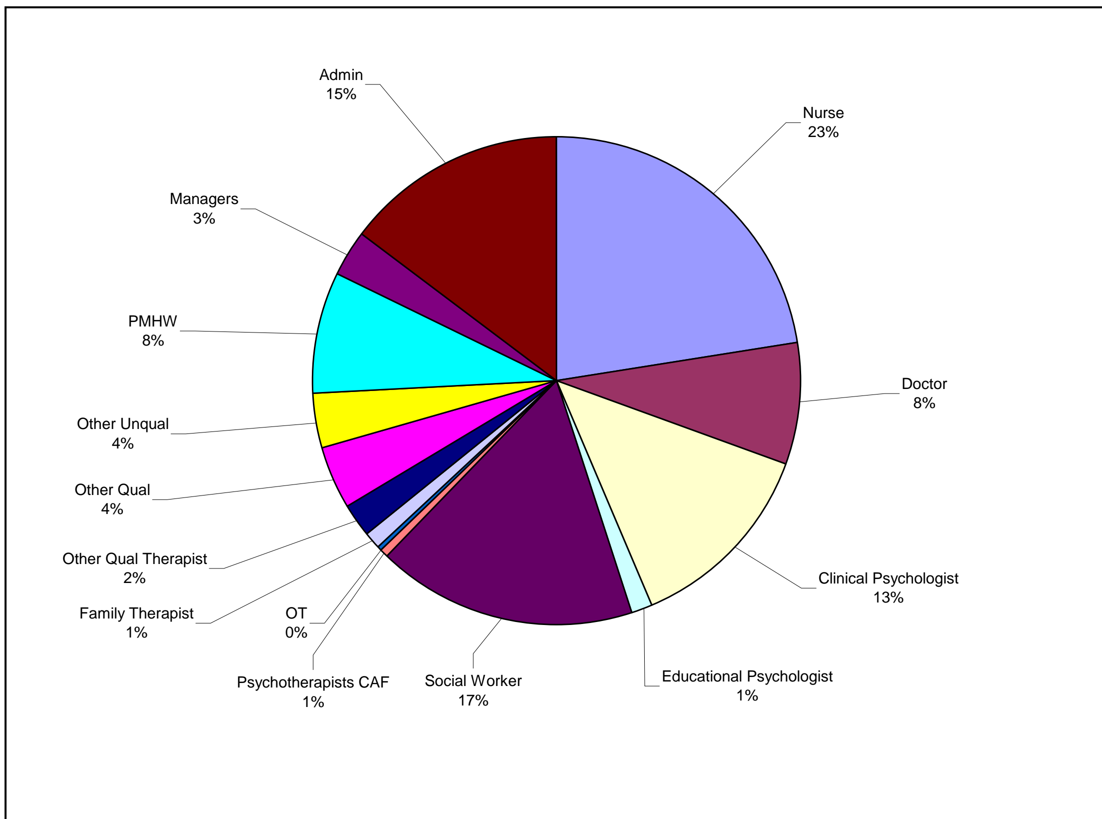


Figure 11 Available disciplinary mix across Pennine CAMHS

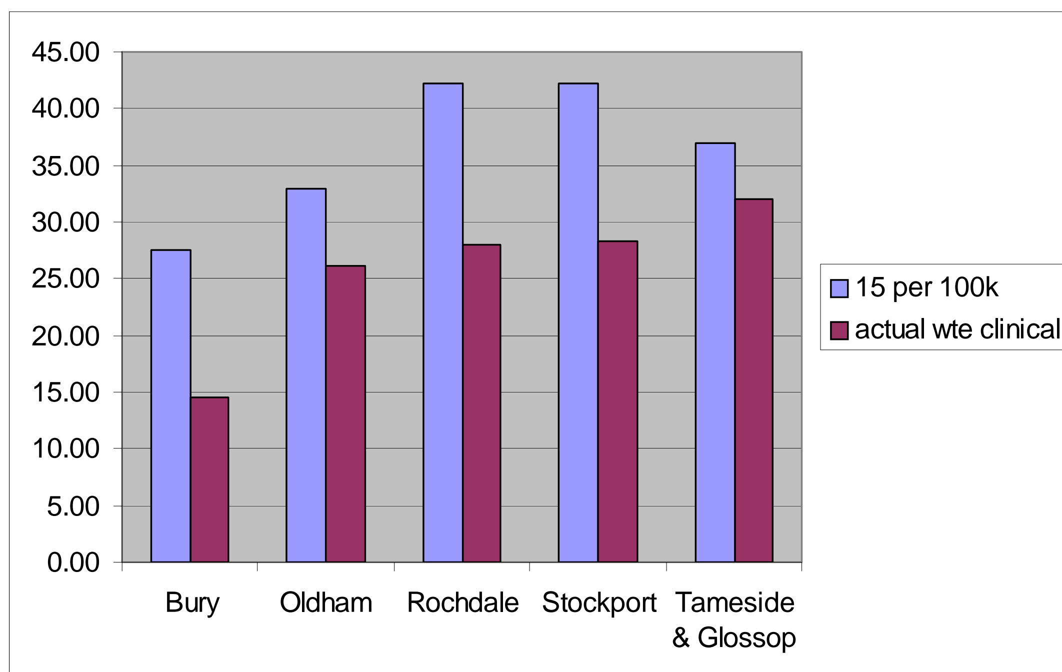


Indicative skill mix was identified by taking evidence for effective interventions and isolating the skills required to deliver them. To see how this process works, please read the full explanation of the evidence for effectiveness, by Wolpert, et al, (2006)[18]. To view the spreadsheet showing how the 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. For further guidance on assessing skill mix, see the quote reproduced below, with the caveat expressed in the footnote.

Although the exact estimates are only "guestimates", the ratio between the different categories may nevertheless be instructive. This suggests that the ratio of therapeutic input required is roughly 3 whole time equivalent (WTE) behavioural, cognitive and interpersonal therapists : 1.5 WTE parent management trainers : 1 WTE systemic/multimodal therapist : 1 WTE person for prescription and monitoring. This is assuming that each WTE is providing just one category of intervention – people who deliver more than one type of treatment would be part time equivalents for each.[19]

The emphasis of the CAMHS workforce plan is on using existing resources more effectively. The fact remains however that the NSF has recommended that numbers of specialist CAMHS practitioners should be 15 WTE per 100,000 population. It is worth noting how the workforce for Pennine CAMHS compares to that. Figure 12 shows that none of the five services has the recommended number of clinical staff. Appendix 7 has the source data for these findings, in which staffing totals from the CAMHS mapping have been set against the latest available (ONS 2001) population numbers. The total WTE of clinical staff across Pennine CAMHS is 129, whereas the recommended level for its total population of 1,128,237 would be 169.

Figure 12 Comparison of Pennine CAMHS WTE with NSF recommendations



[18] *Drawing on the Evidence* DotEBooklet2006.pdf

[19] The quote is from **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.

PART 3
1. The six principles of CAMHS workforce planning
2. Strategic vision for future services
3. Increasing capacity and capability

3.1 This plan addresses the local issues identified within the six principles of CAMHS workforce planning, under the headings below.[20] It is in keeping with the approach adopted by Pennine Care, entitled "A Patient Centred Approach to Workforce Planning".

(a) Workforce Design and Planning

Local knowledge suggests the general CAMHS workforce is ageing. A contributory factor may be that historically staff have started at band 6. A decision to recruit staff at a lower band, including newly qualified staff, requires a framework in which sufficiently numbered and qualified senior staff are able to provide supervision.

(b) Recruitment and Retention

The five boroughs suffer from their proximity to Manchester. As a significant metropolitan area, Manchester can offer more in the way of infra structure, particularly transport and housing. Additionally staff are attracted by academic links and research and development opportunities, as well as better conditions and higher rates of pay for some professions. As Manchester has a teaching hospital, psychiatrists who train there are more likely to stay and there are more training posts (specialist registrars and house officers) available, especially for in-patient services.

Whilst overall retention within specialist CAMHS is felt to be reasonable, there is a higher turnover in Stockport and difficulty in recruiting in Bury. Within children's services as a whole the poor recruitment of social workers has an impact across the whole system. This is a national problem, which is not reflected in the numbers of social workers actually located in specialist CAMHS (see Figure 8 above).

Additional pressure has been created by the increased recruitment of approved social workers (ASW) following the review of the National Service Framework. ASWs are required to be part of the adult mental health rota, which creates difficulties for CAMHS and has an impact on the workforce for 16-17 year old services.

Experience indicates that having provided training for the workforce, staff then tend to move on, which is a retention issue.

(c) New Ways of Working
Psychiatry training in Manchester has not been entirely compatible with new ways of working, a model is currently being developed across the five Pennine boroughs, including by psychiatrists newly appointed in Stockport.

There are issues around the transition from CAMHS to adult services – thresholds, skills and interests differ between the two services, as well as across the boroughs.

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[20] Nixon, B., (2005) *Delivering workforce capacity, capability and sustainability in Child and Adolescent Mental Health Services.*

The pay and conditions for psychiatrist are also more favourable for psychiatrists in Manchester, which poses additional challenges in recruitment and retention.

(d) New Roles
An aging workforce in CAMHS and national shortages in some skill areas provide the impetus for examining what added value new roles could bring to specialist CAMHS. There are always newly qualified nurses within the system (Bands 5) and these have traditionally moved straight into in-patient work before gaining enough experience to apply for community posts.

(e) Leadership
Leadership training has been available from the workforce development confederation (WDC), but not widely taken up by specialist CAMHS staff. There is a general lack of awareness around the wider leadership agenda. The planning group agrees there is a need to address this area, looking at leadership in commissioning as well as provision.

3.2 Strategic vision for future services

3.2.1 The four key principles for CAMHS across Pennine are that children:

- have the ability to develop psychologically, emotionally, intellectually, culturally and spiritually
- are safe from psychological trauma and abuse
- have their wishes and feelings taken into consideration
- have equal and timely access to appropriate, high quality mental health services.

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 CAMHS teams, based on analysis of the evidence for effective practice.[21] Evidence will comprise three levels, in keeping with CAMHS Outcomes Research Consortium (CORC) principles:[22]

- Research based evidence, such as summarised in *Drawing on the Evidence* (referenced above)
- Values based evidence, usually contained within policy and guidance
- Practice based evidence – collected by practitioners using robust audit tools and/or service user feedback

3.3 Workforce capacity required for future services

3.3.1 The indicative skill mix provided in Figure 10 above is a first step in reviewing and revising the capability of the workforce to provide evidence based interventions. A next important step and a significant element of the implementation plan will be to conduct an audit of the skills currently available within the existing workforce and to make decisions on closing any gaps. The levels of skill will also be audited, with a view to developing appropriate training and supervision at all levels – there will not be an expectation that all staff will be qualified, but that qualified staff in each skill area will lead, supervise and support that area.

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[21] For a full explanation of the evidence for effectiveness, consult Wolpert, et al, (2006) *Drawing on the Evidence* DotEBooklet2006.pdf

[22] http://www.corc.uk.net/

3.4 Increasing the capacity and capability of specialist CAMHS

(a) Workforce Design and Planning

- Link into the cross- Pennine workforce plan produced by Pennine Care.
- Address the issues arising out of an aging workforce, by looking at both recruitment of younger staff and flexible working for older employees that will avoid a dramatic loss of skill and knowledge when large numbers retire (This is already in place in the Trust as a whole).
- Implement the learning from the inreach/outreach project and the day unit where band 5 staff have been supported within a preceptorship scheme with a robust development plan to progress to band 6.

(b) Recruitment and Retention

- Examine the reasons why staff turnover is higher in some areas than others.
- Address the concerns about the difficulty in recruiting social workers across the boroughs, looking at the impact on CAMHS of vacancy, agency and locum workers and identifying ways to improve the situation.
- Work with Human Resources and Workforce Leads to develop attractive, competitive packages and incentives in recruitment. These should be borough based as well as Pennine wide
- Within the workforce planning group agree career pathways to promote retention, paying attention to rewards and incentives.
- Use the liaison link workers in the “Cottoning on to CAMHS” project as a recruitment pool for training up into other posts, where appropriate.

(c) New Ways of Working

- Continue to develop multidisciplinary working and use New Ways of Working[23] to inform role definition and development of all practitioners.
- Continue to develop learning disability (LD) training for CAMHS,
- Pursue programmes that skill up adult service psychiatrists in autistic spectrum disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)

(d) New Roles

- Look at the potential for developing assistant practitioners, child health workers, and youth workers for example.
- Examine the feasibility of recruiting newly qualified nurses into community services, identifying the supports that would be required.
- Identify ways of making recruitment as open as possible, tapping into new markets, learning from the successes already achieved by the cross borough project *Cottoning on to CAMHS*, which has employed liaison link workers to engage with harder to reach communities
- Tap into national changes in role, examining the potential for recruiting youth workers, health visitors, etc.
- Use the learning from the current advanced practitioner in training with a view to develop further.

[23] Royal College of Psychiatry (2005) *New Ways of Working for Psychiatrists.* http://www.lincoln.ac.uk/ccawi/publications/NWW%20Psychiatrists.pdf

(e) Leadership

- Make links with the new North West Leadership Academy [24] and ensure CAMHS is on their agenda.
- Look at the feasibility of joint development programmes in leadership for managers, senior clinical staff and commissioners. (Pilot action learning sets, for example).
- Discuss with Trust training section the possibility of an introductory training on leadership for staff at all levels.

3.5 Education and training throughout tiers 1-4.

See each borough plan and how it links with its local children's workforce plan.

- Each borough work on their tier 1 training strategies
- Order the national Tier 1 training CD Everybody's Business and run a train the trainers day for suitably qualified specialist staff to deliver to universal services

[24] http://www.northwest.nhs.uk/leadership_academy/developments/

PART 4
1. Implementation plan
2. Goals and milestones
3. Monitoring and review

Proposals:

- The plan will be circulated throughout Pennine Care, including senior management and the whole CAMHS workforce, as well as to each CYPSYP for comment and to link into their children's services workforce plans.
- Each CAMHS partnership will look at the plan in detail and include it within their 2007-10 strategy
- Pennine care will work with each of the borough CAMHS Strategy groups to look at skilling up the work force, conducting an audit of skills in the teams and relating to the suggested team skill mix. There will need to be recognition that some training might need to be resourced to ensure an appropriate skill mix.
- Each strategy group will bring back to CYPSYP and the cross-Pennine group its implementation plan

The following sections will be completed after the cross-Pennine meeting on 21 May 2007

4.1.1 Links with Workforce Development Confederation/Strategic Health Authority

4.1.2 Implementation plan

Task	Resources needed	Responsible person	Deadline for completion

4.2 Goals and milestones.
4.3.1 Processes and methods to be used in monitoring.
4.3.2 Evaluation and review date: