



A profile of **children's health services,**
child and adolescent mental health services
and **maternity services**
in England 2007/8

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Foreword

I am pleased to introduce the 2007 report of the child health, child and adolescent mental health services (CAMHS) and maternity service mapping exercise, marking the third successful year for child health and maternity service mapping and the sixth for CAMHS. The mapping exercise has become an essential source of information on children's health and maternity services. Through its annual snapshot, it shows how services are commissioned and delivered, and it is starting to track change as the Government's children's agenda is being implemented.

Just some of the evidence of change provided in this report includes:

- Continued growth in expenditure on child health, CAMHS and maternity services and in the workforce delivering the services
- Good progress by primary care trusts since reorganisation in establishing public health strategies based on comprehensive assessments of child health needs
- Significant increases in the provision of support for parents through the delivery of structured parenting programmes
- Further development of child-friendly urgent care facilities
- Wider adoption of key worker systems for disabled children and their families
- Improvements in the development of comprehensive CAMHS with continued reduction in waiting times.

As the mapping initiative is a dynamic process, it is altered each year in line with policy priorities and in this data collection we particularly welcome the introduction of information on:

- NHS responsibilities with regard to safeguarding children
- The involvement of children, young people and families in the design, planning, development and delivery of services.

As previously, the report is organised around the 11 standards of the Children's National Service Framework, emphasising the important role mapping plays in enhancing the connection between national policy and local service delivery. An executive summary of the key messages has been published separately for wider circulation. Both these documents provide national summaries; all the information reported is openly accessible on the mapping website, www.childrensmapping.org.uk, where it can be examined at national, regional or local levels.

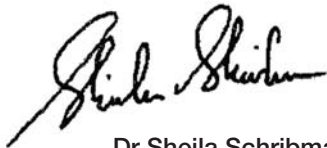
Despite being a voluntary exercise, it is very encouraging that a high participation rate has been maintained. This ensures the usefulness of the information gathered and emphasises the value of the information in enhancing understanding of the connection between national policy, local strategy and service delivery.

The mapping exercise is a large undertaking involving 363 PCTs and other NHS trusts and 150 local authorities. Information is provided on almost 5,000 child health, CAMHS and maternity services with many service managers inputting the description of their own service. Conversations sparked by this information

is not only enhancing understanding of synergies between policy, investment and services, but scrutiny of the mapping data is also having an impact on the efficiency of services through supporting service redesign to improve outcomes for children.

With this strong foundation, the child health, CAMHS and maternity service mapping exercise is being extended, with the support of the Department of Children, Schools and Families (DCSF), to encompass all children's services that come under the umbrella of the new Children's Trusts. This will provide new opportunities to track the growth of inter-agency working and joint commissioning in order to provide an integrated account of services for children and parents. In partnership with the Child and Maternal Health Observatory (ChiMat) new data tools are being developed with wider scope and use.

Finally, none of this would have been possible without the support of all of you who have contributed to this important piece of work. Many thanks for your help in establishing an on-going source of information and understanding of provision for children.



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Contents

1. Introduction	6
Overview	7
Background	7
Purpose of mapping	7
Project management	8
Mapping process	8
Accuracy and completion	9
Using this atlas	10
Local access to data	10
2. Commissioning, expenditure, and leadership	11
Introduction	12
An overview of expenditure on child health, CAMHS and maternity services	12
Total expenditure	13
Commissioning arrangements	13
Expenditure by service categories	14
Spend per child on children's health services	15
Spend per birth on maternity services	15
CAMHS expenditure	16
Individual care expenditure	17
PCT leadership for children's issues and involvement in planning forums	18
3. Children's workforce	19
Introduction	20
Summary of the children's workforce	21
CAMHS workforce	27
4. Service overview	30
Introduction	31
Overview of child health, CAMHS and maternity services	31
Achievement of Every Child Matters outcomes	35
Information and involvement	36
5. Delivering NSF Standard 1 - Promoting health and well-being, identifying needs and intervening early	38
Introduction	39
PCT provision of public health strategy	39
Completion of child health needs assessments	40
PCT child health promotion programme	41
Public health advice and immunisation	41
Qualified school nurse provision	42
6. Delivering NSF Standard 2 - Supporting parenting	43
Introduction	44
Provision of structured parenting programmes	44
Health and lifestyle advice for parents	45
7. Delivering NSF Standard 3 - Child, young person and family-centred services	46
Introduction	47
Improving access to children's health services	47
8. Delivering NSF Standard 4 - Growing up into adulthood	48
Introduction	49
Services for adolescents and young people	49

Transition arrangements	50
Promoting a healthy lifestyle for young people	50
9. Delivering NSF Standard 5 – Safeguarding and promoting the welfare of children and young people	52
Introduction	53
PCT responsibilities	53
NHS provider trust responsibilities	54
Provision of dedicated safeguarding services	58
Protocols for responding to children suspected of experiencing violence or abuse	58
10. Delivering NSF Standard 6 - Children and young people who are ill and Standard 7 - Children and young people in hospital	59
Introduction	60
Characteristics of paediatric emergency care services	60
Models of care in general paediatric services	61
Diabetes services delivered through general paediatric services	62
Paediatric surgery	63
Specialist paediatric services	65
Network of care for critically ill children	66
11 Delivering NSF Standard 8 - Disabled children and young people and those with complex health needs	67
Introduction	68
Disability services	68
Key worker system	69
Disability assessment	70
Palliative care	71
12. Delivering NSF Standard 9 - The mental health and psychological well-being of children and young people	72
Introduction	73
Towards comprehensive CAMHS provision	74
Functions and interventions	80
Outcomes measures	82
CAMHS caseload	83
13. Delivering NSF Standard 10 - Medicines for children and young people	86
Introduction	87
Nurse prescribing	87
Parent and carer management of medication in hospital	88
14. Delivering NSF Standard 11 - Maternity services	89
Introduction	90
Maternity service provision	90
Antenatal care	92
Intrapartum care	92
Neonatal services	94
Appendix 1: Technical notes on the mapping exercise	96
Appendix 2: CAMHS technical notes	98
Appendix 3: Completion rates 2006 and 2007	99
Appendix 4: Service categories and types 2007	102
Appendix 5: Working definition of CAMHS tiered system	103
Appendix 6: Child Health, CAMHS and Maternity Service Mapping Steering Group 2007-2008	105
Appendix 7: Child Health, CAMHS and Maternity Service Mapping Expert Reference Group 2007-2008	106
References	107
Acknowledgements	109

Chapter 1.

Introduction



Overview

- 1.1 This report is the third in a series of profiles produced to report the results of the annual child health, child and adolescent mental health services (CAMHS) and maternity services mapping exercise in England. The 2007 exercise was carried out between 1st November 2007 and 28th February 2008 and it marked the third child health and maternity service mapping data collection and the sixth CAMHS mapping exercise. The report summarises the findings at a national level with some references to regions but all data can be interrogated at the level of Strategic Health Authority (SHA), NHS organisation, and individual service at: www.childrensmapping.org.uk/reports.
- 1.2 Child health, CAMHS and maternity service mapping is an online data collection and reporting system that creates an annual snapshot of national service provision and investment. As annual data accumulates, trends are generated that indicate where, and in what direction, change is taking place. This underlines the principle aim of the mapping exercise to contribute to the monitoring of the implementation of the National Service Framework for Children, Young People and Maternity Services (NSF)¹ and the Every Child Matters (ECM)² agenda.

Background

- 1.3 The mapping of children's services began with specialist CAMHS in 2002. Since then CAMHS mapping has been completed each year and the data reported has been used to support the measurement of performance and to help drive forward improvements in CAMHS investment, staffing and activity. In 2005, the mapping system was extended to cover dedicated child health and maternity services and in 2007 the first joint report of the mapping exercise was published which was structured around the 11 standards of the children's NSF.
- 1.4 The mapping system was further developed in 2006 and 2007 for pilot exercises to capture local authority (LA) commissioned services. Building on the success of these pilots, an integrated children's services mapping exercise was launched in October 2008 designed to map all the services that come under the responsibility of Children's Trusts.

Purpose of mapping

- 1.5 The purposes of the child health, CAMHS and maternity services mapping exercise are to:
 - Support Primary Care Trusts (PCTs) and other partners in developing joint commissioning strategies
 - Support joint service planning, development and provision
 - Assist in the bid for resources
 - Act as a source of data for national, regional and local performance monitoring
 - Provide annual updates for the development and maintenance of local service directories.
- 1.6 The mapping system is also beginning to support local and national benchmarking and can be used alongside other information, such as, national indicators and vital signs.

Project management

- 1.7 The mapping exercise is funded by the Department of Health and managed and developed by the National Mapping Team led by Bob Foster with Claire Thomson and Pauline Dowson. The Durham Mapping Team in the School of Applied Social Sciences at Durham University run the exercise, developing and maintaining the online systems and reporting the results.
- 1.8 The work programme of the project is overseen by a steering group, led by the Department of Health, with representation from the Department for Children, Schools and Families, Regional Government Offices, the Healthcare Commission, the Association of Directors of Children's Services, the NHS, the third sector and key professional associations.
- 1.9 The exercise is advised by an Expert Working Group made up of policy and workforce leads, commissioners, service managers and practitioners across children's services.
- 1.10 The approval of the Review of Central Returns (ROCR) at the Department of Health for the mapping process was granted in July 2006. The Gateway references for the work in 2006 and 2007 were:
 - CAMHS 2006 - ROCR/OR/016/002 - SUB204/017.
 - National Child Health and Maternity Services Mapping - ROCR/OR/0170.

Mapping process

- 1.11 The mapping exercise follows an annual cycle with distinct phases:
 - 1. Review and development:** Although changes are kept to a minimum in the interest of comparing data year-on-year, improvements are made to the data collection in response to feedback from the field and new questions are added to reflect changes in policy or emerging areas of interest in service delivery.
 - 2. Data collection:** All data is input online by PCTs, NHS Foundation Trusts and other NHS trusts that provide child health, CAMHS or maternity services. Local authorities are also involved in inputting CAMHS data. Each relevant organisation is asked to nominate a senior member of staff to act as the Mapping Lead, taking responsibility for overseeing and coordinating the exercise for their organisation. The Mapping Lead is responsible for setting up the exercise, structuring it to suit local circumstances, and nominating colleagues to assist in the completion of the exercise. As the details of all services reported in the previous year are imported into the current data set, the annual exercise is essentially one of data revision. The data collection period runs from the beginning of November to the end of February, describing the services in operation on 30th November. Finance data is collected for the previous and current financial year. To end the data collection phase, all data is signed off by the Chief Executive Officer of each participating organisation and the Directors of Children's Services for LA CAMHS performance information.
 - 3. Data checks:** The Durham Mapping Team carries out a series of checks on the data before releasing reports on an open access website.
 - 4. Reporting:** Online and published reports are prepared throughout the summer months. These include the publication of a national 'atlas', reports on specific topics and one-off reports on request.

Accuracy and completion

- 1.12 Although child health, CAMHS and maternity service mapping is a voluntary exercise, response rates of over 90% were achieved in 2007 giving considerable confidence in the accuracy of the data. As the completion rates rise (see Appendix 1) the accuracy of the data can be expected to rise also but the information should be read with caution as there are still gaps and inconsistencies. Despite this, it provides a valuable national profile of provision and investment, enabling pertinent questions to be raised and policy issues to be debated.
- 1.13 This is a report of the data collected in 2007 with some reference to the 2006 exercise. Limited reference is also made to the 2005 child health and maternity service exercise but, as this was the first year of the exercise, the data should be viewed with particular care. When it was first launched in 2005, the online data collection process was unfamiliar to the majority of staff participating and they did not have access to some of the information in the format in which it was requested. Great improvements have since been made to the data inputting process but it remains a data collection of ambitious scope which involves a large number of staff and so an element of variation in the results is inevitable.
- 1.14 The mapping exercise has clear boundaries – the inclusion of dedicated child health services, specialist CAMHS tiers 2 to 4 (see Appendix 5) and maternity services. However, it can be difficult to define dedicated children’s services. All-age health services should not be included in the mapping exercise and yet it may be appropriate to include services such as accident and emergency units that do not have a separate children’s unit/team but do have a child and family friendly area and operate a children’s pathway of care. A common-sense approach is called for in order to apply a single service mapping template across the country taking into account regional and historic differences, but this is not always easy to achieve.
- 1.15 At a national level the mapping data gives a good indication of levels of service provision, investment and the direction of change. At regional and local levels, gaps and inconsistencies tend to be easier to identify by those with local knowledge. Consequently, the mapping data may raise as many questions as it answers. Paradoxically, this is one of its major strengths as it can stimulate informed debate and help to develop understanding both of the nature of services provided, and who they are being provided for. Where data stands out as different, this may indicate errors in inputting or missing information that can be corrected next year. Equally there may be reasons for the difference that are helpful to articulate and explore.
- 1.16 Where data needs further investigation, it can be ‘drilled into’ using the online tables on the mapping website at www.childrensmapping.org.uk/reports. By clicking on the hyperlinked names on the left-hand side of all tables, access is given to the original questionnaire completed about each service and the totality of information submitted about that service can be scrutinised.

Using this atlas

- 1.17 This report is designed to reflect national policy initiatives, such as the NSF and ECM agendas, and is structured as follows:

Section 1: Introduction giving the background to the mapping exercise and an overview of the mapping process and approach to reporting.

Section 2: Commissioning, expenditure and leadership showing trends in the way services are commissioned and changes in expenditure on child health, CAMHS and maternity services.

Section 3: Workforce describing the make up of the child health, CAMHS and maternity service workforce.

Section 4: Service overview giving a summary of the services mapped and their key characteristics in order to set the scene for sections 5 to 14.

Sections 5 to 14: Delivering NSF standards connecting the mapping exercise to the NSF standards and reporting the findings most relevant to each standard.

Appendices: Technical aspects and governance arrangements providing explanations of the technical aspects of the exercise, completion rates, services types, the CAMHS 4-tier system and membership of steering and expert reference groups.

A summary of this report has been published separately in booklet format to provide the 'Key Messages' from the data collection.

Local access to data

- 1.18 The Durham Mapping Team is continuing to develop the reporting of mapping data and provision of tools for data interrogation. If you have any difficulty accessing these, contact our helpdesk on 0191 334 1489 or by email at help@childrensmapping.org.uk.

Chapter 2.

Commissioning, expenditure and leadership



Introduction

- 2.1 This section reports the findings of the finance mapping that was completed by PCTs and local authority CAMHS commissioners. It describes investment in child health, CAMHS and maternity services for the financial year April 2006 to March 2007.
- 2.2 The section reports the finance mapping results as follows:
- An overview of spend on child health, CAMHS and maternity services
 - Total expenditure
 - Commissioning arrangements
 - Expenditure by service categories
 - Spend per child on child health services
 - Spend per birth on maternity services
 - CAMHS expenditure
 - Trends
 - PCT and LA share of CAMHS investment
 - CAMHS spend per child
 - Individual care expenditure
 - PCT leadership for children's issues and involvement in planning forums.
- 2.3 Completion rates for finance mapping are shown in Appendix 3. The rate of sign off by Chief Executive Officers of PCTs and Directors of Children's Services in local authorities was 95%, up from 87% and 88% respectively in 2006. Sign off indicated their agreement with the data submitted. Further confidence in the data was given by the fact that 95% of individual PCT finance spreadsheets and 93% of LA spreadsheets were confirmed complete. However, inconsistencies in the data remain as the data is complex and errors are difficult to identify without detailed local knowledge. Also 48% of spreadsheets contained estimated data only. Therefore, the data should be interpreted with caution.
- 2.4 In this chapter, the data is reported at a national level only. Detailed tables of the data used can be found and downloaded from the mapping website at: www.childrensmapping.org.uk/reports.

An overview of expenditure on child health, CAMHS and maternity services

- 2.5 The aim of the finance mapping exercise is to identify annual national expenditure on child health, CAMHS and maternity services, to distinguish investment in particular service categories and to track changes in expenditure.
- 2.6 The identification of funding for children's health services remained difficult as:
- Contracts for children's health services often remained wrapped up in single service level agreements for all-age services and did not specify the child specific elements of the contract
 - The commissioning of health services was in a state of transition with the implementation of payment by results, practice-based commissioning and world class commissioning having an impact
 - The development of Children's Trusts was placing greater emphasis on joint commissioning of community-based services with local authorities.
- 2.7 In the finance mapping, spend and budget data covered staff, non-staff and a proportion of overhead costs but capital costs were excluded. Where PCTs were unable to disaggregate child health spend within the timeframe, they were asked to provide estimates and to indicate where estimates had been used.

Total expenditure

2.8 In 2006/7, the total reported expenditure on child health, CAMHS and maternity services (including LA expenditure on CAMHS) was £5,047M, an increase of 12% on the £4,504M reported in 2005/6. Two factors should be noted when considering these figures:

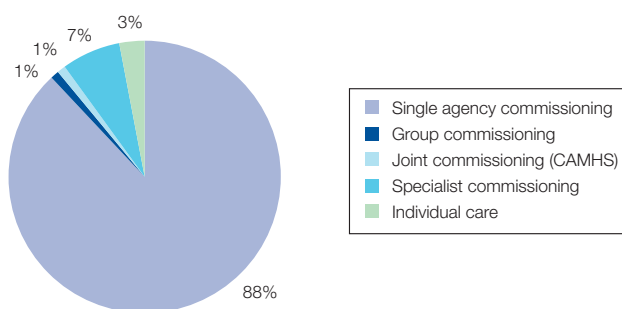
1. This total is based on returns submitted by 96% of PCTs in 2006 and 95% in 2007, indicating there was under-reporting in both years.
2. A more complete description of finances was submitted in 2007 when PCTs confirmed completion of 2,004 spreadsheets compared to 1,761 in 2006 an increase of 14%. In both years 48% of the spreadsheets contained estimates of expenditure.

In addition, some submissions were incomplete. Therefore it is not possible to either confirm the spending increase indicated or to estimate the extent of under-reporting.

Commissioning arrangements

2.9 The majority of child health, CAMHS and maternity services were commissioned through single PCT commissioning arrangements (Fig. 2.1). This accounted for 88% of the reported child health budget. Specialist commissioning for regional and sub-regional specialities accounted for 7% of the budget and 'spot' commissioning for a further 3%. 'Spot' purchasing was usually for the support of individual children with complex needs and, although a small proportion of the total budget, PCTs were keen to record this expenditure as it could have a serious impact on funding earmarked for service development and improvement. Group commissioning, in which one PCT commissioned on behalf of others, accounted for 1% of the total budget as did joint commissioning with local authorities which was only used for CAMHS expenditure.

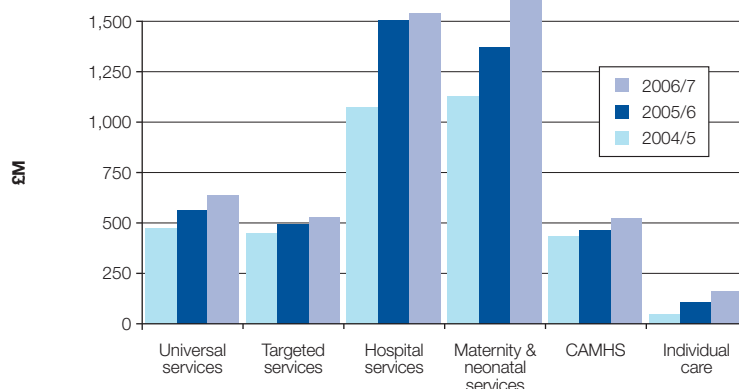
Fig. 2.1: Commissioning arrangements for child health, CAMHS and maternity service expenditure 2006/7 (£5,047M)



Expenditure by service categories

2.10 The largest reported growth in expenditure was in maternity and neonatal services which increased from £1,372M in 2005/6 to £1,654M in 2006/7, growth of 21% (Fig. 2.2). Spending on universal services - school health and early years/health visiting services – increased 13% from £563M in 2005/6 to £637 in 2006/7. Spending on CAMHS also increase by 13% from £461M in 2005/6 to £523M in 2006/7.

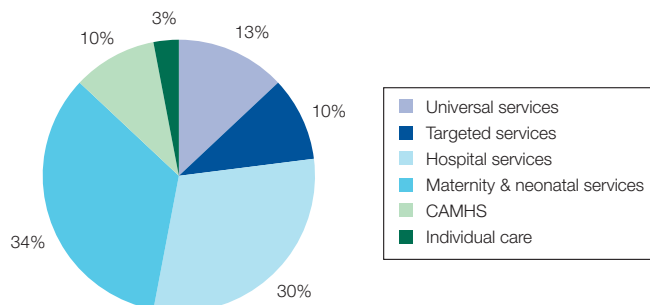
Fig. 2.2: Reported child health, CAMHS and maternity service expenditure by service category 2004/5 to 2006/7



2.11 Expenditure on targeted services (including community paediatrics, children’s therapy services, and services for children with disabilities, complex needs and in special circumstances) increased by 7% from £496M in 2005/6 to £529M in 2006/7. Children’s hospital service expenditure rose by only 2% from £1,506M in 2005/6 to £1,538M in 2006/7. In the same period, spend on individual care rose 50% from £111M to £166M but this was in part due to changes in the way the data was collected.

2.12 Out of a total reported expenditure of £5,047M in 2006/7, £1,654M (34%) was spent on maternity services, £1,538M (30%) on hospital services, £637M (13%) on universal services, £529M (10%) on targeted services and £523M on CAMHS (10%) (Fig. 2.3).

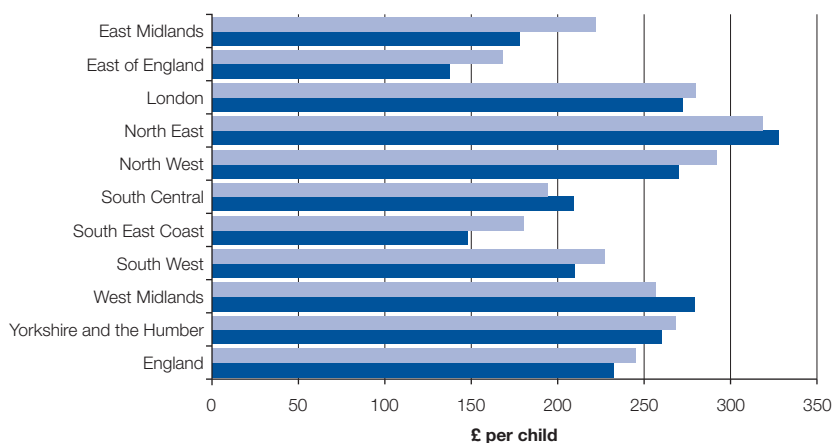
Fig. 2.3: Reported expenditure on child health, CAMHS and maternity services by service category 2006/7 (N=£5,047M)



Spend per child on children's health services

2.13 The national child health spend per child of the population aged 0 to 17 years of age was £245 in 2006/7 compared to £232 in 2005/6, an increase of 6%. The inter-quartile range for PCT spend per child in 2006/7 was £196 to £331 compared to £180 to £322 in 2005/6. The average spend per child for SHAs ranged from £168 to £319 with spend in all but 3 SHAs showing a decrease in 2006/7 (Fig. 2.4).

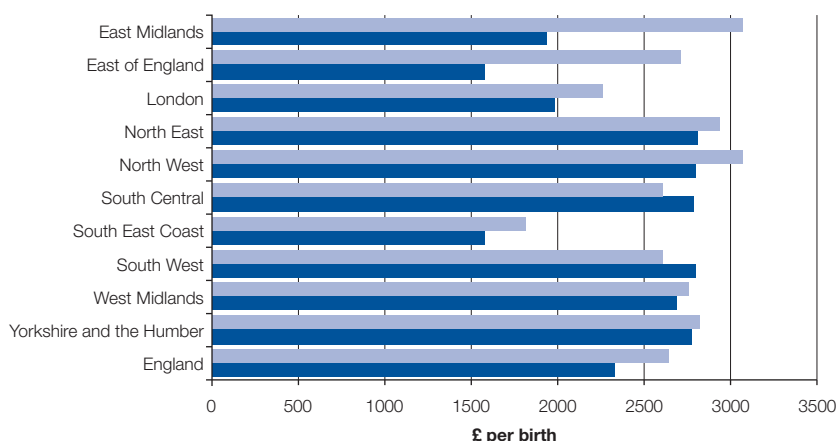
Fig. 2.4: Spend per child aged 0 to 17 on child health services 2005/6 and 2006/7



Spend per birth on maternity services

2.14 National expenditure per birth on maternity services was £2,672 in 2006/7 compared to £2,360 in 2005/6, an increase of 13%. In 2005/6, the inter-quartile range of PCT spend was £1,429 to £3,087 rising to £1,850 to £3,181 in 2006/7. The average per SHA varied between £1,844 and £3,117 with 2 SHAs recording a decrease in spend per birth in 2006/7 (Fig. 2.5).

Fig. 2.5: Spend per birth on maternity services 2005/6 and 2006/7



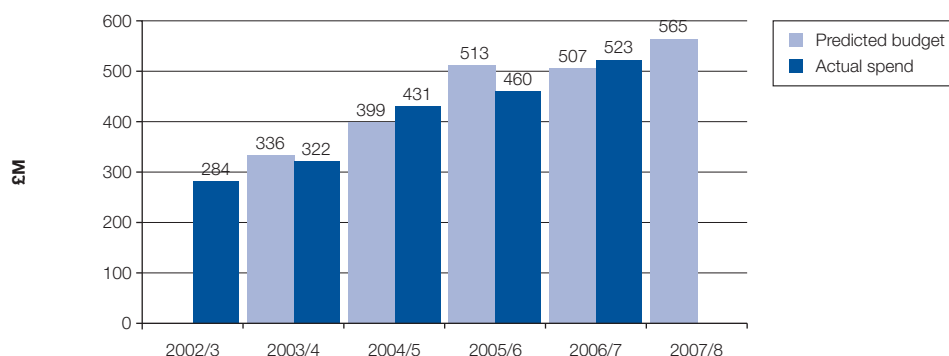
CAMHS expenditure

Trends

2.15 Actual expenditure on CAMHS tiers 2-4 (see Appendix 5) in 2006/7 was £523M. This was an increase of 14% on 2005/6 and much stronger growth than the previous year when the increase had been only 7%. Between 2003/4 (when CAMHS mapping data became reliable) and 2006/7 the overall growth in spend on CAMHS has been in the order of 62% (Fig. 2.6).

2.16 Although direct year-on-year comparisons can be problematic because of changes to the way finance data has been collected, it is interesting to note that only twice has actual expenditure exceeded that predicted. The first time was in 2004/5 when the rise could be attributed to local authorities being invited to map their expenditure on specialist CAMHS. The second time spending exceeded budget was in 2006/7 when a difference of 3% was recorded between the actual spend of £523M and a predicted budget of £507M. A further increase of 8% has been predicted for 2007/8 which would take annual spending on CAMHS up to £565M.

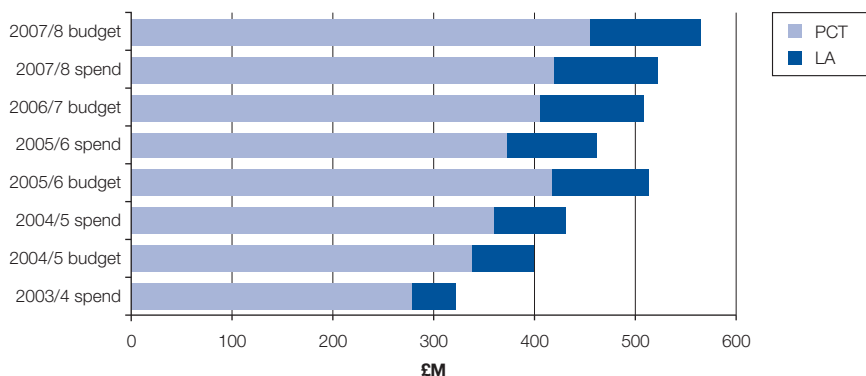
Fig. 2.6: Trends in CAMHS commissioning spend and budget 2003 to 2008



PCT and LA share of CAMHS expenditure

2.17 In 2006/7, CAMHS spending by PCTs was £419M and local authority reported expenditure was £103M (Fig. 2.7). However, as only 77% of local authorities submitted finance data, this was an underestimate. The proportion of the reported CAMHS budget provided by local authorities has remained around 20% since 2005/6.

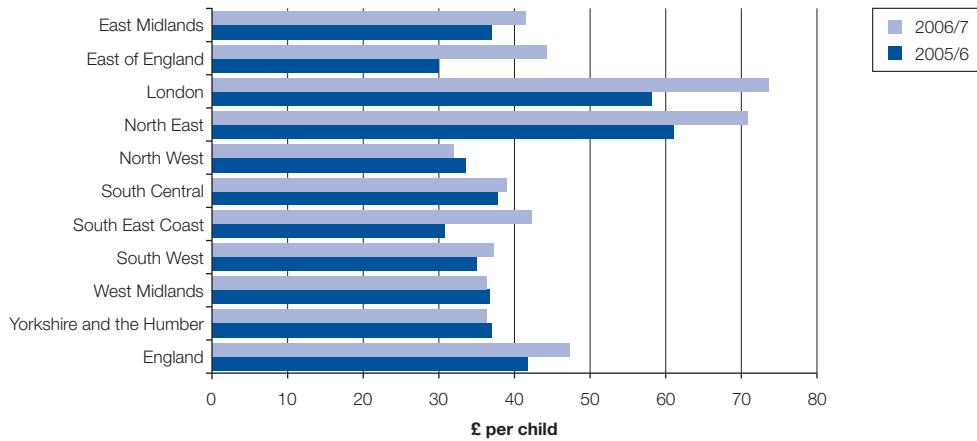
Fig. 2.7: Trends in PCT and LA CAMHS expenditure and budget 2003 to 2008



CAMHS spend per child

2.18 PCT and local authority national CAMHS spend per child of the population aged 0 to 17 was £47.32 in 2006/7 with a PCT inter-quartile range of £26.26 to £48.43. This was a 13% increase on the 2005/6 figure of £41.71 per child (PCT inter-quartile range of £26.05 to £45.36). The SHA average showed large variation ranging from £31.99 to £73.63 (Fig. 2.8).

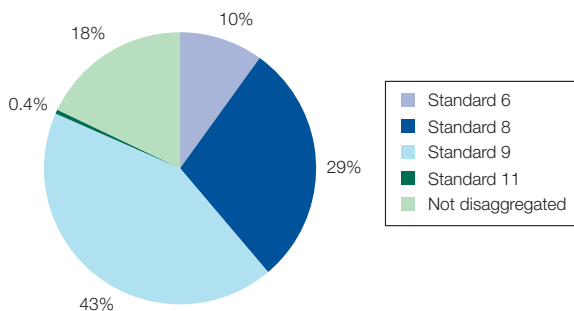
Fig. 2.8: CAMHS spend per child aged 0 to 17 by SHA 2005/6 to 2006/7



Individual care expenditure

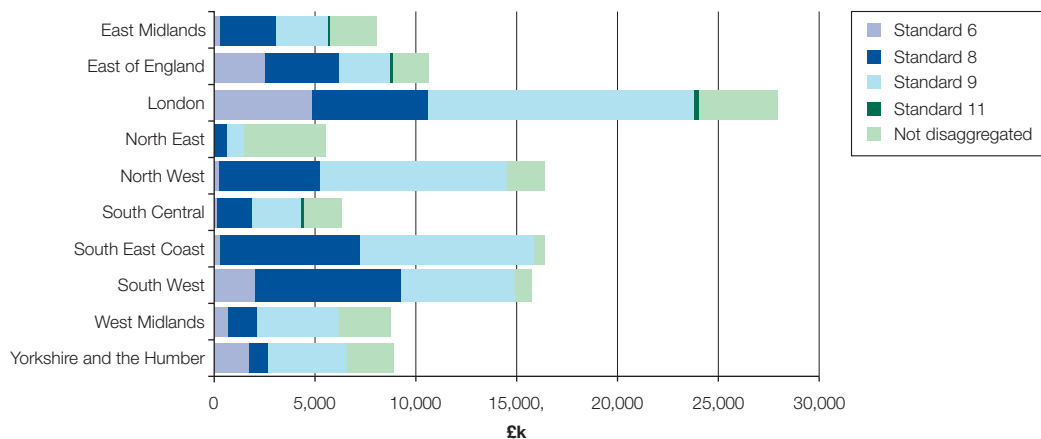
2.19 Expenditure on individual care packages, often termed 'spot' purchasing was £166M in 2006/7 compared to £110M in 2005/6, an increase of 50%. Whilst the majority was for out of area placements, some complex care packages were provided within localities. Spending on NSF Standard 9, CAMHS provision, accounted for £70.3M (42%). £48.9M (29%) was spent on Standard 8 services providing care and treatment for children who are disabled, have complex needs or require palliative care (Fig. 2.9). £16.6M (10%) was spent on NSF Standard 6 services that support children who are ill or have long term conditions. Overall, it was not possible to disaggregate £29.7M (18%) of the individual care budget as it supported children and young people whose needs crossed a number of categories.

Fig. 2.9: Use of the individual care budget by NSF Standards 2006/7 (N=£166M)



2.20 There was considerable variation in the distribution of spending on individual care by SHA, especially in expenditure on CAMHS (Fig. 2.10).

Fig. 2.10: Individual care spend on services defined by NSF Standards by SHA 2006/7 (N=£166M)

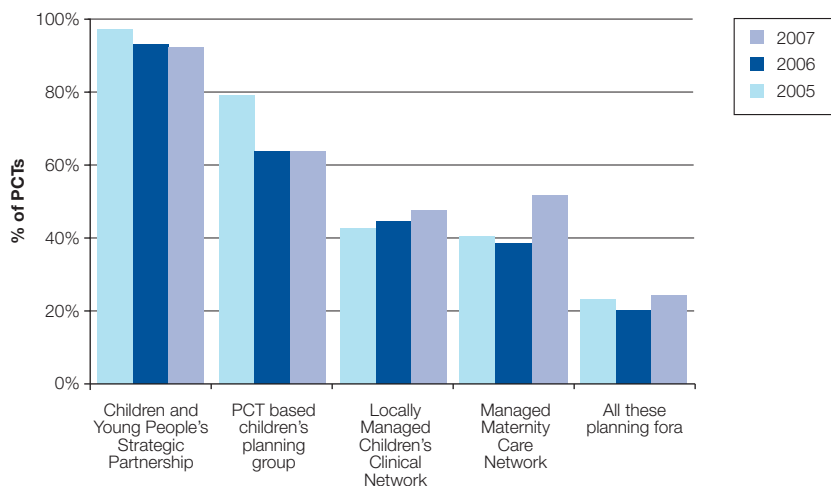


PCT leadership for children’s issues and involvement in planning forums

2.21 In 2007, 146 (96%) PCTs reported having a child health lead in post. Of these, 88 (60%) were dedicated leads, the remaining 58 shared the children’s lead role with other responsibilities. Sixty one (42%) of the PCT children’s leads were directors and 44 (30%) were members of the PCT Board.

2.22 Involvement in children’s planning forums remained stable between 2006 and 2007 with 142 (93%) PCTs reporting involvement in the local Children and Young People’s Strategic Partnership (Fig. 2.11). The number of PCTs running PCT-based children’s planning groups was also unchanged at 98 (64%). Involvement in locally managed children’s clinical networks increased slightly from 68 (45%) PCTs in 2006 to 73 (48%) in 2007. Participation in Managed Maternity Care Networks had similarly improved from 59 (39%) PCTs in 2006 to 80 (53%) in 2007. Involvement in all these planning forums was still low with only 38 (25%) PCTs reporting this level of participation.

Fig. 2.11: Trends in PCT participation in planning forums and clinical networks 2005 to 2007



Chapter 3.

Children's workforce



Introduction

- 3.1 This section explores the workforce of child health, CAMHS and maternity services, looking in particular at their professional make-up and the distribution of professional staff across different service categories.
- 3.2 As staff are an integral part of any service, the mapping exercise has included them in the description of services. Information on the interdisciplinary nature of the workforce helps to explain the service being delivered and information on the staff team size provides an indicator of service capacity. However, only general data is collected in order to reduce the burden of data collection and to ensure the information is appropriate for open-access reporting on the mapping website.
- 3.3 The findings are reported as follows:
- Workforce definitions and data issues
 - Summary of the children's workforce
 - Trends in the distribution of staff
 - Trends in professional staff
 - Characteristics of
 - Medical workforce
 - Nursing workforce
 - Allied health professionals
 - Maternity workforce
 - CAMHS workforce
 - Professionals in the CAMHS workforce
 - Care staff

Workforce definitions and data issues

- 3.4 In the mapping, each service is asked to record the number of staff in post on 30th November. Bank staff and other temporary staff who are filling funded posts are included. Locums who are temporarily replacing a staff member who is still in post are excluded, as are unsalaried trainees. Staff are counted in terms of whole time equivalent (wte) and headcount but only wte are reported here. Further information is available on the mapping website at: www.childrensmapping.org.uk/reports.
- 3.5 To capture the interdisciplinary nature of services, staff numbers are recorded by professional group but it is the profession required by the post that should be recorded rather than the professional background of the post-holder. For example, a manager who is a fully qualified children's nurse would be recorded as a manager unless the post required the nurse qualification and experience. Similarly, staff whose time is split between more than one post, or type of activity, should have their time apportioned accordingly. For example, a manager who works as a half-time manager and half-time nurse with clinical duties should be recorded as 0.5 wte manager and 0.5 wte nurse.
- 3.6 Services are also asked to apportion staff time appropriately when they work across services or units. This is particularly relevant for specialist medical, nursing and therapy staff contributing to more than one service/team on a sessional basis. Only the sessional input to a service should be counted but it has taken time for this to be understood by the many participants in the mapping exercise.

3.7 Another difficulty that has arisen in defining the child health workforce has been the identification of dedicated children's services. Health professionals who work with children as part of an all-age service should not be included in the mapping exercise but this distinction can be difficult in services, such as A&E, which have a separate environment and pathway of care for children, but not necessarily a separate children's staff team. This issue caused particular difficulty in 2006 when the Healthcare Commission carried out a pilot exercise to test the use of mapping data as a source of information for 10 performance indicators on staff training introduced as a follow-up to their 2006 review of services for children in hospital³. The Healthcare Commission was interested in all medical staff working with children whether they were located in dedicated children's services or not. The result was the over inclusion of medical and other specialist staff in hospital services in the 2006 mapping exercise. This was corrected in 2007 facilitated by a clear separation of the Healthcare Commission questions from the service questionnaires leading to a significant reduction of hospital staff being mapped (see below).

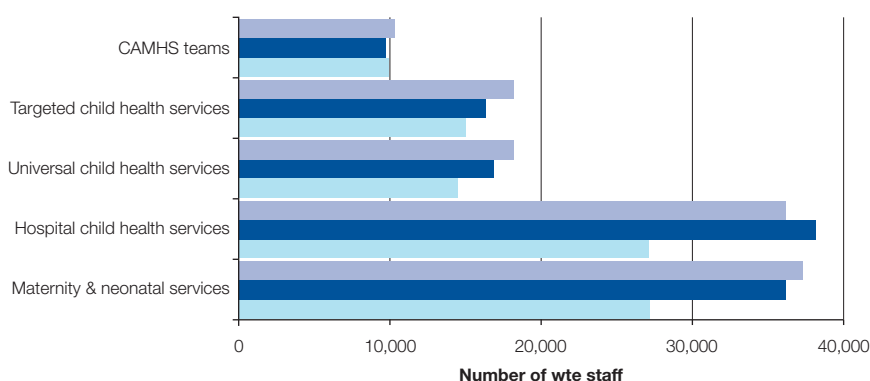
Summary of the children's workforce

Trends in the distribution of staff

3.8 The child health, CAMHS and maternity service workforce increased 3% from 117,317 whole time equivalent (wte) in 2006 to 120,529 wte in 2007. All areas of service provision saw an increase in staffing over this period except hospital services which reported a decrease of 5% (Fig. 3.1). However this followed a very substantial increase of 41% the previous year as a result of improved data capture and an enthusiastic response to the Healthcare Commission carrying out a pilot exercise (para 3.7). Therefore, the drop in hospital staff numbers recorded in 2007 was a welcome correction, indicating an improvement in understanding of both the Healthcare Commission measures and the mapping requirements.

3.9 The highest reported increase in workforce was in targeted services which showed 11% growth. The universal service workforce increased by 8% and maternity service staffing by 3%. The CAMHS workforce, after a reduction of 2% between 2005 and 2006 showed a renewed growth of 7%.

Fig. 3.1: Trends in child health, CAMHS and maternity services workforce 2005 to 2007 (wte staff in post)



Trends in professional staff

3.10 Increases were recorded in the number of nurses, midwives and support workers employed in child health, CAMHS and maternity services (Fig. 3.2). The nursing workforce increased by 5% from 40,240 wte in 2006 to 42,393 wte in 2007. The number of midwives rose by 8% from 18,265 wte in 2006 to 19,648 wte in 2007. The number of support workers, which included maternity support workers and unqualified staff saw the largest increase from 12,760 wte in 2006 to 15,226 wte in 2007, an increase of 19%. Decreases were recorded in the medical workforce (minus 17%), the allied health professional workforce (a fall of 3%) and the number of administrators and managers which decreased by 8% (Table 3.1). These decreases were largely due to the difficulties in mapping explained in paragraphs 3.6 & 7 and more detailed descriptions of key professional staff groups are examined below.

Fig. 3.2: Trends in child health, CAMHS and maternity services workforce by key professional groups 2005 to 2007 (wte staff in post)

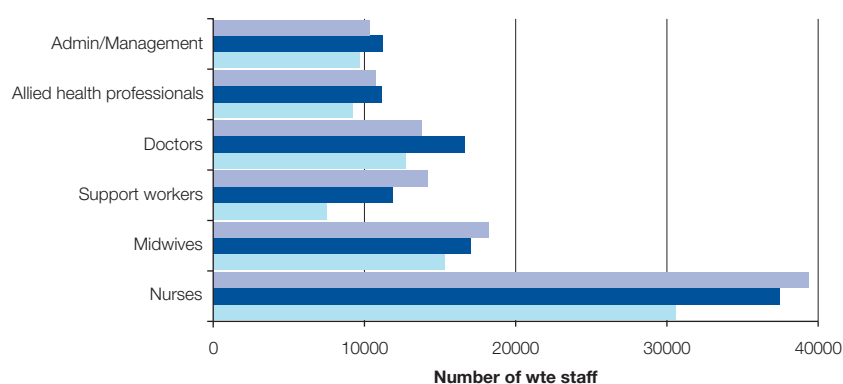


Table 3.1: Changes in selected professional groups 2006 and 2007 (wte staff in post)

Service category	Medical		Nursing		Allied health professionals		Support workers	
	2006	2007	2006	2007	2006	2007	2006	2007
Hospital services	10,282	8,163	17,403	18,180	1,909	1,727	2,881	3,231
Maternity	5,112	4,249	5,139	5,849	580	408	4,967	5,887
Universal	64	32	11,617	12,220	123	143	3,023	3,589
Targeted	1,310	1,236	3,396	3,825	6,698	6,965	1,489	1,888
CAMHS	1,064	1,145	2,685	2,286	2,402	2,314	400	616
Not assigned		27		33		5		15
All categories	17,832	14,852	40,240	42,393	11,712	11,562	12,760	15,226

Change	Medical		Nursing		Allied health professionals		Support workers	
	2006 to 2007	% Change	2006 to 2007	% Change	2006 to 2007	% Change	2006 to 2007	% Change
Hospital services	-2119	-21%	777	4%	-182	-10%	350	12%
Maternity	-863	-17%	710	14%	-172	-30%	920	19%
Universal	-32	-50%	603	5%	20	16%	566	19%
Targeted	-74	-6%	429	13%	267	4%	399	27%
CAMHS	81	8%	-399	-15%	-88	-4%	616	
All categories	-2980	-17%	2,153	5%	-150	-1%	2,866	19%

Medical workforce

3.11 Four categories of medical staff were identified in the mapping exercise. In 2007, of the 14,852 wte doctors 5,454 wte were consultants (37%), 2,030 wte career grade doctors (14%) and 7,316 wte trainees (49%) (Fig. 3.3). In addition there were 52 wte GPs with a special interest in paediatrics (the only GP specialism included). Table 3.2 shows there was a decline in the wte of doctors in post recorded in the mapping in 2007. Overall, there was a fall of 2,980 wte (17%) but the majority (2,119 wte) were doctors in hospital services and the decline in numbers was corrective recording after widespread over-reporting in 2006 (see above).

Fig. 3.3: Type of doctors in the workforce 2007 (N=14,852 wte)

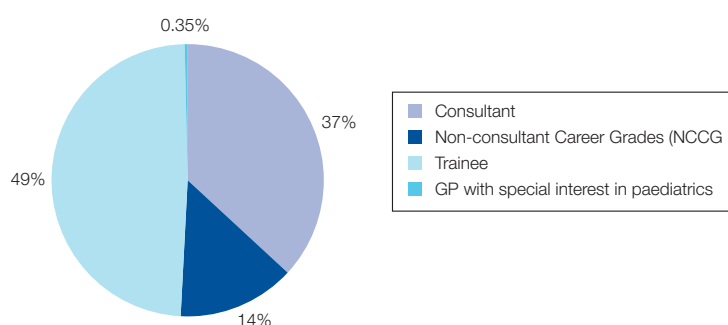


Table 3.2: Changes in the employment of medical staff in child health, CAMHS and maternity services 2006 and 2007 (wte staff in post)

Service category	Medical		Non-consultant Career Grades		Trainee		GP special interest in paediatrics		All medical staff	
	2006	2007	2006	2007	2006	2007	2006	2007	2006	2007
Hospital services	3,750	2,877	1,715	923	4,804	4,344	13	18	10,282	8,163
Maternity	1,513	1,333	806	431	2,790	2,480	5	4	5,112	4,249
Universal	14	7	38	24	12	1			64	32
Targeted	554	563	527	471	210	176	19	26	1,310	1,236
CAMHS	not asked	668	not asked	179	not asked	295	not asked	3	1,064	1,145
Not assigned		6		2		19				27
All categories		5,454		2,030		7,316		52	17,832	14,852
Service category	Medical		Non-consultant Career Grades		Trainee		GP special interest in paediatrics		All medical staff	
	2006 to 2007	% Change	2006 to 2007	% Change	2006 to 2007	% Change	2006 to 2007	% Change	2006 to 2007	% Change
Hospital services	-873	-23%	-792	-46%	-460	-10%	5		-2119	-21%
Maternity	-180	-12%	-375	-47%	-310	-11%	1		-864	-17%
Universal	-7	-50%	-14	-37%	-11	-92%			-31	-48%
Targeted	9	2%	-56	-11%	-34	-16%	7		-74	-6%
CAMHS									81	8%
All categories									-2980	-17%

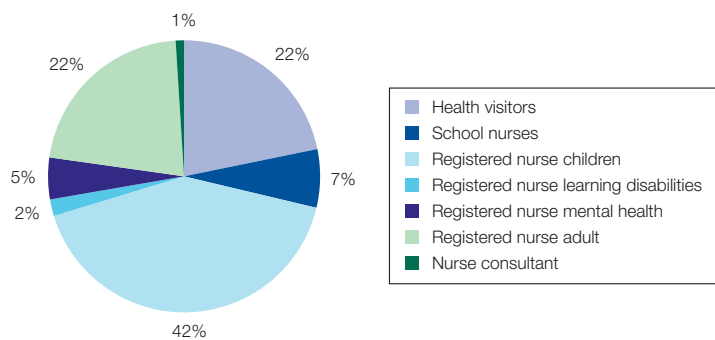
3.12 Overall in 2007, 55% of doctors worked in children's hospital services, 29% in maternity services and 8% in both targeted children's health services and CAMHS. Hospital services employed 53% of consultants (2,877 wte), 45% of career grade doctors (923 wte) and 59% of trainees (4,344 wte). Maternity services employed 24% of consultants (1,333 wte), 21% of career grade doctors (431 wte) and 34% of trainees (2,480 wte). In targeted services there were 10% of consultants (563 wte), 23% of career grade doctors (471 wte), 2% of trainees (176 wte) and half of the GPs with a special interest in paediatrics (26 wte). Universal services employed just 0.2% of doctors (7 wte consultants, 24 wte career grade doctors and 1 wte trainee).

3.13 In 2007, in CAMHS there were 668 wte consultant psychiatrists (12% of the consultant workforce) and 179 wte career grade doctors (9%). CAMHS also employed 295 wte trainee doctors (4% of the trainee workforce) and 3 wte GPs. No information was gathered on categories of medical staff in 2006.

Nursing workforce

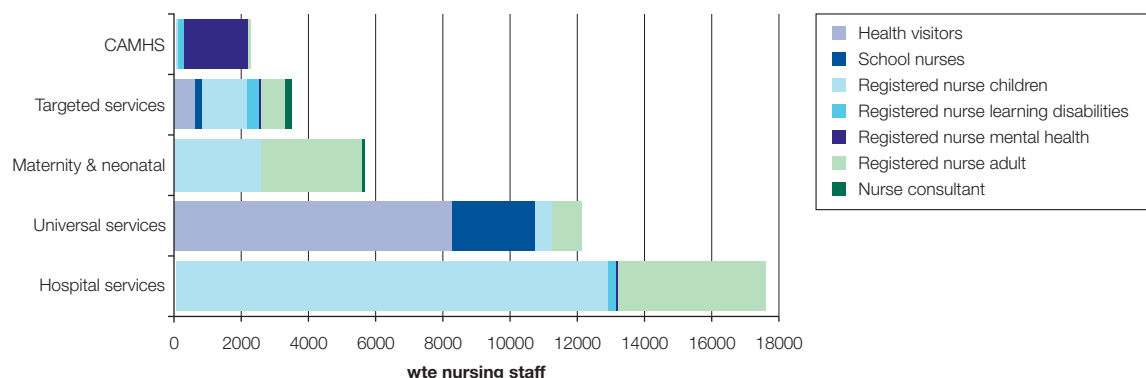
- 3.14 In 2007, the nursing workforce (excluding midwives) in child health, CAMHS and maternity services was made up of 17,284 wte registered children's nurses (42%), 8,907 wte health visitors (22%), 9,010 wte registered adult nurses (22%), 2,759 wte school nurses (7%) and 2090 wte (5%) registered mental health nurses (including community psychiatric nurses). Also 852 wte registered learning disability nurses made up 2% of the workforce (Fig. 3.4). However, it should be noted that no definitions were given for these categories of nurses beyond guidance that school nurses should include nurses with specialist public health practitioners – School Nursing registration.
- 3.15 An additional 1,219 wte nurses were recorded as designated nurses for looked after children. All other named and designated professionals were classified by their professional background and are reported in section 9.

Fig. 3.4: Type of nurses in the child health, CAMHS and maternity services workforce 2007 (N=42,393 wte)



- 3.16 Children's hospital services employed 43% of the nursing workforce (17,601 wte), made up principally of registered children's nurses (12,815 wte) and registered adult nurses (4,340 wte) (Fig. 3.5). Universal children's services accounted for 30% of the nursing workforce (12,147 wte) and they employed 93% of health visitors (8,243 wte) and 90% of qualified school nurses (2,469 wte). Maternity and neonatal services accounted for 14% of nursing staff (5,617 wte), employing 34% of adult nurses (3,029 wte) and 15% of registered children's nurses (2,566 wte). Targeted services had a very mixed nursing workforce that included registered children's nurses (1,333 wte), registered adult nurses (709 wte), health visitors (597 wte), registered nurses for learning disabilities (382 wte), school nurses (218 wte) and nurse consultants (217 wte). 80% of nurse consultants were employed in targeted services.
- 3.17 CAMHS employed 6% of the nursing workforce but 93% of registered mental health nurses (1,934 wte) and 21% of registered nurses for learning disabilities (180 wte).

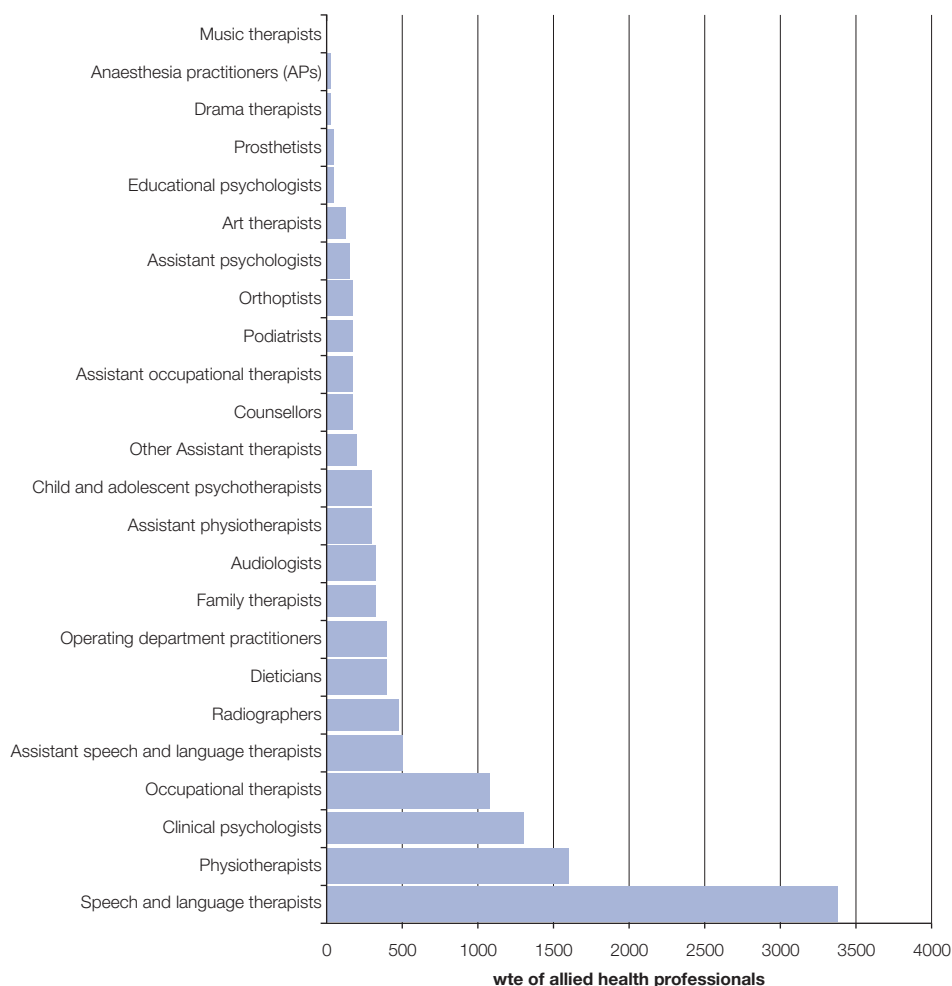
Fig. 3.5: Distribution of nursing workforce 2007 (N=42,393 wte)



Allied health professionals

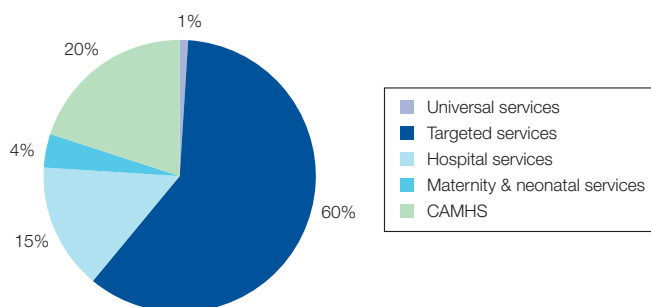
- 3.18 The child health, CAMHS and maternity services workforce included 11,562 wte allied health professionals. There were 3,347 wte speech and language therapists (29% of the allied health professional workforce) and 498 wte assistant speech and language therapists (4%) (Fig. 3.6). 1,599 wte were physiotherapists (14% of the workforce) and 303 wte (3%) were physiotherapy assistants. Occupational therapists accounted for 1,055 wte (9%) of the workforce with an additional 170 wte (1%) provided by occupational therapy assistants.
- 3.19 Clinical psychologists made up 11% of the workforce with 1,300 wte and assistant psychologists 1% with 146 wte. Family therapists comprised 3% with 329 wte with a similar percentage of child and adolescent psychotherapists. Just 1% (170 wte) were counsellors.
- 3.20 Services recorded 470 wte radiographers, 398 wte dieticians, 386 wte operating department practitioners, 319 wte audiologists, 169 wte podiatrists, 162 wte orthoptists and 147 wte art, music and drama therapists.

Fig. 3.6: Allied health professional workforce 2007 (N=11,562 wte)



3.21 The majority (60%) of allied health professionals worked in children's therapy and other targeted services (Fig. 3.7). 20% worked in CAMHS, 15% in children's hospital services and 4% in maternity and neonatal services.

Fig. 3.7: Distribution of allied health professionals by category of services 2007 (N=11,562 wte)



Maternity workforce

3.22 A total of 19,457 wte midwives were recorded, 96% of whom worked in maternity services and 3% in children's hospital services (Table 3.3). Of the 3,322 wte maternity support workers in the workforce, 95% worked in maternity services, 3% in children's hospital services and 1% in universal services.

Table 3.3: Maternity workforce by service type 2007

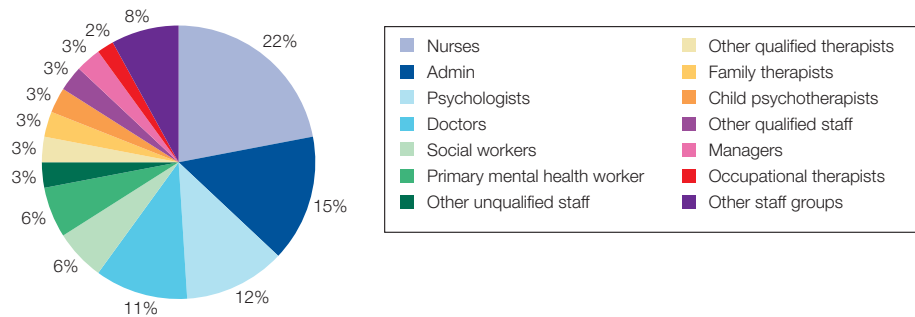
Service Type	Head of midwifery wte	Midwifery wte	Maternity support workers wte
Maternity and neonatal services	177	18,757	3,171
Hospital services	4	568	103
Universal services	1.5	90	38
Targeted services	8.	43	10
Total	191	19,457	3,322

CAMHS workforce

Professionals in the CAMHS workforce

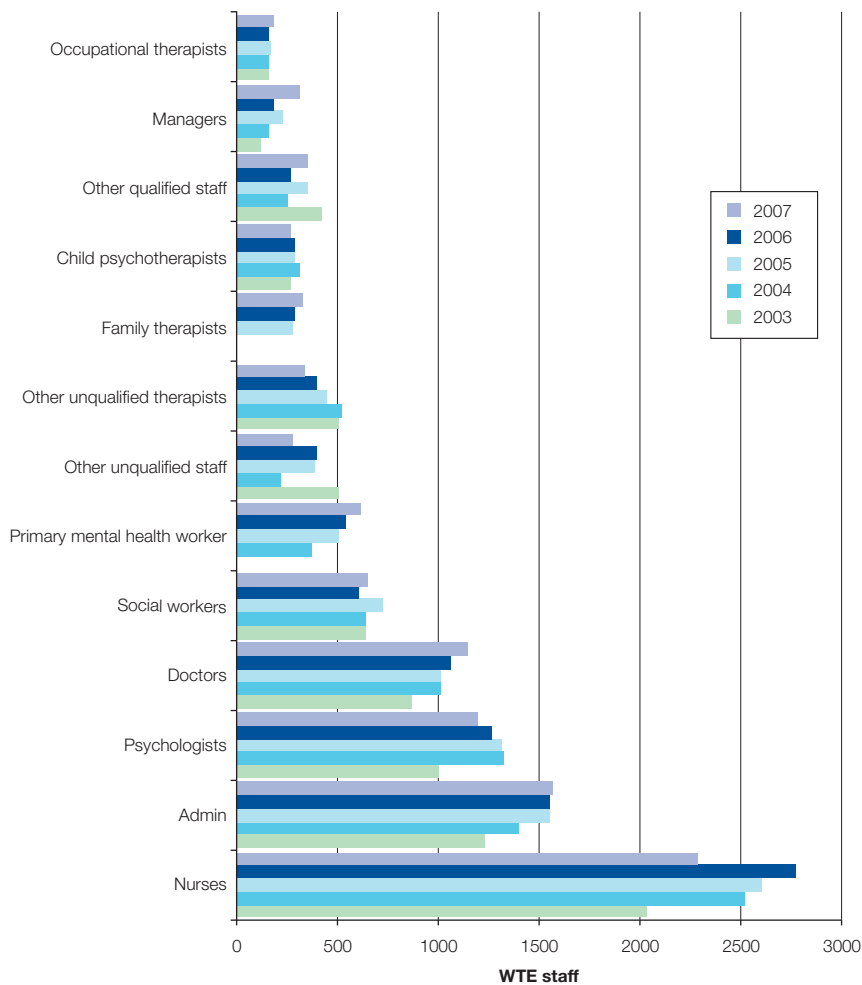
3.23 CAMHS were staffed by a wide range of professionals in order to meet the diverse and specialist needs of children and young people with mental health problems and disorders (Fig. 3.8). Nurses were the largest professional group, accounting for 22% of the workforce in 2007 (28% in 2006 and 26% in 2005). The other main professions that made up the workforce were doctors (11% of the workforce in 2007 and 2006, 10% in 2005), clinical psychologists (12% of the workforce in 2007 and 2006 and 13% in 2005), and administrators (15% of staff in 2007, 16% in 2006 and 2005).

Fig. 3.8: Total CAMHS workforce by profession 2007 (N=10,375 wte)



3.24 Overall the CAMHS workforce grew in size by 34% between 2003 and 2007 but the growth was variable amongst professional groups (Fig. 3.9). However, some of the trends have been affected by changes in the way staffing has been classified. For example, primary mental health workers were first mapped separately in 2004 and family therapists in 2005.

Fig. 3.9: Trends in the CAMHS workforce by profession 2003 to 2007



3.25 The principal areas of growth in 2007 were as follows:

- The number of doctors increased from 1,064 wte in 2006 to 1,145 wte in 2007 (8%).
- The number of primary mental health workers, a relatively new role, increased from 548 wte in 2006 to 619 wte in 2007 (13%).
- The social work workforce increased to 657 wte from 599 wte in 2006 but remained below the 722 wte recorded in 2005. This fluctuation in the number of social workers recorded could in part be due to reduced reliance on CAMHS partnerships to undertake the mapping exercise when CAMHS mapping merged with child health and maternity service mapping in 2006.
- The number of family therapists has shown a steady rise since they were first mapped separately in 2005. In 2007 there were 326 wte, a rise of 10% on the 548 wte recorded in 2006. At the same time the number of 'other qualified therapists' has shown a steady decline.
- The 'other qualified staff' workforce has varied considerably each year but returned to 2005 levels in 2007 with 354 wte.
- The number of managers showed strong growth with 315 wte compared to 188 wte in 2006 and 227 wte in 2005, a rise of 39%.

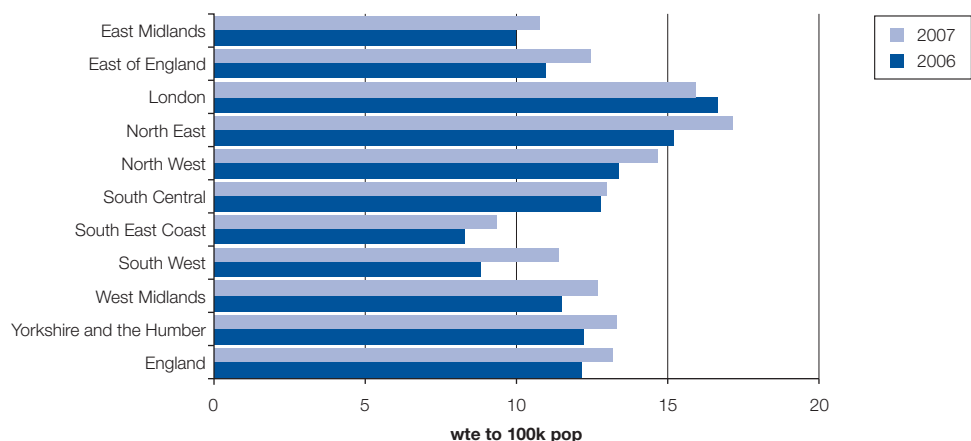
Care staff

3.26 Care staff are defined as all qualified and unqualified staff in post, excluding administrative staff and managers. The NSF sets out guidelines for levels of staffing in tier 3 CAMHS provision. These propose that generic specialist multi-disciplinary CAMHS at tier 3, with teaching responsibilities and providing evidence-based interventions for 0-17 year olds, would need a minimum of 20 wte care staff per 100,000 total population, and a non-teaching service, a minimum of 15 wte care staff⁴. However, it is acknowledged that it is not straightforward to estimate the numbers of care staff needed for viable multi-disciplinary teams at tier 3 that meet local demands, and provide a sustainable service. Much depends on the local demography, demand and range of services available within the area.

3.27 No specific tier 3 service data are collected in the mapping as the original pilot study found that teams operated across tiers and within broad team types. Therefore local teams have been used as a proxy for tier 3 services as many deliver elements of tier 3 and all deliver to a defined local population.

3.28 Counting care staff only, the number of staff per 100k population in local CAMHS teams was 13.2 wte in 2007. This has increased steadily from 10.2 wte in 2004 to 11.7 wte per 100k in 2005 and 12.2k in 2006. A large degree of variation remains across SHA areas, ranging from 8.3 to 16.7 wte per 100k in 2006 and from 9.3 to 17.1 wte in 2007 (Fig. 3.10).

Fig. 3.10: Care staff in local teams per 100k total population for comparison with NSF estimates of tier 3 requirements 2006 and 2007



Chapter 4.

Service overview



Introduction

- 4.1 This section provides an overview of the services reported in the 2007 mapping exercise in order to set the scene for the following sections on progress being made towards meeting NSF standards. It reports the responses to a series of questions that were asked of all services for the first time in 2007 and therefore no comparative data is available from previous years. These questions focused on the users of the services by identifying:
- Who services were designed to support and whether services targeted particular children and young people on the grounds of age or vulnerability
 - Which Every Child Matters outcomes services were set up to achieve
 - Whether service users participated in service planning and delivery and providing feedback on their experiences
 - How children, young people and families found out about services.
- 4.2 The mapping findings reported in this section are as follows:
- Overview of child health, CAMHS and maternity services
 - Trends in the number of services mapped
 - Age range accepted in services
 - Targeting vulnerable groups
 - Achievement of Every Child Matters outcomes
 - Information and involvement
 - Involvement in service design
 - Collecting feedback from users of services
 - Publication of information about services.
- 4.3 In this chapter, the data is reported at a national level only. Detailed tables of the data used can be found and downloaded from the mapping website at: www.childrensmapping.org.uk/reports.

Overview of child health, CAMHS and maternity services

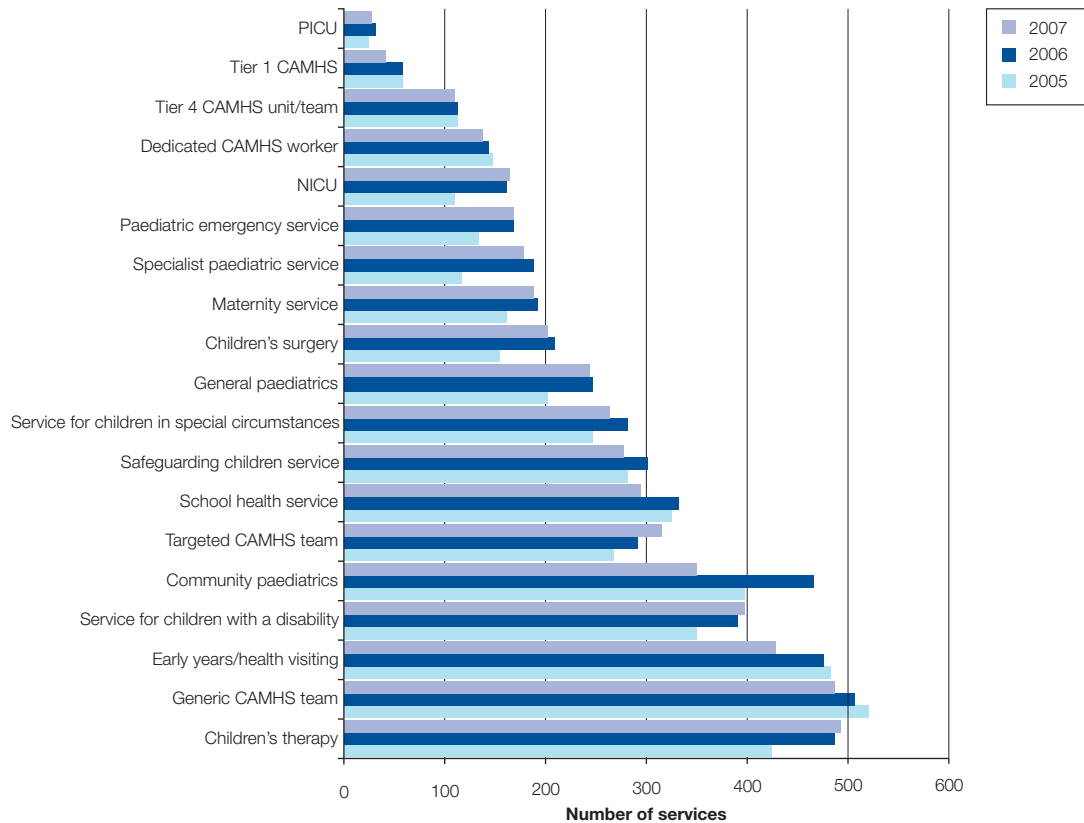
Trends in the number of services mapped

- 4.4 In 2007, the mapping exercise achieved returns from 4,813 child health, CAMHS and maternity services, a reduction of 5% from 5,057 in 2006. Changes were reported in the number of universal and targeted services mapped (see Appendix 3 for full list of service categories), the number of universal services declining by 11% and the number of targeted services by 6%. In contrast the number of maternity services (including neonatal services) and CAMHS teams reported remained stable.
- 4.5 A detailed breakdown of changes to service types shows that the number of services recorded in the mapping continued to fluctuate with many services showing a slight decline (Fig. 4.1). To have confidence in data on the number of services mapped, it is important to consider the rate of completion of the exercise. These were very high at over 90% and are presented for each service type in Appendix 1, Table 3b. In addition, information was collected on changes to the way services were mapped. Of the 4,813 services recorded, information on whether there was a change in the way the service was mapped in 2007 was

given by 4,500 services (93%). For 3,739 services (83%) no change was reported. For those services that had changed:

- 85 services (2%) were newly resourced during 2007
- 198 services (4%) were new to mapping having been missed previously
- 290 services (6%) had been mapped before but had been reconfigured during the previous 12 months
- 188 services (4%) had been mapped previously but described differently.

Fig. 4.1: Trends in the number of children's health, CAMHS and maternity services 2005 to 2007

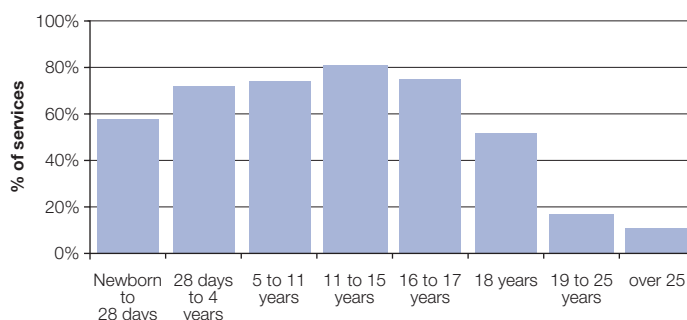


Age range accepted in services

4.6 Information about the age band of children and young people that services provide for was recorded by 4,539 services (94% of all services mapped). Of those services where age information was provided, 2,649 (55%) worked with newborn babies up to the age of 28 days and 242 of these services were provided for this group only. 3,246 services (72%) provided for pre-school aged children, 1,183 of which only provided for children under the age of 5. 3,376 services (74%) were provided for primary school-aged children and 3,665 (81%) for children and adolescents up to the age of 15 (Fig. 4.2). 329 services worked with a minimum age of eleven and 323 services worked with a maximum age of 15.

4.7 The majority of services were provided for young people up to the age of 17 and 18. 3,407 services (75%) included 16 and 17 year olds and 2,342 services (52%) were open to 18 year olds. Only 775 services (17%) provided for the 19 to 25 age group and 498 services (11%) for adults.

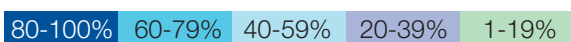
Fig. 4.2: The age of children and young people that services work with 2007 (N=4,539)



4.8 The age bands worked with varied by the type of service provided (Table 4.1) but almost all services worked with the whole spectrum of ages. With regard to services providing for adults over the age of 25, there was some ambiguity in the interpretation of the question asked. Some services may have included the carers and parents of children, for example, 10% of community paediatric services and some may have indicated that they were all-age services, such as, 46% of accident and emergency services and 20% of children’s surgery. There is also missing data. For example, it could be expected that 100% of neonatal services (NICU) provide for newborn babies, and so the information below should be read as indicative only.

Table 4.1: The age bands of children and young people that services work with by service type 2007 (N=4,539)

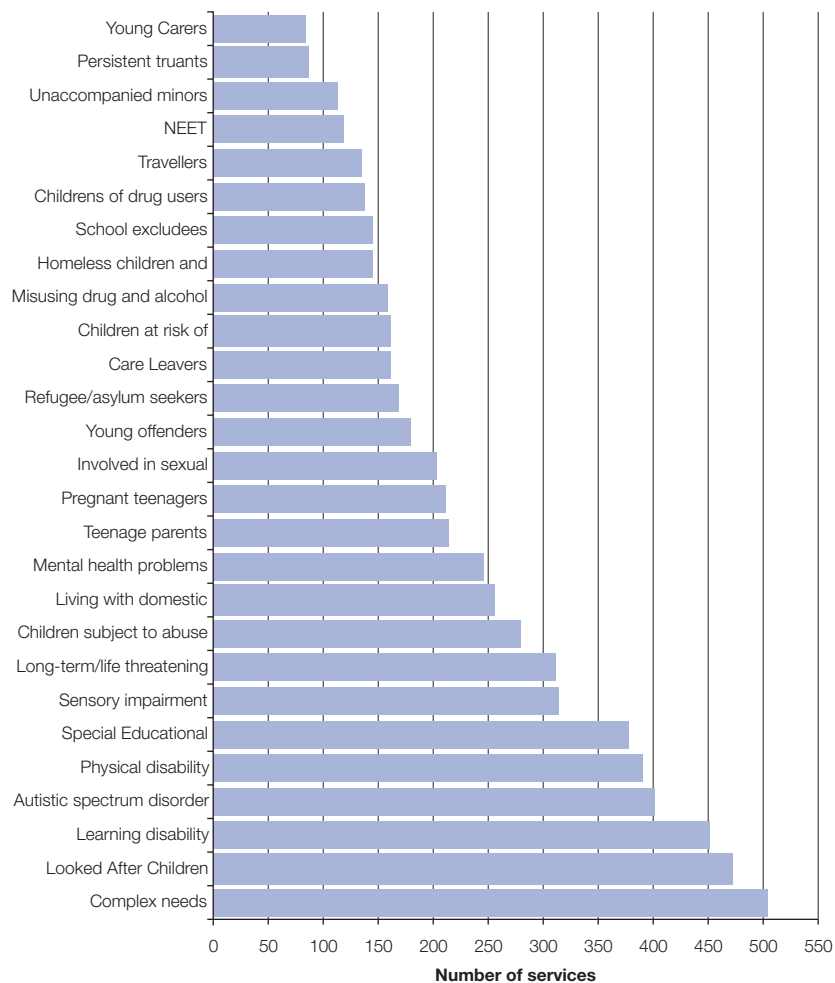
	Newborn to 28 days	28 days to 4 years	5 to 11 years	11 to 15 years	16 to 17 years	18 years	19 to 25 years	Over 25 years
NICU & SCBU	95%	55%						
Paediatric emergency service	92%	94%	94%	94%	78%	56%	46%	46%
Maternity service	89%	5%	3%	49%	56%	56%	53%	54%
Safeguarding children service	88%	87%	88%	88%	85%	54%	14%	6%
Early years and health visiting service	86%	92%	27%	23%	31%	29%	18%	16%
General paediatrics	86%	94%	94%	95%	74%	37%	5%	4%
PICU	76%	90%	86%	86%	76%	21%	3%	
Specialist paediatric service	69%	83%	85%	85%	74%	37%	14%	8%
Children’s therapy service	62%	85%	88%	87%	80%	63%	14%	7%
Community paediatrics	57%	73%	74%	80%	76%	61%	20%	10%
Service for children in special circumstances	55%	58%	64%	83%	82%	66%	31%	15%
Service for children with a disability	45%	78%	75%	72%	71%	57%	14%	5%
Children’s surgery	33%	86%	93%	93%	73%	42%	21%	20%
Multidisciplinary generic CAMHS	33%	69%	86%	89%	84%	42%	3%	1%
Single disciplinary generic CAMHS	22%	64%	83%	90%	72%	48%	12%	2%
Targeted CAMHS team	21%	52%	73%	85%	82%	49%	12%	3%
Dedicated CAMHS worker	20%	38%	67%	83%	73%	45%	7%	2%
Tier 1 CAMHS	14%	33%	48%	71%	67%	52%	24%	10%
School health service	5%	9%	84%	87%	80%	52%	7%	2%
Tier 4 CAMHS unit/team	5%	10%	40%	92%	74%	50%	8%	2%



Targeting vulnerable groups

4.9 In 2007, with changes made to the way in which information was collected on the targeting of services towards specific groups of vulnerable children and young people, 1,112 services reported that all or part of their activity targeted one or more groups. Of these, 503 services (45%) delivered targeted provision for children with complex needs. Children with a range of disabilities were the most commonly targeted groups (Fig. 4.3). 451 services (40%) provided specifically for children with a learning disability, 400 services (30%) for children with an autistic spectrum disorder, 389 services (35%) for children with a physical disability, 376 services (34%) for children with special educational needs (SEN), 314 services (28%) for children with a sensory impairment and 245 services (22%) for children with mental health problems.

Fig. 4.3: Vulnerable groups targeted by child health, CAMHS and maternity services 2007 (N=1,122)



4.10 Other groups targeted included:

- Looked after children (473 services) and care leavers (160 services)
- Children subject to abuse (260 services), children living with domestic violence (255 services) and children involved in sexual exploitation (202 services)
- Teenage parents (213 services) and pregnant teenagers (212 services)
- Young offenders (180 services) and children at risk of offending (160 services)
- Refugees and asylum seekers (170 services) and unaccompanied minors (114 services).

Achievement of Every Child Matters outcomes

4.11 In 2007, for the first time, all services were asked to indicate which of the 5 Every Child Matters outcomes they aimed to achieve. There was little consistency in response to the questions, some services indicating that they made a contribution to each outcome while others selected only the outcomes most closely linked to their specific service. However, the results give an indication of the contribution children's health services make to the children's agenda (Table 4.2).

Table 4.2: Percentage of services in each service type achieving Every Child Matters outcomes 2007

Service Type	Be healthy	Stay Safe	Enjoy and Achieve	Make a Positive Contribution	Achieve Economic Well-being
School health	88%	83%	77%	74%	38%
Early years/health visiting	92%	88%	81%	57%	57%
Children's therapy	84%	45%	76%	58%	31%
Service for disabled children	87%	69%	78%	58%	38%
Safeguarding children	60%	89%	29%	28%	18%
Service for children in special circumstances	85%	72%	57%	55%	39%
Tier 1 CAMHS	83%	69%	74%	74%	33%
Community paediatrics	85%	64%	59%	45%	22%
Children's surgery	87%	45%	22%	16%	6%
Specialist paediatrics	76%	55%	53%	37%	19%
PICU	79%	55%	24%	10%	10%
General paediatrics	93%	72%	46%	36%	17%
Paediatric emergency	89%	80%	17%	15%	5%
NICU/SCBU	86%	73%	8%	3%	8%
Maternity service	84%	71%	12%	18%	14%
Multidisciplinary generic CAMHS team	93%	71%	68%	74%	34%
Single disciplinary generic CAMHS team	88%	74%	60%	71%	21%
Targeted CAMHS team	93%	73%	70%	76%	33%
Dedicated CAMHS worker	92%	73%	76%	78%	33%
Tier 4 CAMHS	95%	75%	76%	78%	43%

Key: % of services of each type achieving ECM outcome

80-100%	60-79%	40-59%	20-39%	1-19%
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Information and involvement

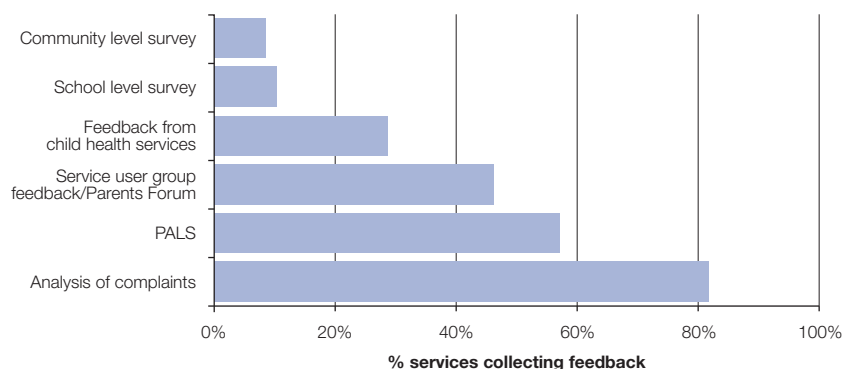
Involvement in service design

4.12 More than half of all child health, CAMHS and maternity services reported that they involved children, young people and/or parents and carers in the design, planning, development and delivery of their service. Again this information was collected for the first time in 2007 and so no comparisons can be made with previous years but 2,744 (57%) of the 4,813 services mapped reported that they encouraged some form of participation. Of these, 1,856 (68%) involved children and young people and 2,371 (86%) involved parents and carers. 1,717 services (63%) carried out one-off, issue-based consultations, 1,544 (56%) maintaining on-going dialogue on specific service developments and 716 (26%) implementing a participation strategy that set out a plan for on-going involvement throughout the service.

Collecting feedback from users of services

4.13 3,628 services (75%) reported that they collected feedback from children, young people and families on their satisfaction with services. However, the most common ways in which this was obtained was from analysis of complaints and from monitoring carried out by the Patient's Advice and Liaison Service (PALS). Of the services that did collect feedback, 2,970 (82%) analysed complaints and 2,079 (57%) used PALS records (Fig. 4.4). 1,047 services (29%) collected feedback from child health services, 367 (10%) obtained feedback through school-based surveys and 314 (9%) carried out community-based surveys.

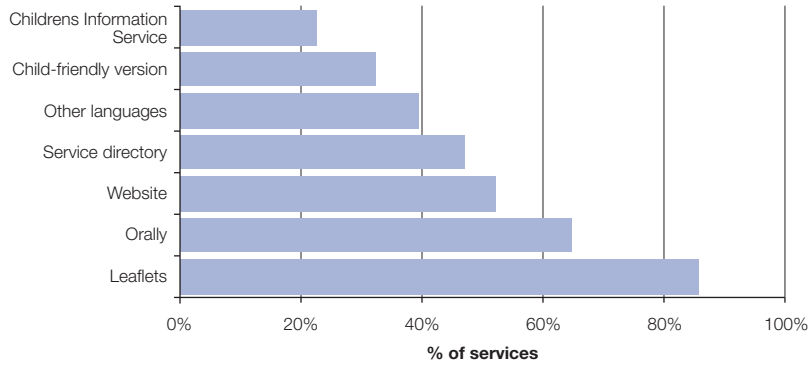
Fig. 4.4: Methods of collecting feedback on satisfaction with services 2007 (N=3,628)



Publication of information about services

4.14 4,073 services (85% of all services) reported the methods used to provide information for children, young people, families, carers and the wider community about the services provided. Of the services providing information, 3,495 (86%) used leaflets, 2,127 (52%) used internet websites, 1,915 (47%) used local service directories and 924 (23%) used their Children's Information Service (Fig. 4.5). Word-of-mouth was an important method of dissemination in 2,639 services (65%). 1,325 services (33%) had produced child-friendly versions of information and 1,609 provided translation of materials in other languages. Only 484 services (12%) relied on just one method, the majority of services using three to five different methods to get their message across.

Fig. 4.5: Methods used for informing children, young people, families, carers and the wider community about services 2007 (N=4,073)



Chapter 5.

Delivering NSF Standard 1:

Promoting health and well-being, identifying needs and intervening early



Introduction

Standard 1

“The health and well-being of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS in partnership with local authorities.”

National Service Framework for Children, Young People and Maternity Services

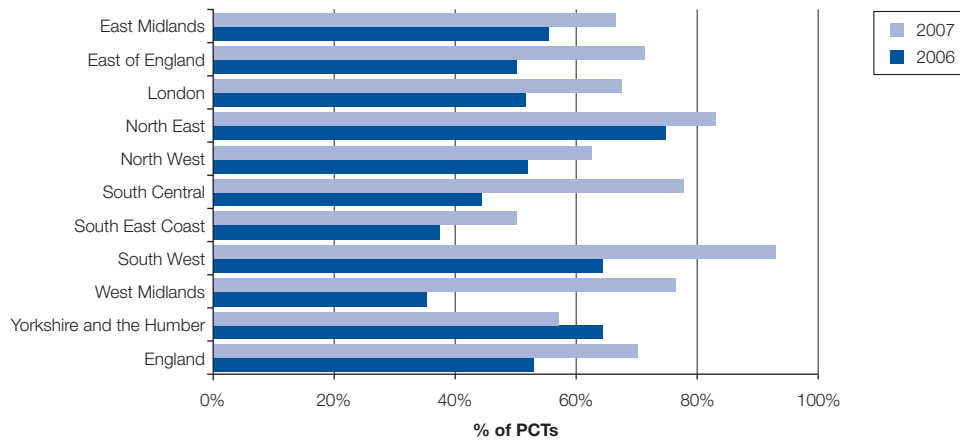
- 5.1 In addition to Standard 1 of the NSF, other key policies of relevance include the White Paper, Choosing Health⁵, the Chief Officers Nursing Review⁶, the updated Child Health Promotion Programme (CHPP)⁷ and Every Child Matters, in particular the ‘Being Healthy’ outcome. All emphasise the importance of the delivery of broad programmes of support for children and families that will help address wider determinants of health and reduce health inequalities where possible.
- 5.2 This section reports mapping findings most related to this theme, as follows:
- PCT provision of a public health strategy
 - Completion of child health needs assessments
 - PCT child health promotion programme
 - Public health advice and immunisation
 - Qualified school nurse provision

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

PCT provision of public health strategy

- 5.3 Since PCTs were given responsibility for public health in the NHS in 2003, they have played an important role in leading the development of local strategies and initiatives to improve the health and wellbeing of their communities. Given the importance of public health for children, young people and families, the mapping exercise included a question for PCT commissioners on whether they had an agreed public health strategy that clearly explains how the public health needs of children and young people will be met as set out in Choosing Health⁸. In 2005, when there were 303 PCTs nationally, 64% of responding PCTs had a public health strategy in place. In 2006, after the reconfiguration of PCTs reduced the number to 152, the proportion with a strategy covering the new PCT areas had declined to 52% but many PCTs reported work in progress and by 2007, 70% of PCTs reported a completed, PCT-wide, up-to-date public health strategy in place. Across SHAs, the proportion of PCTs with a public health strategy ranged from 50% to 93% (Fig. 5.1).

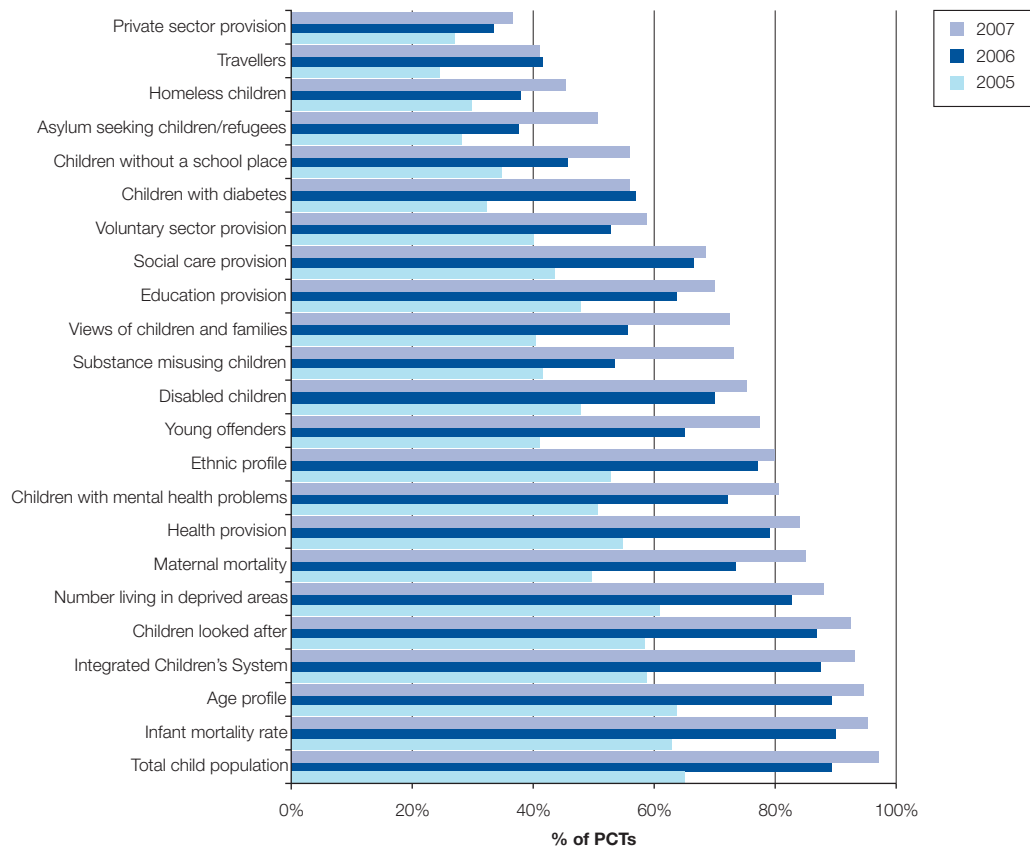
Fig. 5.1: Proportion of PCTs in SHAs with a completed public health strategy in place 2006 and 2007



Completion of child health needs assessments

5.4 In 2007, 131 PCTs (86%) had completed a fully comprehensive child health needs assessment, strong progress from the previous year when only 72 PCTs (47%) had a completed needs assessment in place. The elements included in strategies had also increased (Fig. 5.2). The most commonly included elements were demographics, infant mortality and deprivation analysis, and assessment of the needs of vulnerable groups, such as, looked after children and children on the child protection register.

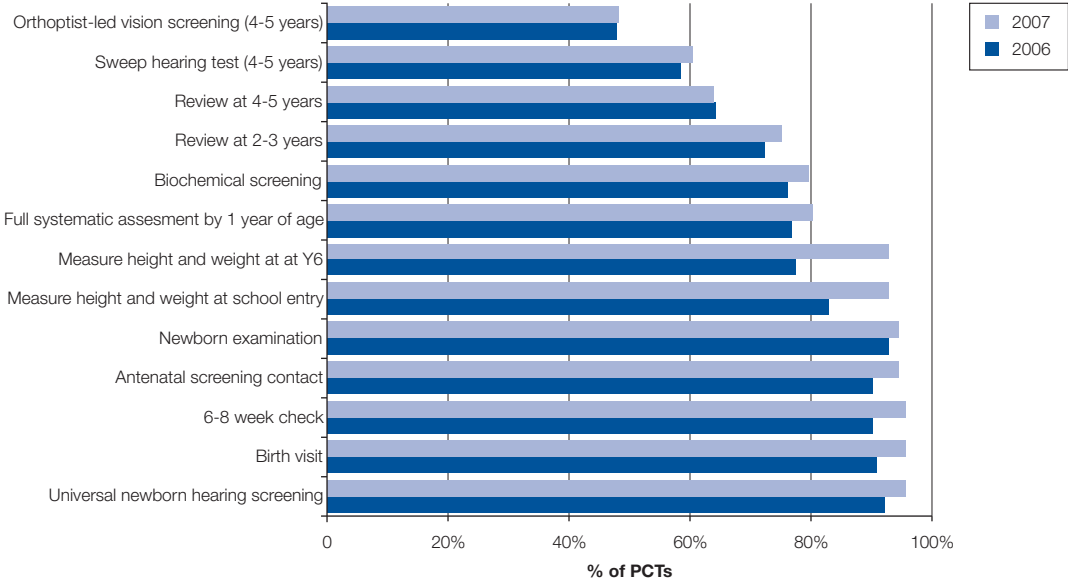
Fig. 5.2: Percentage of PCTs completing elements of a child health needs assessment 2005 to 2007



PCT child health promotion programme

- 5.5 The NSF requires PCTs to ensure a Child Health Promotion Programme is offered to all children that is personalised and appropriate to meet the needs of the child and family. This acknowledges that more support should be available for children and families who are vulnerable or have complex needs. The programme should also try to counteract low take up by actively encouraging participation.
- 5.6 With this policy framework in mind, PCTs were asked if they commissioned appropriate screening and other health promotion programmes for their whole population. A high rate of provision was found with over 95% of PCTs having arrangements in place for antenatal screening, the examination of newborns, birth visits, neonatal hearing screening and 6-8 week checks. The proportion of PCTs with arrangements for the measurement of height and weight when children enter school had risen from 83% to 93% since 2006 and the proportion with arrangements for the measurement of height and weight of children in year 6 had risen from 78% to 93% (Fig. 5.3). However, only 48% of PCTs reported that they had arrangements in place for a vision screening programme for 4 to 5 year olds and 61% for Sweep hearing tests for this age group.

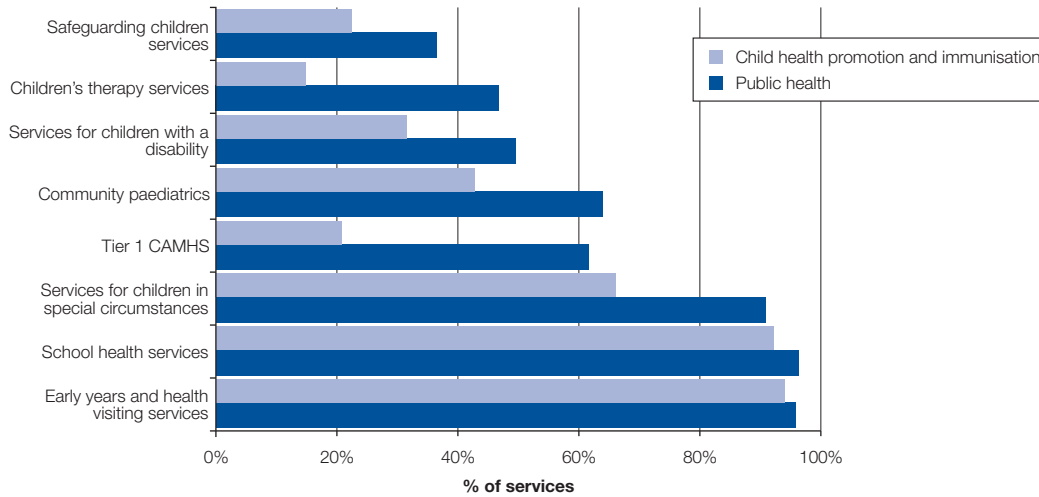
Fig. 5.3: PCTs reporting childhood screening programmes in place 2006 and 2007



Public health advice and immunisation

- 5.7 Almost all school health services and early years and health visiting services reported having a focus on the provision of public health, health promotion and immunisation (Fig. 5.4). Services for children in special circumstances also reported the importance of this work with 91% providing public health and 66% providing immunisation and health promotion advice and support. ‘Targeted’ services were less likely to deliver immunisation programmes or health promotion but public health was a focus for 64% of community paediatric services, 49% of services for children with a disability and 47% of children’s therapy services.

Fig. 5.4: Percentage of universal and targeted services reporting a focus on public health, health promotion and immunisation 2007 (N=1,238)



Qualified school nurse provision

To address the shortfall in nursing provision for the school aged child, PCTs, children's trusts and local authorities are encouraged to work towards having at a minimum, one full-time, all year round, qualified school nurse for each school cluster or group of primary schools and its secondary school taking account of health needs and school population.

Chief Nursing Officer's review of the nursing, midwifery and health visiting contribution to vulnerable children and young people

- 5.8 Since 2005, the child health mapping exercise has sought to collect data on the number of qualified school nurses employed per cluster of schools. That is nurses who have completed the specialist community public health nurse (school nursing) qualification. However, this has proved difficult as the concept of a school cluster is differently understood by services and the definition provided on the mapping website was insufficient to establish consistency in the way information was recorded. With the aim of improving the accuracy of data, the method of collecting the number of school clusters was altered in 2007 with PCTs instead of services being asked to provide the information but this resulted in only 70% of PCTs responding to the question. Consequently, rate of school nurse per school cluster cannot be reported for 2007.
- 5.9 The number of qualified school nurses working in the child health workforce increased from 2,414 wte in 2006 to 2,759 wte in 2007. Almost 80% of this workforce was employed in school health services. The number of qualified school nurses rose by 26% between 2005 and 2006 from 1,561 wte to 1,976 wte and by 8% between 2006 and 2007 when 2,137 wte were recorded.

Chapter 6.

Delivering NSF Standard 2: Supporting parenting



Standard 2

Parents or carers are enabled to receive the information, services and support that will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.

National Service Framework for Children, Young People and Maternity Services

Introduction

6.1 This section reports the findings most related to this theme, as follows:

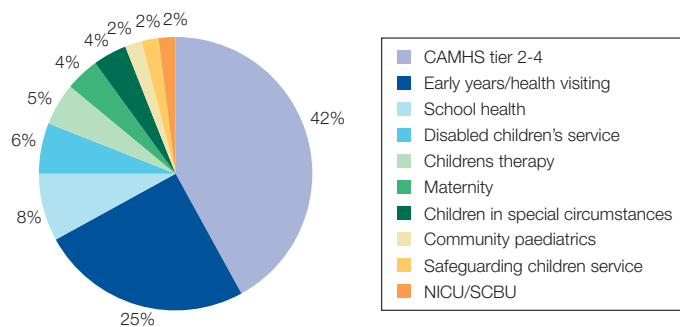
- Provision of parenting programmes
- Health and lifestyle advice for parents

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

Provision of structured parenting programmes

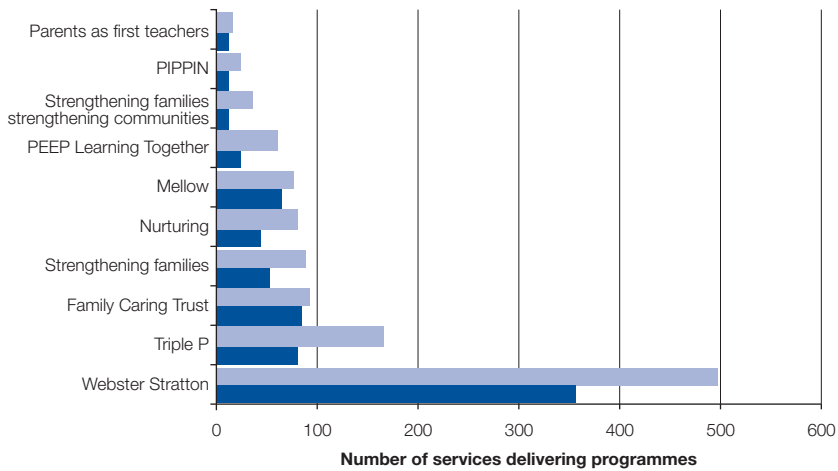
6.2 There was 38% growth in the provision of structured parenting programmes between 2006 and 2007 with the number of services providing a programme increasing from 804 to 1,112. 42% of services providing programmes were CAMHS and 25% were early years and health visiting services (Fig. 6.1).

Fig. 6.1: Types of services providing structured parenting programmes 2007 (N=1,112)



6.3 The most frequently used programme was Webster Stratton which was used by 496 (45%) services. Triple P was used by 165 services (15%) and Family Caring Trust by 91 services (8%). The use of other programmes remained low but was growing (Fig. 6.2).

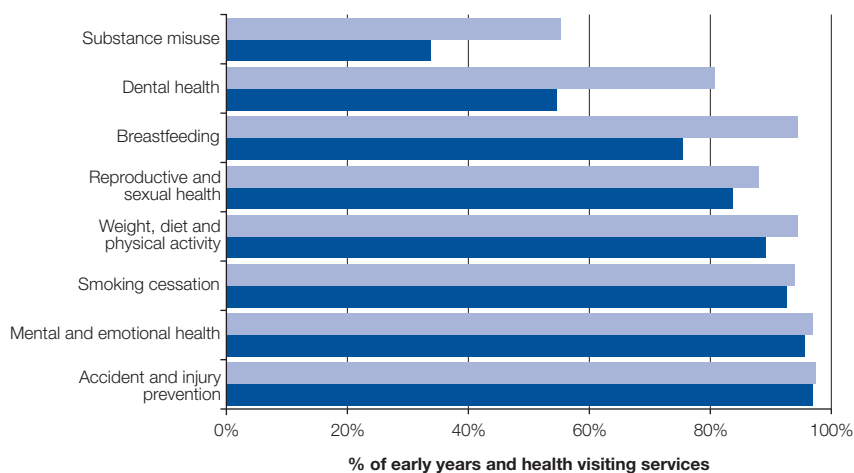
Fig. 6.2: Parenting programme provision 2006 and 2007



Health and lifestyle advice for parents

6.4 Early years and health visiting services play a key role in providing parents with public health and lifestyle information and advice. 97% of services reported a focus of their work was on ensuring the safety of children and parents and on accident and injury prevention (Fig. 6.3). A focus on the mental health and emotional wellbeing of children and parents, particularly of mothers with young babies, was also reported by 97% of services. 95% of services provided advice on nutrition, weight and exercise, 94% on smoking cessation. In 2007, 94% of services reported a focus on breastfeeding compared to 76% in 2006. Increases in the number of services providing a focus on dental health and substance misuse were also reported.

Fig. 6.3: Health promotion for parents provided through early years and health visiting services 2006 and 2007



Chapter 7.

Delivering NSF Standard 3: Child, young person and family-centred services



Standard 3

Children and young people and families receive high quality services which are co-ordinated around their individual and family needs and take account of their views.

National Service Framework for Children, Young People and Maternity Services

Introduction

7.1 This section reports mapping findings most related to this theme, as follows:

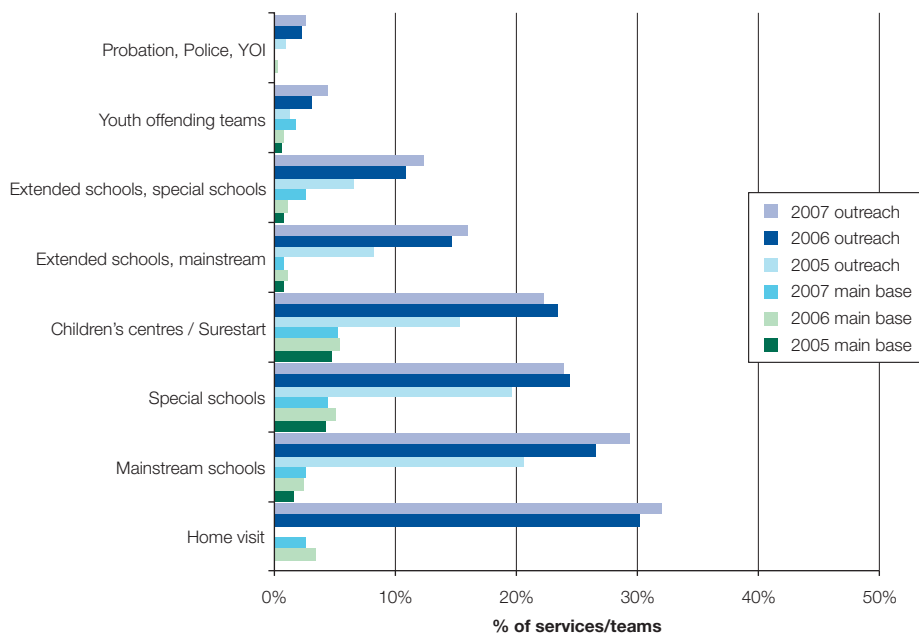
- Improving access to children’s health services

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

Improving access to children’s health services

7.2 Continued progress was recorded in the provision of children’s health services in settings that are convenient to children, young people and their families. While little change was found in the location of the administrative base of services, they were found to be working into a wider range of settings. 36% of services were providing home visits, 33% were working in schools, 27% were reaching into special schools and 25% were working in Sure Start Children’s Centres (Fig. 7.1).

Fig. 7.1: Trends in the development of child health, CAMHS and maternity services in a range of community settings 2005 to 2007



Chapter 8.

Delivering NSF Standard 4:

Growing up into adulthood



Standard 4

All young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood.

National Service Framework for Children, Young People and Maternity Services

Introduction

8.1 This section reports mapping findings most related to this theme, as follows:

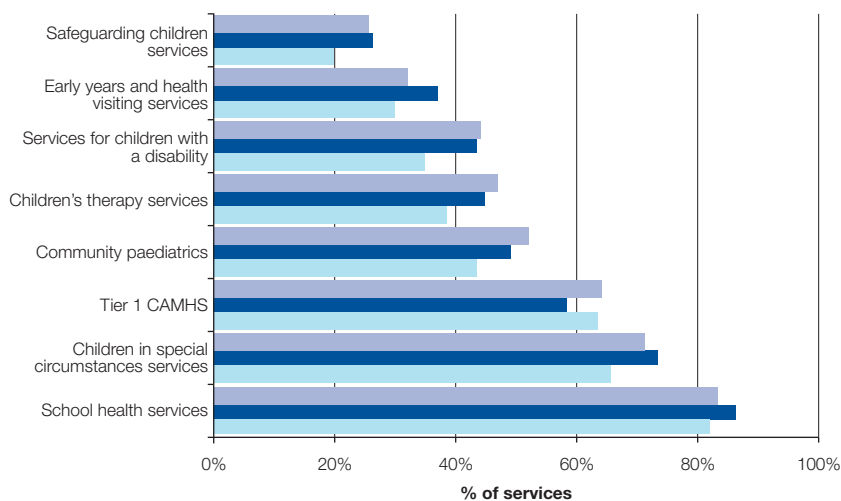
- Services for adolescents and young people
- Transition arrangements
- Promoting a healthy lifestyle for young people

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

Services for adolescents and young people

8.2 Working with adolescents was a focus of work for over 80% of school health services and over 70% of services for children in special circumstances, many of which were supporting looked after children and children leaving the care system (Fig. 8.1).

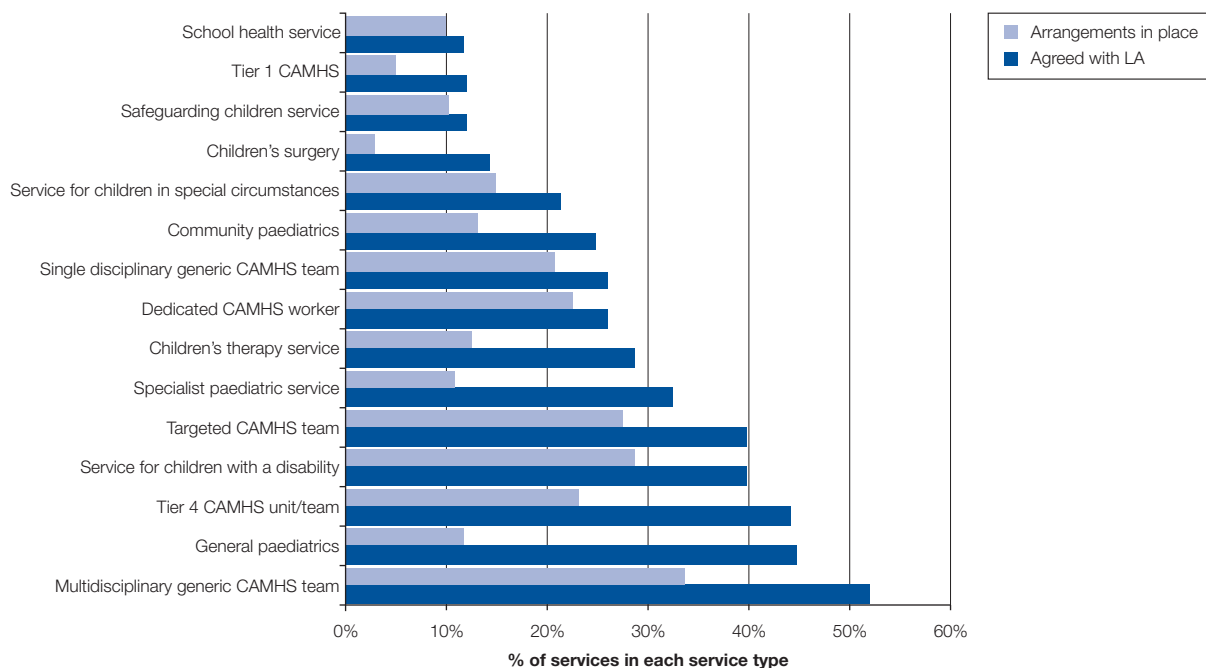
Fig. 8.1: Services reporting a focus of work with adolescents and young people 2005 to 2007



Transition arrangements

8.3 All services which indicated that they worked with young people aged 16 and over were asked if they had transition arrangements in place to support young people transferring to adult services where appropriate. 1,203 services reported having transition arrangements and 697 (58%) of these had agreed the arrangements with the relevant local authorities. CAMHS and services for children with a disability were the most likely to have transition arrangements and to have agreed them with the LA (Fig. 8.2). General, specialist and community paediatric services had arrangements in between 25% and 45% of services but less than 15% had agreements with the LA.

Fig. 8.2: Provision of transition arrangements by service type 2007 (N=1,203)



Promoting a healthy lifestyle for young people

8.4 Services were asked if their provision for children, young people and families had a focus on promoting a healthy lifestyle and it is likely that school health services and other services that focus on lifestyle issues such as substance misuse, smoking cessation and sexual health are mainly targeted at adolescents. Sexual health and the prevention of teenage pregnancy was a concern of 96% of school health services, 90% of services for children in special circumstances and 65% of safeguarding services (Table 8.1). Help with smoking cessation was provided by 91% of school health services and 75% of services for children in special circumstances. Support and advice on substance misuse was provided by 75% of school health services and 68% of services for children in special circumstances. Advice on healthy weight and physical activity was provided by 96% of school health services, 76% of services for children in special circumstances and 79% of services for children with disabilities.

Table 8.1: Percentage of school health and targeted services with a focus on promoting a healthy lifestyle for children and young people 2007 (N=1,912)

Type of service	Breastfeeding	Mental and emotional health	Sexual health / preventing teenage pregnancy	Accident and injury prevention	Smoking cessation	Substance misuse	Weight, diet and physical activity
School health services	19%	96%	96%	90%	91%	75%	96%
Services for children in special circumstances	30%	88%	90%	71%	75%	68%	76%
Safeguarding children services	23%	78%	65%	76%	36%	59%	43%
Services for children with a disability/special needs	8%	85%	44%	68%	26%	15%	79%
Community paediatrics	16%	60%	35%	43%	24%	23%	67%
Tier 1 CAMHS	13%	96%	57%	30%	30%	44%	35%
Children's therapy services	12%	37%	1%	33%	8%	1%	65%

Chapter 9.

Delivering NSF Standard 5: Safeguarding and promoting the welfare of children and young people



Standard 5

All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

National Service Framework for Children, Young People and Maternity Services

Introduction

9.1 In 2007, the mapping exercise expanded its collection of information on safeguarding to record the arrangements in place in NHS organisations for the delivery of Working Together to Safeguard Children⁹. Little comparative data is available from previous years but this established a baseline against which future findings can be measured.

9.2 This chapter reports the following:

- PCT responsibilities
 - Provision of designated staff
 - Safeguarding standards in commissioning contracts
- NHS provider trust responsibilities
 - Safeguarding lead on Trust Board
 - Availability of named professionals for safeguarding
 - Provision of examination and assessment for suspected physical abuse
 - Provision of examination and assessment for suspected sexual abuse
- Provision of dedicated safeguarding services
 - Protocols for responding to children suspected of experiencing violence or abuse

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

PCT responsibilities

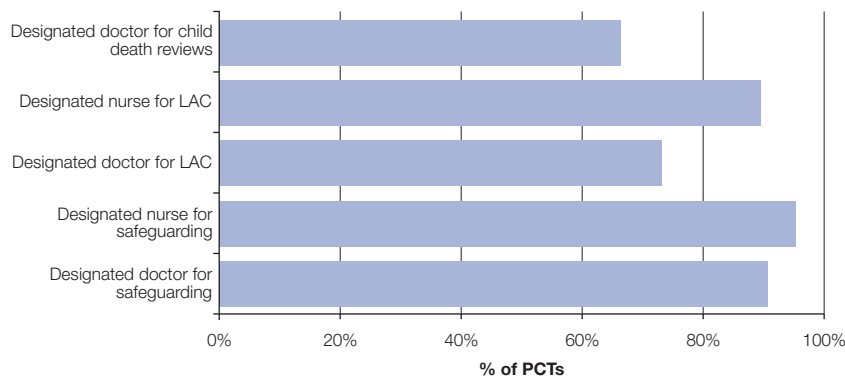
Provision of designated staff

9.3 PCTs are responsible for identifying a senior paediatrician and senior nurse to undertake the roles of designated professionals for safeguarding children across the health economy. Designated doctors and nurses should provide a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the area that they serve, including all health providers working within the PCT area. Designated professionals should also work with the Local Safeguarding Children's Board (LSCB) and ensure appropriate information sharing between key agencies. Of the 152 PCTs, 138 (91%) reported having a designated doctor for safeguarding in post and 145 (95%) had a designated nurse for safeguarding. All except one designated doctor were paediatricians, the exception being a GP. All designated nurses were on senior staff grades.

9.4 101 PCTs (66%) had a designated doctor for child death reviews in post although this did not become a national requirement until April 2008, 2 months after the mapping data collection closed. An additional 10 PCTs reported having plans to appoint by the April deadline.

9.5 PCTs are also expected to have designated staff to work with local Councils with Social Services Responsibilities (CSSRs) to ensure that the health needs of looked after children (LAC) are met. These designated doctors and nurses should provide strategic and clinical leadership and advice to defined (PCT) populations. However, only 70% of PCTs across the country reported having a designated doctor for LAC with 88% reporting a designated nurse for LAC (Fig. 9.1).

Fig. 9.1: PCT provision of designated staff for safeguarding, child death reviews and looked after children 2007 (N=152)



Safeguarding standards in commissioning contracts

9.6 PCTs are expected to ensure that safeguarding and promoting the welfare of children are integral to clinical governance and audit arrangements. Therefore, service specifications drawn up by PCT commissioners should include service standards for safeguarding. 108 PCTs (71%) reported that standards for safeguarding were specified in commissioning contracts for children's health services and of these PCTs, 94 (87%) ensured the standards were monitored.

NHS provider trust responsibilities

Safeguarding lead on Trust Board

9.7 NHS trusts and NHS Foundation Trusts are statutory partners with local authorities in establishing and operating Local Safeguarding Children Boards (LSCBs) and should share responsibility for the effective discharge of LSCB functions in safeguarding and promoting the welfare of children. In order to carry out these functions, representation on the LSCB should be at an appropriately senior level, and in the 2007 mapping exercise, provider trusts were asked about this leadership. Of the 363 NHS trusts providing child health, CAMHS or maternity services, 341 (94%) reported having a safeguarding lead on the Trust Board and 259 of these (76%) were members of the LSCB.

Availability of named professionals for safeguarding

9.8 All PCTs and NHS trusts are required to identify a named doctor and a named nurse (or midwife) who will have a key role promoting good professional practice within the trust, and providing advice and expertise for fellow professionals. They should have specific expertise in children's health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

9.9 Of the 363 NHS providers of child health, CAMHS and maternity services, 326 (90%) reported having a named doctor for safeguarding in post, 338 (93%) a named nurse, and 174 (48%) a named midwife (Table 9.1). In all, there were 448 named doctor posts. In 241 (66%) provider trusts, the named doctor role was filled by a single doctor, in 46 provider trusts (13%) the role was shared between two doctors and in the remaining 41 (11%) it was shared between 3 or more doctors. 313 (70%) named doctors were paediatricians but GPs, child and adolescent psychiatrists and a range of other specialists also fulfilled the role, often working in partnership with paediatricians.

Table 9.1: Provision of named professionals for safeguarding 2007

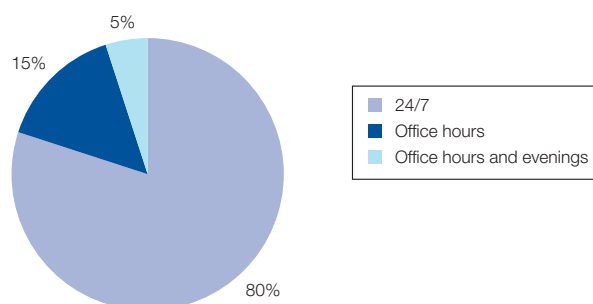
Type of service	Trusts with named professionals	% of trusts providing child health services	Number of staff
Named doctor	326	90%	448 (headcount)
Named nurse	338	93%	466 wte
Named midwife	174	48%	136 wte
Total PCTs and other child health, CAMHS and maternity service providers	363		

Provision of examination and assessment for suspected physical abuse

9.10 146 PCTs (96%) reported that they had arrangements in place for the provision of specialist assessments and examinations of children referred for suspected physical abuse. In 68 PCTs (47%) this was provided by the PCT themselves, often in partnership with other NHS trusts. In total, 90% of PCTs commissioned with NHS trusts to provide the assessments and examinations. Only 16% of PCTs had arrangements with tertiary centres.

9.11 220 PCTs and provider trusts provided the specialist assessments. Of these services, 80% were available on a 24/7 basis, 5% in the daytime and evening and 15% within normal office hours only (Fig. 9.2). The service was provided by the on-call general paediatrician rota in 77% of services, by a specific paediatric child abuse rota in 40%, A&E staff in 15% and by the medical examiner in 8% (some services indicated more than one type of rota in use).

Fig. 9.2: Availability of specialist assessments and examination of suspected physical abuse 2007 (N=220)

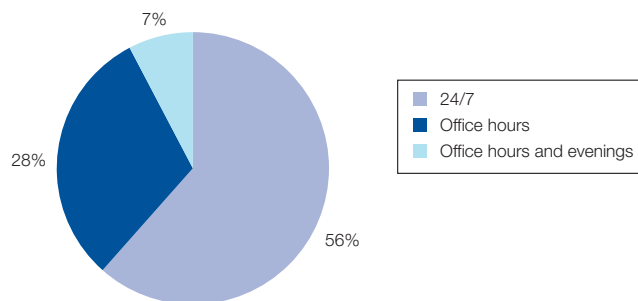


Provision of examination and assessment for suspected sexual abuse

9.12 75% of PCTs had arrangements with other NHS provider trusts for the provision of specialist assessment and examinations of children referred for suspected sexual abuse. 44% of PCTs provided, or contributed to, the service themselves and 22% of PCTs had arrangements with specialist children's tertiary centres.

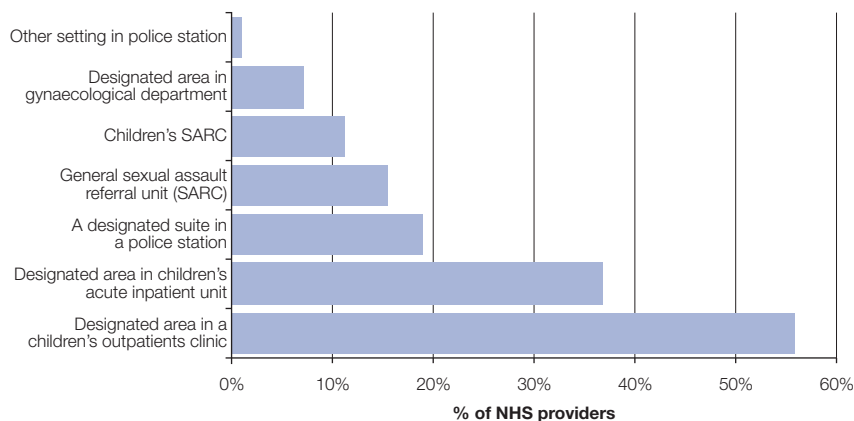
9.13 178 PCTs and provider trusts provided specialist medical examinations for suspected sexual abuse. Of these services, 56% were available on a 24/7 basis, 7% in the daytime and evening and 28% within normal office hours only (Fig. 9.3). The service was provided by a specific paediatric child sexual abuse rota in 52% of services, by the on-call general paediatrician rota in 47% of services, by the medical examiner in 35% and by A&E staff in 6%. Assessments and examinations were always carried out by two doctors in 34% of services, by one doctor in 14% and by sometimes one and sometimes two in 51%.

Fig. 9.3: Availability of specialist assessments and examination of suspected sexual abuse 2007 (N=178)



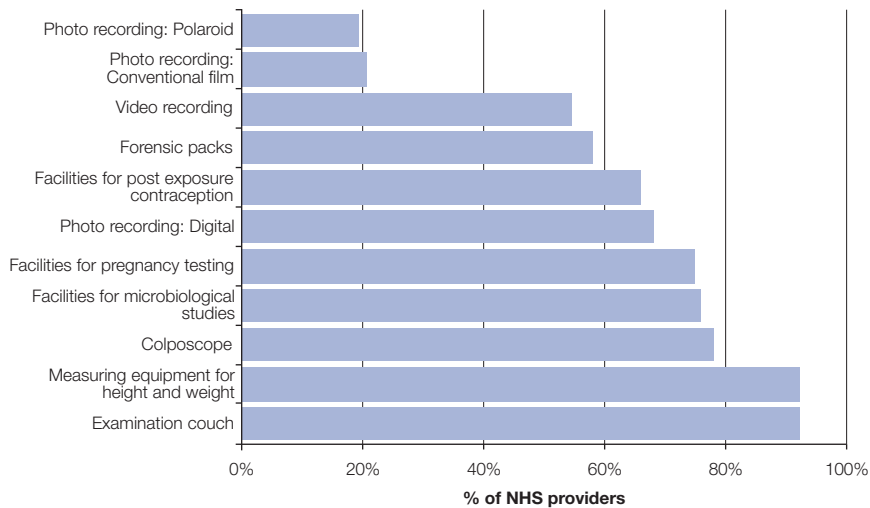
9.14 Examinations were carried out in more than one location in many services with 57% being carried out in designated areas in children's outpatient departments, 39% in a designated area in children's acute inpatient units, 20% in a designated suite in a police station, 16% in a general sexual assault referral unit (SARC) and 13% in a children's SARC (Fig. 9.4). An additional 7% of services used designated areas in the gynaecological department and 1% used other settings in police stations.

Fig. 9.4: Location of specialist assessments and examination of suspected sexual abuse 2007 (N=178 NHS providers)



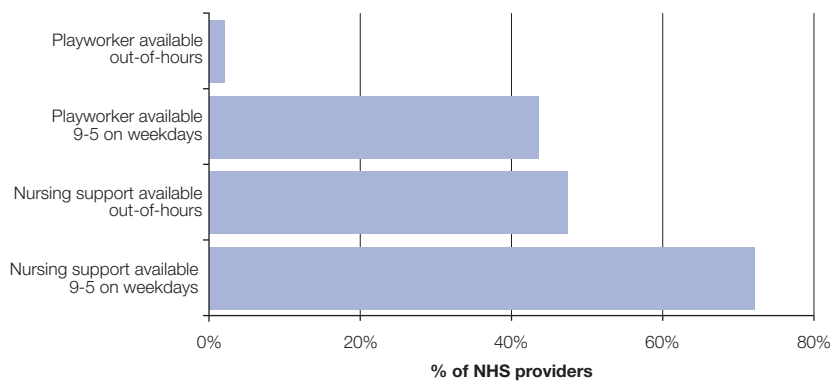
9.15 The availability of equipment for specialist examinations of suspected sexual abuse varied, with 83% of services having access to a colposcope, 80% to microbiological studies, 79% to pregnancy testing and 73% to digital photographic recording (Fig. 9.5).

Fig. 9.5: Equipment available for specialist assessments and examination of suspected sexual abuse 2007 (N=178)



9.16 Nurses were available to support children and young people during assessments and examinations for suspected sexual abuse in 73% of services during office hours but only 51% of services on a 24/7 basis (Fig. 9.6). Play workers were available in 46% of services during the day and in only 2% out-of-office hours.

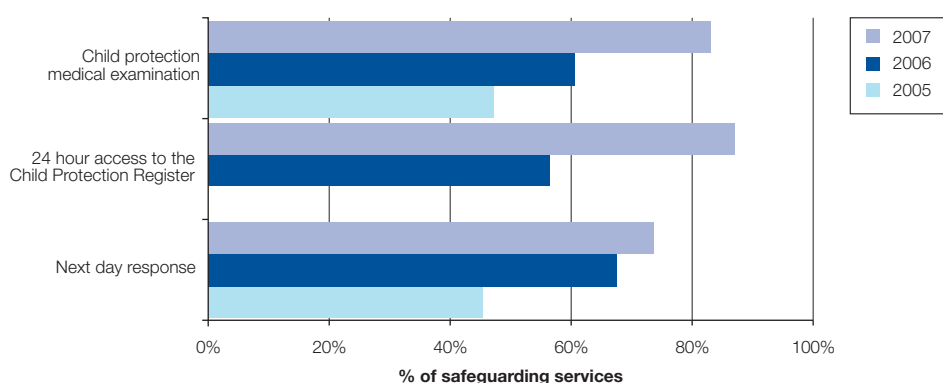
Fig. 9.6: Availability of nurses and play workers during specialist assessments and examination of suspected sexual abuse 2007(N=178)



Provision of dedicated safeguarding services

9.17 The number of dedicated safeguarding services mapped in 2007 dropped to 277 from 303 in 2006 but the workforce increased from 1,150 wte in 2006 to 2,045 wte in 2007. Many of these services did not provide a direct service to children or young people but contributed to the safeguarding infrastructure in NHS trusts through running child protection training programmes, providing professional leadership and input into interagency strategic planning and development. Consequently, only 83% of safeguarding services provided medical examinations for children referred for suspected abuse and 87% of services had access to the child protection register (Fig. 9.7).

Fig. 9.7: Features of safeguarding services 2005 to 2007



Protocols for responding to children suspected of experiencing violence or abuse

9.18 All child health, CAMHS and maternity services were asked if they had protocols in place for identifying and responding to children and young people who are victims of physical, emotional and sexual abuse or neglect and domestic violence. 4,195 services (86%) reported that they had a protocol in place. In 3,704 of these services (88%) the protocols required staff to respond to unsolicited information and in 3,078 services (73%) staff were required to actively enquire where abuse was suspected. Almost 100% of services recorded and referred on when abuse was suspected. 4,179 services reported that they made a formal record of information gathered and 4,186 services refer on to other agencies where appropriate. A preventative or therapeutic service was provided in 2,079 services (50%).

Chapter 10.

Delivering NSF Standards 6 and 7:

Children and young people who are ill and children and young people in hospital



Standard 6 – Children and Young People who are ill

All children and young people who are ill, or thought to be ill, or injured will have timely access to appropriate advice and to effective services which address their health, social, educational and emotional needs throughout the period of their illness.

Standard 7 – Children and Young People in Hospital

Children and young people receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings.

National Service Framework for Children, Young People and Maternity Services

Introduction

10.1 In addition to the NSF, other policy that has influenced hospital care includes the Kennedy Report¹¹, the NSF for Long Term Conditions¹², the Children Act (1989 and 2004), the Paediatric and Congenital Cardiac Services Review¹³ and the Neonatal Intensive Care Review - Strategy for Improvement¹⁴. All stress the importance of child friendly hospital care that provides appropriately for all levels of need, whether it is around seeking help in emergencies or the provision of on-going support for complex conditions, surgery or acute illness or intensive care.

10.2 This section reports the mapping findings related to this theme, as follows:

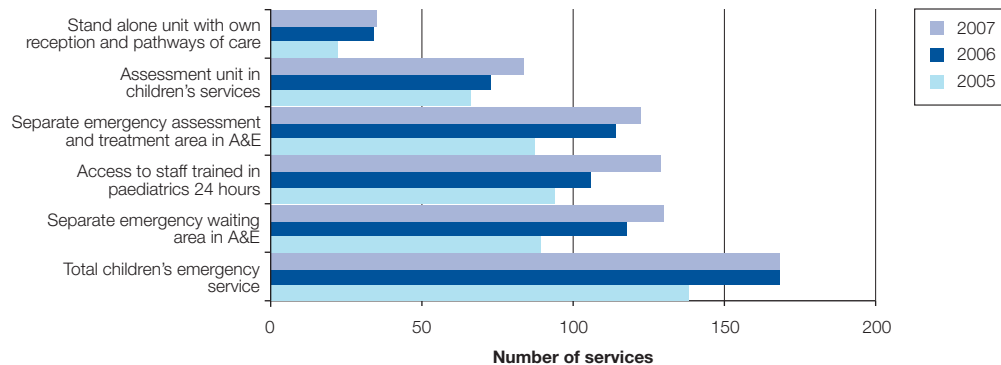
- Characteristics of paediatric emergency care services
- Models of care in general paediatric services
- Diabetes services delivered through general paediatrics
- Paediatric surgery
- Specialist paediatric services
- Networks of care for critically ill children

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

Characteristics of paediatric emergency care services

10.3 169 children's emergency services were reported in both 2006 and 2007. In 2007, this included one new stand alone emergency care unit designed specifically for children with its own reception and pathways of care. Considerable progress in the development of child-friendly accident and emergency (A&E) facilities was also reported (Fig. 10.1). The number of units that were part of A&E but had a separate waiting area for children had risen from 118 in 2006 to 130 in 2007; the number with 24/7 access to staff trained in paediatrics had risen from 106 in 2006 to 129 in 2007; and the number of A&E departments with separate emergency assessment and treatment areas for children had risen from 114 in 2006 to 123 in 2007.

Fig. 10.1: Trends in the development of paediatric emergency services 2005 to 2007

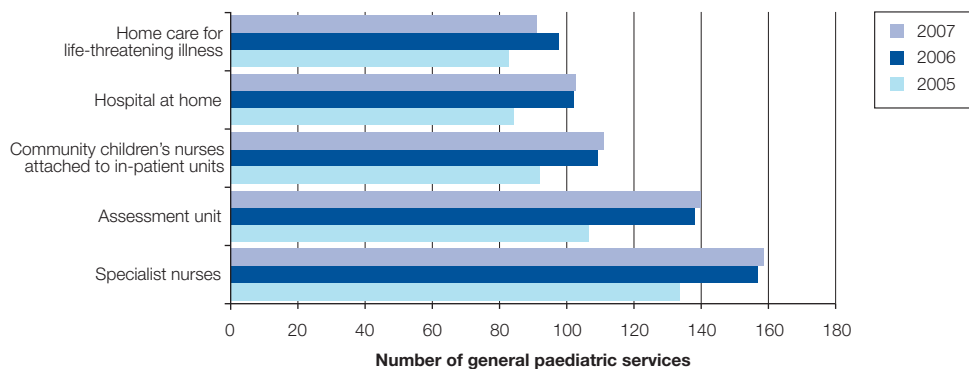


Models of care in general paediatric services

10.4 Key policy emphasises the importance of bringing hospital services as close as possible to the child and family. To achieve this, hospital services are expected to increase their accessibility by extending into the community and ensuring better links between hospital and home. The mapping exercise examined progress in general paediatric services developing a range of models of care, including inpatient and outpatient care and a range of alternatives to hospital admissions.

10.5 The number of general paediatric services mapped remained fairly static with 246 in 2006 and 242 in 2007. There was little change in the provision of alternative models of inpatient care in general paediatric services (Fig. 10.2). The most commonly provided alternative was specialist nursing provision that was reported in 159 services in 2007 (up from 157 in 2006). 140 services had specialist assessment units (up from 138 in 2006) and in 111 services community children's nurses were attached to inpatient units to make links between home and hospital for children and their families (up from 109 in 2006). The number of hospital at home services increased by 1 to 103 in 2007. These provided home nursing teams who supported children with acute, long term or complex health care needs traditionally cared for in hospital. The number of general paediatric services providing home care for children with life threatening illnesses enabling children to stay at home when they might previously have been admitted to hospital, dropped slightly from 98 in 2006 to 91 in 2007.

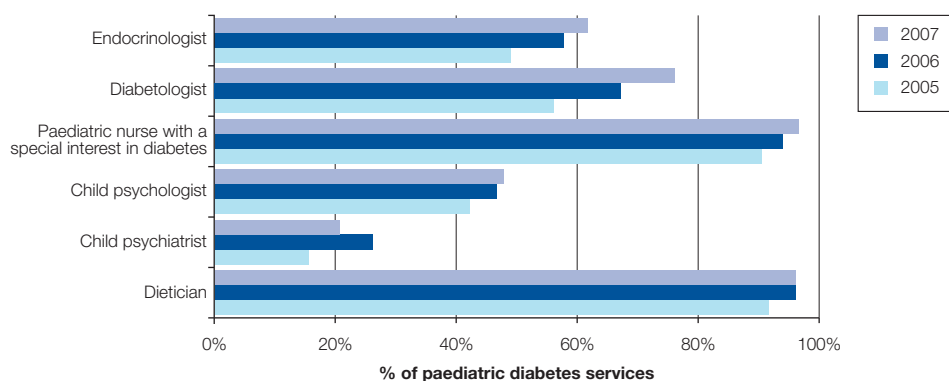
Fig. 10.2: Trends in models of care in general paediatrics 2005 to 2007



Diabetes services delivered through general paediatric services

- 10.6 Standards on the clinical care of children and young people with diabetes can be found in the NSF for Diabetes¹⁵. The children's section focuses on early clinical assessment and management, continuity of care across all settings and transition to adulthood. More recently, 'Making every young person with diabetes matter'¹⁶ provided guidance for commissioners and organisers of services, care and the workforce.
- 10.7 In total, 207 of the 242 general paediatric services mapped (86%) provided diabetes care. Most often services offered a combination of provision including inpatient units, outpatient services and outreach from hospital ensuring good links were available between hospital and home care. Of the 207 diabetes services, 150 (72%) provided all three models of care. 189 services (91%) provided inpatient care, 195 (94%) outpatient care and 165 (80%) outreach. All services managed Type 1 diabetes while 188 services (91% of general paediatric services providing diabetes care) managed children and young people with Type 2 diabetes.
- 10.8 Children and young people with diabetes need access to a range of services and experts in child health and diabetes in order to minimise the risks involved in the long-term management of the condition. Improvements in access to a range of specialists for diabetes care continued to be reported. 200 services (97%) had access to a children's nurse with a special interest in diabetes compared to 193 (94%) in 2006 (Fig. 10.3). 199 services (96%) reported access to a dietician (as in 2006). 158 services (76%) had access to a diabetologist (67% in 2006) and 128 services (62%) had access to an endocrinologist (58% in 2005). Child psychology input was available in 99 (48%) services and child psychiatry could be accessed in 42 services (20%), down from 53 services (26%) in 2006.

Fig. 10.3: Trends in access to particular expertise for diabetes in general paediatric services 2005 to 2007



- 10.9 Retinal screening was provided by 115 services (56%) and 156 services (75%) had local agreements in place to ensure 24 hour access to emergency advice for children and young people from competent staff. 143 services (69%) regularly documented assessments of need.

Age appropriate diabetes services

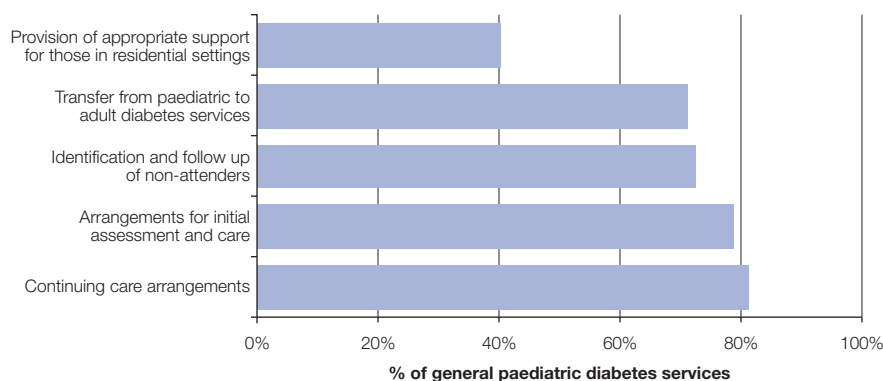
10.10 Of the 207 general paediatric diabetes services, 164 services reported a service designed for children, 145 (70%) had a specific early years service and 134 (65%) provided a service specifically for adolescents and young people. Of the children's services, 151 (92%) had individual diabetes management plans agreed by the parent/guardian, school and Children and Young Persons' Diabetic Team. These individual management plans were available on all occasions in 124 (76%) children's services and were available in most situations in 27 services (16%). Only 11 children's diabetes services (7%) had no individual management plans agreed by families and staff available.

10.11 Of the 134 services specifically for young people, 89 services (66%) had diabetes transition key workers available on all occasions and 37 services (28%) had them available for most situations. Only 8 services (6%) had no provision of diabetes transition key workers.

10.12 The diabetes services reported having the following protocols in place (Fig. 10.4):

- Continuing care arrangements – 168 services (81%)
- Arrangements for initial assessment and care – 163 services (79%)
- Identification and follow up of non-attenders – 150 services (72%)
- Transfer from paediatric to adult diabetes services - 148 services (71%)
- Provision of appropriate support for children and young people in residential settings – 83 services (40%).

Fig. 10.4: Protocols in place in paediatric diabetes services 2007 (N=207)



Paediatric surgery

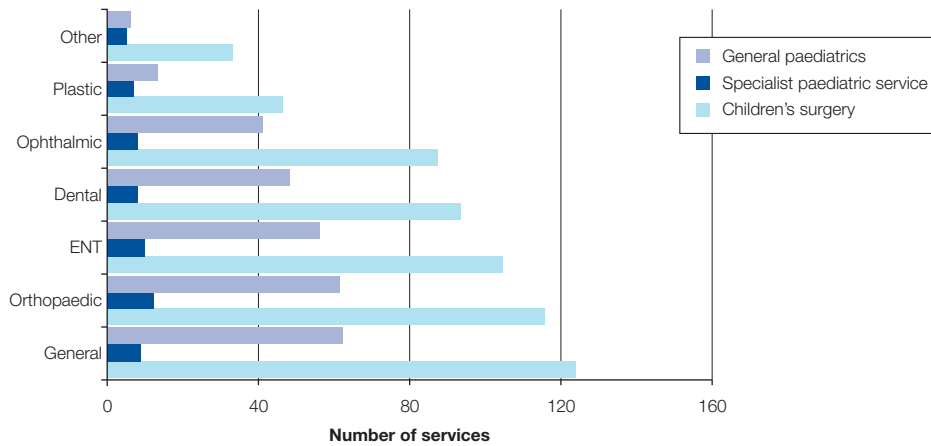
Dedicated operating lists for children are the ideal, but in many specialties this is not practical or feasible. In these circumstances, children should be put to the start of the list with appropriately trained staff in the reception, anaesthetic room, theatre and recovery areas.

National Service Framework for Children, Young People and Maternity Services

10.13 Overall, the number of paediatric surgery services mapped in 2007 declined to 203 from 210 in 2006. 193 services (95%) provided day surgery and 114 (56%) services provided outpatient surgery compared to 69 (33%) in 2006.

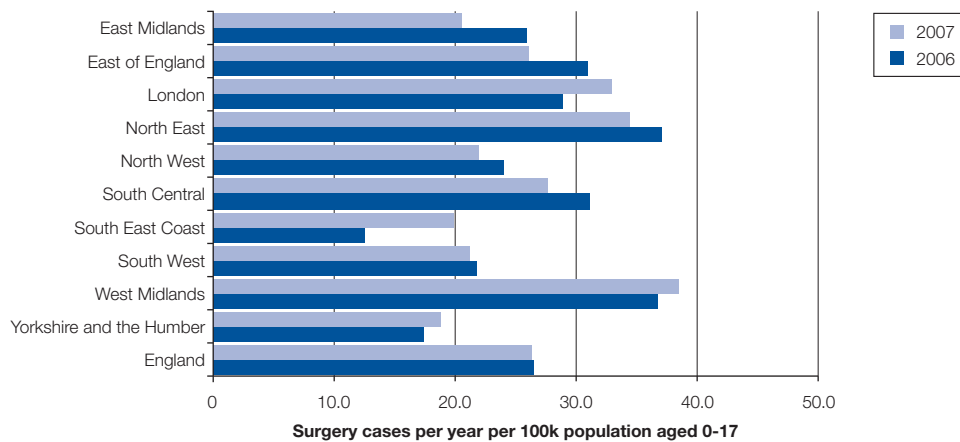
10.14 Of the paediatric surgery services, 123 (60%) provided general surgery, 115 (56%) orthopaedic surgery and 104 (51%) ear nose and throat (ENT) surgery. 93 services (46%) specialised in dental surgery, 87 (43%) in ophthalmic surgery and 46 (23%) in plastic surgery. Specialist and general paediatric services also undertook surgery, the specialisms provided by general paediatrics mirroring those of surgery services (Fig. 10.5).

Fig. 10.5: Surgery specialties 2007



10.15 A considerable reduction in the number of medical staff in post in surgery services was recorded with staff decreasing from 3,295 in 2006 to 2,000 in 2007. This can be attributed to the over inclusion of all-age surgery services in 2006, the first year performance data was collected from children's hospital services for the Healthcare Commission (para 3.7). The number of surgery cases undertaken in the 12 months from January to December was 293,413 in 2006 and 290,688 in 2007. The average number per 100k population aged 0 to 17 years fell slightly from 26.5 in 2006 to 26.2 in 2007. The ratio of surgery case per child in SHAs ranged from 12.6 to 37.2 in 2006 and from 18.9 to 38.5 in 2007 (Fig. 10.6).

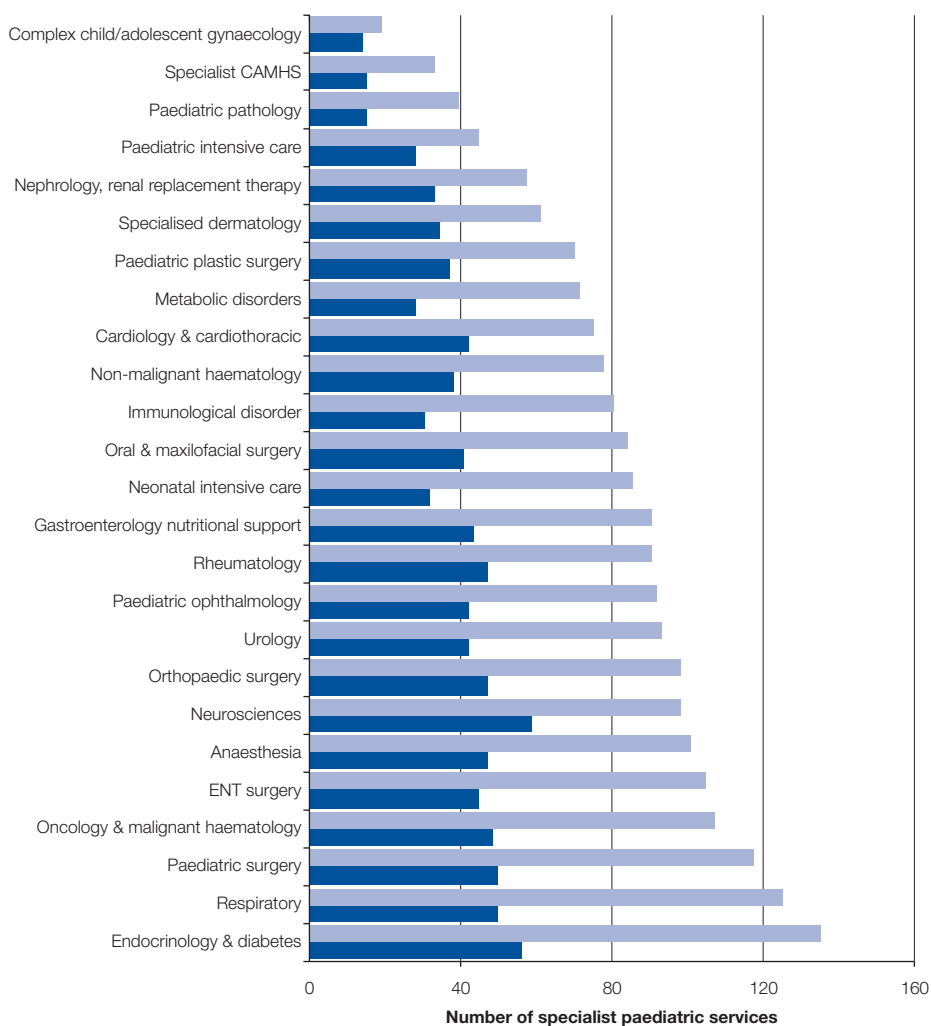
Fig. 10.6: Average number of children's surgery cases per 100k population aged 0 to 17 by SHA 2006 and 2007



Specialist paediatric services

10.16 The number of specialist paediatric services recorded decreased from 188 in 2006 to 177 in 2007 but the tertiary functions provided by the services were much more thoroughly reported in 2007 (Fig. 10.7) owing to improvements in the design of the data collection tool. In 2007, 135 services (76%) provided paediatric endocrinology and diabetes care, 125 services (71%) respiratory specialisms, 118 (67%) paediatric surgery, 107 (60%) oncology and malignant haematology, 105 (59%) ear, nose and throat (ENT) surgery and 101 (57%) paediatric anaesthesia.

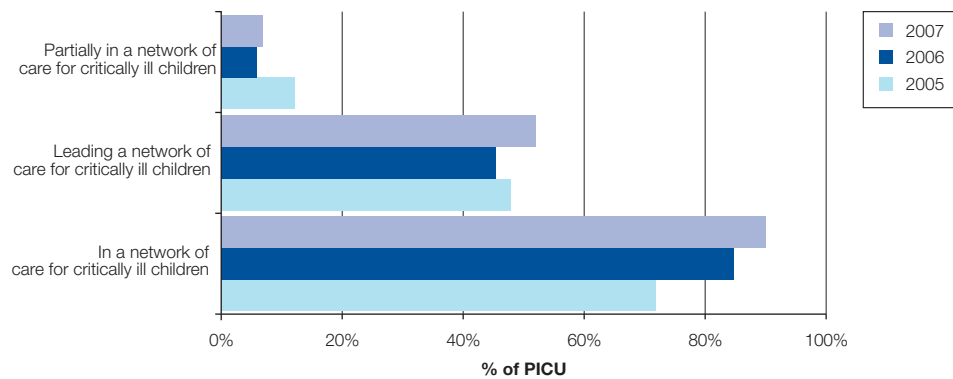
Fig. 10.7: Tertiary functions provided by specialist paediatric services 2006 and 2007 by SHA



Network of care for critically ill children

10.17 Of the 29 paediatric intensive care units (PICU) mapped, all reported belonging to a managed clinical network for critically ill children. 15 (52%) services led the network, up from 45% in 2006 (Fig. 10.8).

Fig. 10.8: Trends in participation in networks of care for critically ill children 2005 to 2007



Chapter 11.

Delivering NSF Standard 8:

Disabled children and young people and those with complex health needs



Standard 8

Children and young people who are disabled or who have complex health needs receive co-ordinated, high quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives.

National Service Framework for Children, Young People and Maternity Services

Introduction

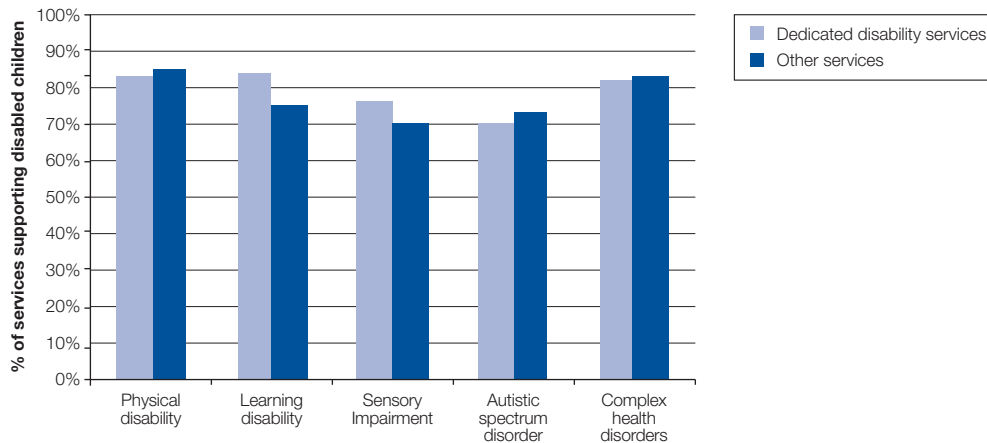
- 11.1 This standard relates to services specifically dedicated to children with a disability and/or special needs, but it is important to acknowledge the high levels of support that children and young people with disabilities receive from other universal, targeted and hospital children's health services.
- 11.2 The scope of disabilities supported is broad and includes learning disabilities, autistic spectrum disorders, sensory impairment, physical impairment and emotional/behavioural disorders. In all areas, policy aims for the reconfiguration of service provision to ensure that child-centred, multi-agency care is available that can respond promptly and effectively to need¹⁷.
- 11.3 This chapter reports the mapping findings most related to this theme, as follows:
- Disability services
 - Key worker system
 - Disability assessment
 - Palliative care

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports.

Disability services

- 11.4 The 2007 mapping exercise recorded 396 dedicated disability services and a further 330 other services, such as children's therapy, that had targeted provision for disabled children and young people. 616 services (85%) provided for children with a physical disability, 604 (83%) for children with complex health disorders, 589 (81%) for children with a learning disability, 537 (74%) for children with a sensory impairment and 524 (72%) for children with autistic spectrum disorders (Fig. 11.1).

Fig. 11.1: Types of disability targeted in dedicated disability services and other child health services 2007 (N=728)



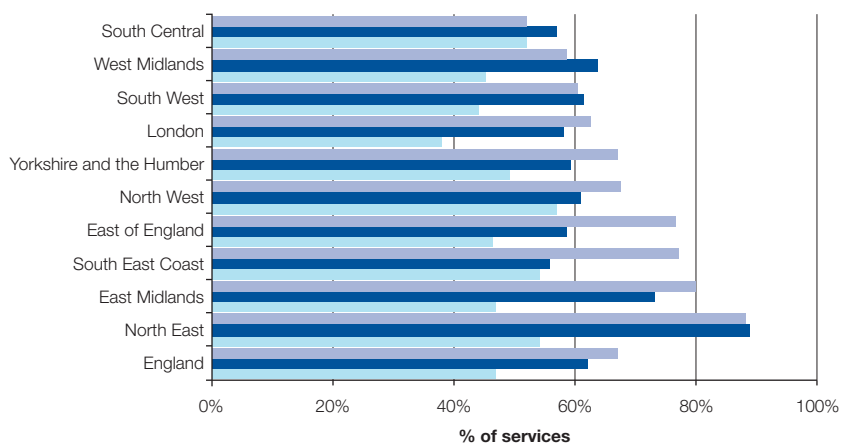
Key worker system

Key worker

A key worker is both a source of support for the families of disabled children and a link by which other services are accessed and used effectively. Key workers have responsibility for working together with the family and with professionals from their own and other services and for ensuring delivery of the plan for the child and family. Workers performing this role may come from a number of different agencies, depending on the particular needs of the child¹⁸.

- 11.5 Good practice recommends that a key worker system is in place to support disabled children with high levels of need. Key workers support parents of severely disabled children by providing a single point of contact with services and a trusted, informed named person to help them access the services they require¹⁹. Improvement was found in the proportion of specialist disability services for children that had adopted a key worker system in 2007 compared to 62% in 2006 and 47% in 2005. Progress in the adoption of a key worker system in SHAs varied (Fig. 11.2) with the proportion of disability services having a system in place ranging from 52% to 88%.

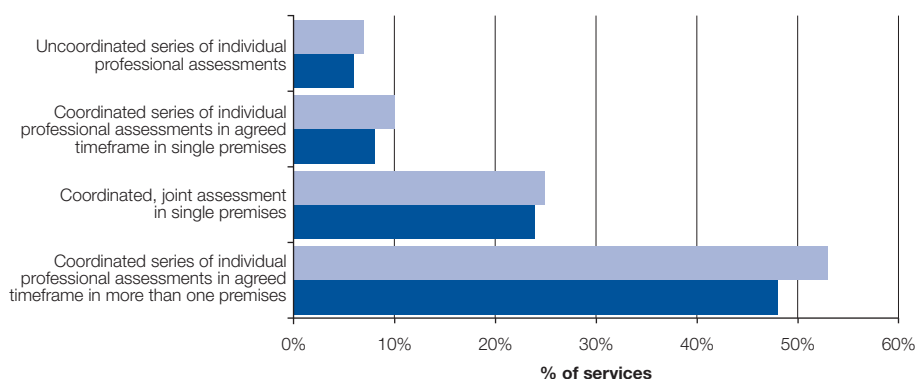
Fig. 11.2: Percentage of disability services operating a key worker system 2005 to 2007 by SHA



Disability assessment

- 11.6 Coordinated assessments to which a range of professionals could contribute were provided by the majority of services for children with a disability or complex needs but there were differences in how these were carried out. The most common approach, provided in 208 services (53%) in 2007 (up from 48% in 2006), was a coordinated series of individual professional assessments made in an agreed timeframe in more than one location, which could include the child's own home. A further 38 services (10%) provided the same type of coordinated assessments but in a single location. In 99 services (25%) a joint approach was taken to the provision of a coordinated assessment and this was achieved in a single location. Uncoordinated individual professional assessments were reported by 6% of services in 2006 and 7% in 2007 (Fig. 11.3).
- 11.7 The initial assessment led to a written report, or family service plan, in 330 services (83%) in 2007 (up from 75% in 2006). In 2007, 260 services (66%) held meetings with parents to share the report (an increase from 57% in 2006).

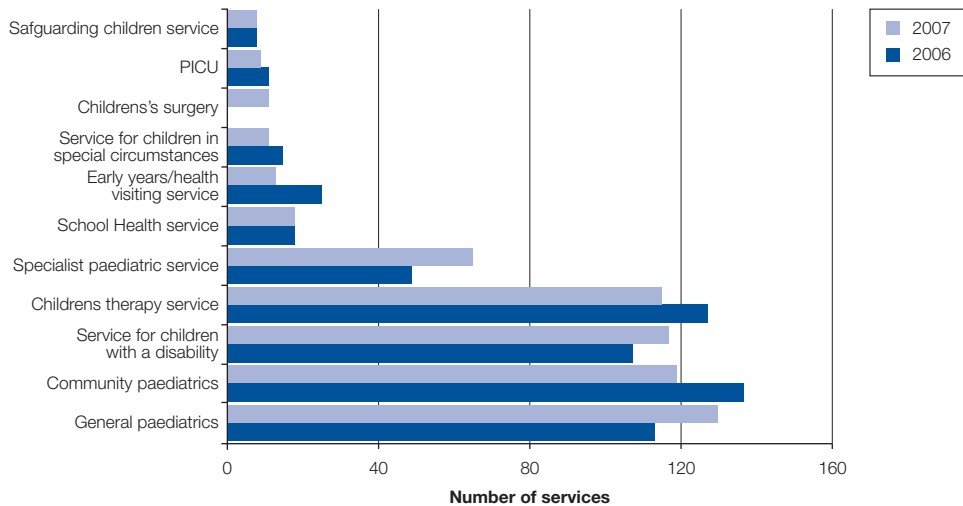
Fig. 11.3: Provision of coordinated assessments in services for disabled children and children with complex needs 2006 and 2007



Palliative care

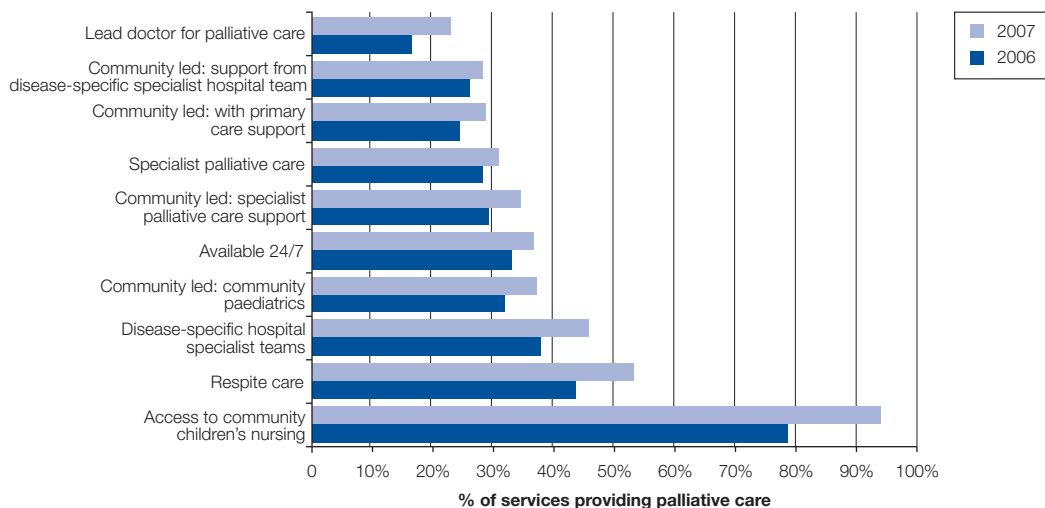
11.8 In 2007, 652 children's health services indicated that they provided palliative care compared to 610 in 2006. The main providers were general and community paediatric services, services for children with disabilities and special needs and children's therapy services (Fig. 11.4).

Fig. 11.4: Number of services providing palliative care 2006 and 2007



11.9 In 2007, the most common type of palliative care provided was respite care which was provided by 241 palliative care services (37%), up from 186 services (30%) in 2006 (Fig 11.5). 208 services (32%) were disease specific hospital specialist teams and 168 (26%) were community services led by community paediatricians.

Fig. 11.5: Percentage of services providing different models of palliative care 2006 and 2007



11.10 Of the palliative care services, 167 (26%) were available 24/7 but 427 services (65%) worked together with the local community children's nursing service to extend the support that could be provided. Only 103 services (16%) had a lead doctor for palliative care.

Chapter 12.

Delivering NSF Standard 9:

The mental health and psychological well-being of children and young people



Standard 9

All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them, and their families.

National Service Framework for Children, Young People and Maternity Services

Introduction

- 12.1 Specialist, or tier 2 to 4, CAMHS (as defined in Appendix 5) were reported through a separate CAMHS mapping exercise from 2003 to 2005. In 2006, CAMHS and child health mapping were combined into a single exercise but changes to the CAMHS collection were kept to a minimum enabling trend data to be tracked back to 2003 wherever possible.
- 12.2 As CAMHS remains a very important element of the mapping exercise, and CAMHS mapping continues to be the only source of national data about CAMHS caseload, the national findings from the exercise are also being reported in a separate CAMHS report that can be found on the mapping website at: www.childrensmapping.org.uk/reports
- 12.3 This chapter reports the findings most related to Standard 9 of the NSF as follows:
- Towards comprehensive CAMHS provision
 - Trends in the provision of specialist CAMHS
 - Tier 4 services
 - Alternatives to inpatient care
 - On-call provision and emergency response
 - Services for people aged sixteen and seventeen
 - Learning disability provision
 - Complex needs
 - ADHD and autistic spectrum disorder provision
 - Functions and interventions
 - Assessment
 - Interventions
 - Use of outcome measures
 - CAMHS caseload
 - National summary and trends
 - New cases seen
 - Cases waiting and length of wait

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports

Towards comprehensive CAMHS provision

Team type definitions

Generic team: Generic CAMHS teams meet a wide range of the mental health and psychological needs of children and adolescents within a defined geographical area. **Generic (multi) teams** are made up of CAMHS professionals from a number of disciplines who work together to ensure integrated provision. **Generic (single) teams** are single-disciplinary groups of staff who provide a range of therapeutic interventions.

Targeted team: These teams provide for children with particular problems or requiring particular types of therapeutic intervention.

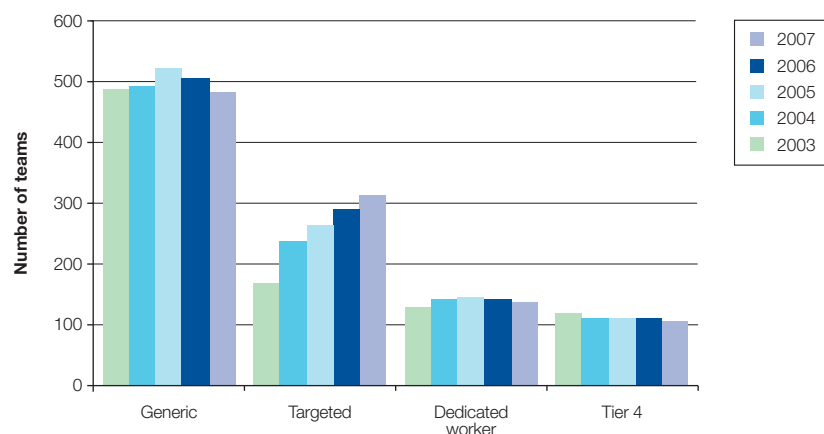
Dedicated worker teams: Dedicated workers are fully trained CAMHS professionals who are out-posted in teams that are not specialist CAMHS teams but have a wider function, such as a youth offending team or a generic social work children's team.

Tier 4 teams: These services provide longer term or more intensive provision. This may take the form of whole- or half-day activities, in-patient care, or outreach support (such as emergency or after care) which is considered an alternative to in-patient care. Some may provide more than one of these types of care.

Trends in the provision of specialist CAMHS

12.4 In 2007, 1,047 specialist CAMHS teams were reported, 1% less than the 1,055 teams mapped in 2006. This was the first year a fall in the number of CAMHS teams had been reported since the first mapping collection in 2003. Only targeted teams continued to increase, with the number of teams growing 10% from 267 in 2005 to 290 in 2006 and a further 8% to 314 in 2007 (Fig. 12.1). Generic CAMHS teams, dedicated CAMHS staff working in non-CAMHS settings and tier 4 services (tertiary services providing hospital inpatient care and intensive treatments) all declined by between 3 and 4%.

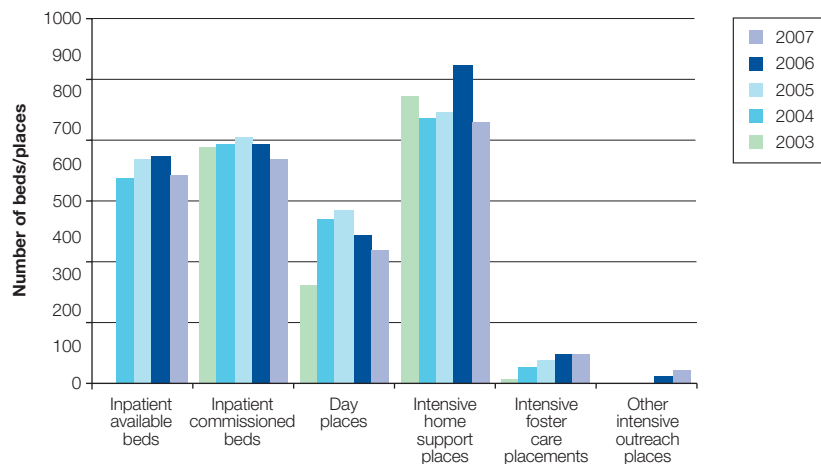
Fig. 12.1: Trends in provision of CAMHS tier 2 to 4 provision 2003 to 2007



Tier 4 services

12.5 In tier 4, there has been a continued fall in the number of services mapped. However, it is important to note that mapping only collects NHS and not independent sector provision. The number of commissioned inpatient beds fell from the 2005 high of 680, to 659 in 2006 and 621 in 2007. Day places dropped from 478 in 2005, to 415 in 2006 and 368 in 2007 (Fig. 12.2). During the same period the provision of intensive home support rose from 747 places in 2005 to 879 places in 2006, but then fell back to 724 places in 2007. The number of intensive foster care places continued to increase from 64 in 2005 to 83 places in 2006 and 86 places in 2007.

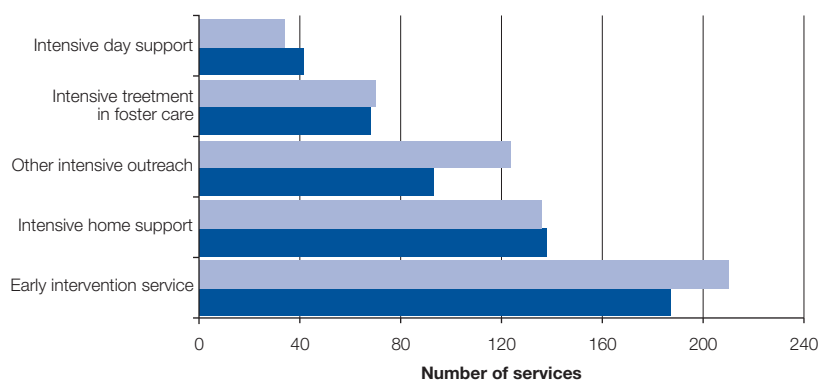
Fig. 12.2: Trends in the capacity of CAMHS tier 4 provision 2003 to 2007



Alternatives to inpatient care

12.6 In addition to tier 4 provision, alternatives to inpatient care were provided by generic, targeted and dedicated worker teams (at tiers 2 and 3). In total, 374 (40%) CAMHS tier 2/3 teams were providing alternatives to inpatient care, a reduction from the 458 (48%) providing this support in 2006. Altogether, 210 teams were providing early intervention services (up from 187 the previous year), 135 intensive home support, 70 intensive foster care, 34 intensive day support and 123 teams provided other forms of intensive outreach (Fig. 12.3).

Fig. 12.3: Provision of alternatives to inpatient care 2006 and 2007



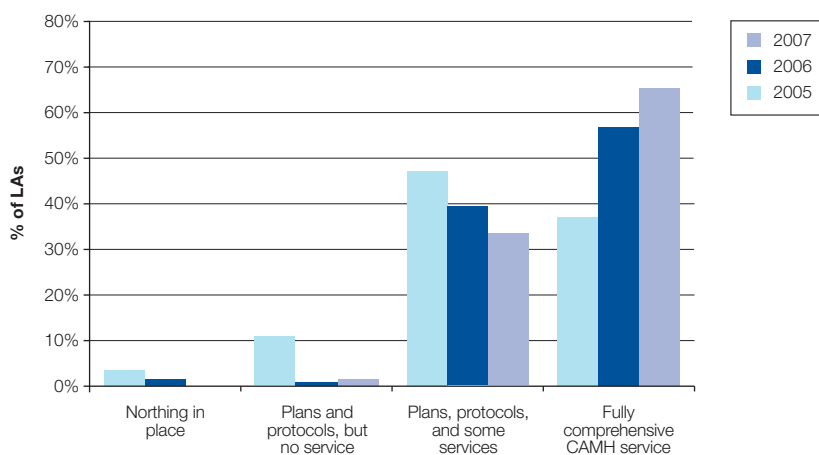
On-call provision and emergency response

Children and young people presenting as emergencies or as requiring urgent assessment and intervention include: those who have rapidly developed a serious or life-threatening condition; those whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support.

National Service Framework for Children, Young People and Maternity Services²⁰

- 12.7 In 2007, NHS CAMHS providers were asked for greater detail about their organisation-wide provision of key aspects of a comprehensive CAMHS using a four point scale (similar to that used in the collection of the local authority PAF A70 indicators)ⁱⁱ. With regard to the provision of a CAMHS on-call service, only 2% of NHS providers reported no services, protocols or plans in place. A further 4% of NHS providers had plans and protocols but no services in place, 34% had some on-call services in place with some still to be developed and 61% had a fully comprehensive on-call service available. 56% of NHS on-call services were staffed by CAMHS professionals.
- 12.8 Next working day appointments for children and young people needing emergency care or assessment were offered by 76% of NHS providers where fully comprehensive services were available and in 21% of trusts where some services were in place. One percent of NHS trusts reported no services, protocols or plans in place for a next day response and 2% did not answer this question.
- 12.9 Similar progress was reported by local authorities (Fig. 12.4). 65% of LAs had fully implemented on-call services available throughout their area while a further 33% of LAs had plans and protocols in place and partially implemented services. Only 1% of LAs had no services in place.

Fig. 12.4: Trends in local authority provision of CAMHS on-call and emergency response 2005 to 2007



- 12.10 In 2007, a total of 513 (49%) CAMHS teams contributed to the on-call provision, up from 448 in 2006. Of the teams contributing to an on-call response, 316 (62%) were generic multi-disciplinary teams, 77 (15%) were tier 4 teams and 101 (20%) were targeted teams. It was interesting to note that over 70% of all tier 4 and generic teams contributed to an on-call service.

ⁱⁱ **Rating scale: 1:** No service in place OR strategic plans to address the issue; **2:** Plans and protocols in place but services have yet to be developed; **3:** Plans and protocols in place and some services; **4:** A fully comprehensive CAMH Service available covering whole area.

ⁱⁱⁱ Not asked of dedicated workers in non-CAMHS teams (N=144)

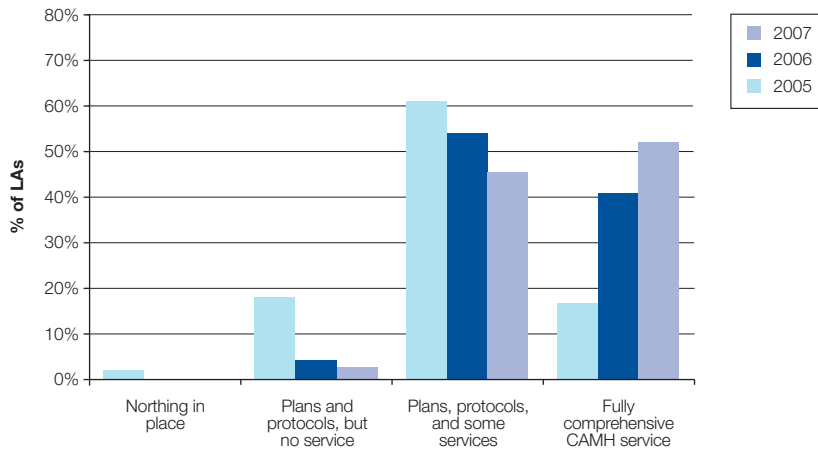
Services for people of sixteen and seventeen years of age

A degree of flexibility is clearly required to ensure that young people receive treatment in an environment that promotes their engagement and responds to their developmental needs. This means that some young people may wish to exercise choice about which service feels most appropriate to them.

NSF for Children, Young People and Maternity Services 2004²¹

- 12.11 The provision of age appropriate services for 16 and 17 year olds became a proxy measure for the provision of a comprehensive CAMHS in response to national concerns about the adequacy of the service to meet the particular mental health needs of young people of this age in transition between children and adult services. There is no prescription of the services to be provided but key elements should include:
- Services appropriate for the developmental needs of 16 and 17 year olds
 - Local arrangements for handling referrals
 - Smooth transition between CAMHS and adult services at the appropriate age
 - Collaboration with early intervention teams for young people with early onset psychosis
 - The use of the Care Programme Approach for young people leaving inpatient care
 - Appropriate attention to child protection needs of young people.
- 12.12 A total of 90% of NHS CAMHS provided age appropriate care for young people aged 16 and 17. 49% of NHS providers provided fully comprehensive age appropriate CAMHS and 41% provided some services, with other services still to be developed. 2% of NHS trusts had plans and protocols in place, but were yet to implement them, while 7% had no services, plans or protocols for age appropriate 16/17 CAMHS provision.
- 12.13 The number of individual teams reporting appropriate provision for 16 and 17 year olds increased from 338 (32%) in 2005 to 553 (52%) in 2006 and 745 (71%) in 2007. There were 18,106 young people aged 16 to 18 on the CAMHS caseload, 17% of the total.
- 12.14 Local authorities were also asked about the provision of services to 16 and 17 year olds who require mental health services appropriate to their age and level of maturity within the council area. 78 local authorities (52%) had fully comprehensive CAMHS for 16 and 17 year olds across the whole council area, up from 25 (17%) in 2005 and 61 (41%) in 2006. 68 (45%) local authorities had plans, protocols and some services and 4 (3%) had plans and protocols but no services (Fig. 12.5). There were no local authorities with nothing in place.

Fig. 12.5: Trends in local authority development of CAMHS appropriate for 16 and 17 year olds 2005 to 2007



Learning disability provision

There is a need to ensure that children and young people with learning disability who require psychiatric care have access to appropriate services that meet their needs and that they are not disadvantaged because of their disability.

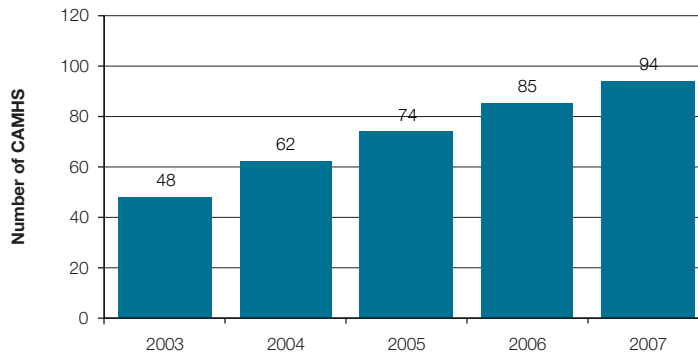
NSF for Children, Young People and Maternity Services 2004²²

12.15 The NSF stresses the importance of equity of access to CAMHS for children and young people with both mental health needs and learning disabilities. Provision would be expected to include:

- Adequate provision of mental health promotion and early intervention
- Specialist staff training for both tier 2/3 and tier 4 staff
- Adequately resourced tiers 2 and 3 learning disability specialist CAMHS
- Access to tier 4 services providing in-patient, day-patient and outreach units.

12.16 There has been steady growth in the number of NHS CAMHS that provide specialist provision for children and young people with mental health problems and learning disabilities. The number of providers with these services has risen from 48 in 2003 to 94 in 2007 (Fig. 12.6). Of the 112 NHS CAMHS providers, 94 (87%) reported having specialist learning disability provision. 36 providers (33%) had a fully comprehensive service and 59 (54%) had some services in place, with others still to be developed. 3 (3%) trusts had plans and protocols but no learning disability services and 9 (8%) NHS providers had no services, plans or protocols.

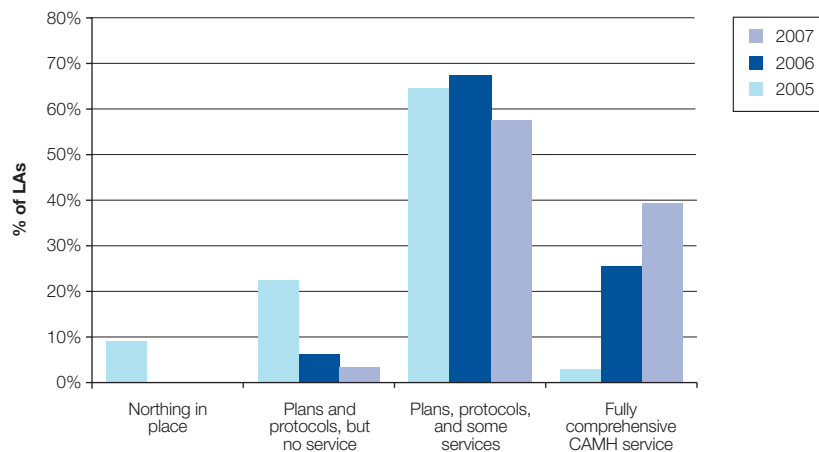
Fig. 12.6: Trends in the development of CAMHS for children and young people with learning disabilities 2003 to 2007



12.17 A total of 722 CAMHS teams (69% of all teams) provided specialist learning disability care, an increase from 590 (55%) teams in 2006 and 346 (33%) teams in 2005. In 2007, CAMHS worked with 9,455 children and young people with a learning disability. The proportion of the CAMHS caseload identified as learning disabled increased from 8% in 2005 to 9% in both 2006 and 2007.

12.18 59 (39%) local authorities had fully comprehensive provision for learning disabled children and young people with mental health problems and 86 (57%) had plans and procedures in place but were yet to ensure provision throughout the LA area (Fig. 12.7). 35 (3%) local authorities reported no specialist learning disability and mental health provision but plans were in place.

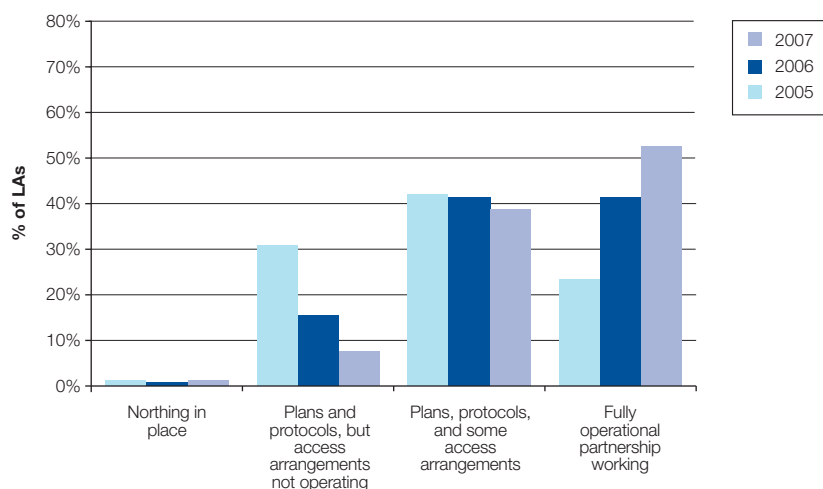
Fig. 12.7: Trends in local authority arrangements for and provision of CAMHS learning disability services 2005 to 2007



Complex needs

12.19 Local authorities reported improved arrangements for and provision of services for children and young people with complex needs. The number of local authorities with fully operational partnership working rose from 35 (23%) in 2005 to 62 (41%) in 2006 and 79 (53%) in 2007. A further 58 (39%) local authorities had plans, protocols and some access arrangements in place but services that were not fully developed. 11 (7%) local authorities had plans and protocols but no access arrangements operating and 2 (1%) had neither services not plans (Fig. 12.8).

Fig. 12.8: Trends in local authority arrangements for and provision of services for children with complex needs 2005 to 2007



ADHD and autistic spectrum disorder provision

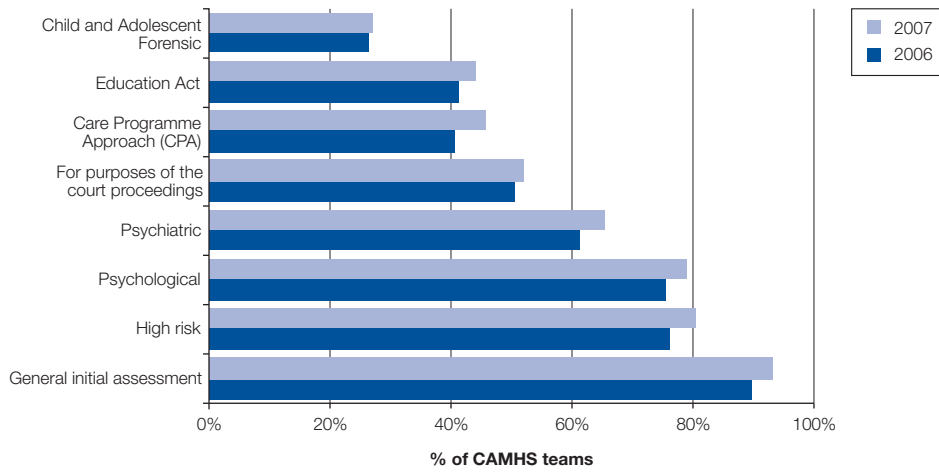
12.20 In the child health mapping exercise, community paediatric services were asked to record if they provided clinics for attention deficit hyperactive disorder (ADHD) and autism spectrum disorder (ASD). ADHD clinics were reported in 183 (52%) of the 349 community paediatric services and 193 (55%) ran ASD clinics.

Functions and interventions

Assessment

12.21 The team classification used in CAMHS mapping was designed to give a broad description of the types of teams provided but it does not describe the work that teams undertake. Therefore, questions were added to the mapping exercise in 2006 to explore what functions and interventions were provided. With regard to assessments, eight different types were investigated. Overall, 976 CAMHS teams (93%) provided general initial assessments. These were provided occasionally by 127 teams (12%) and on a regular basis by 849 (81%) teams (Fig. 12.9). High risk assessments were provided by 842 teams (76%), psychological assessments by 829 (75%), psychiatric assessments by 685 (65%) and assessment for court proceedings by 547 (52%). An increased number of teams were reported to be delivering all types of assessment investigated (Fig. 12.9)

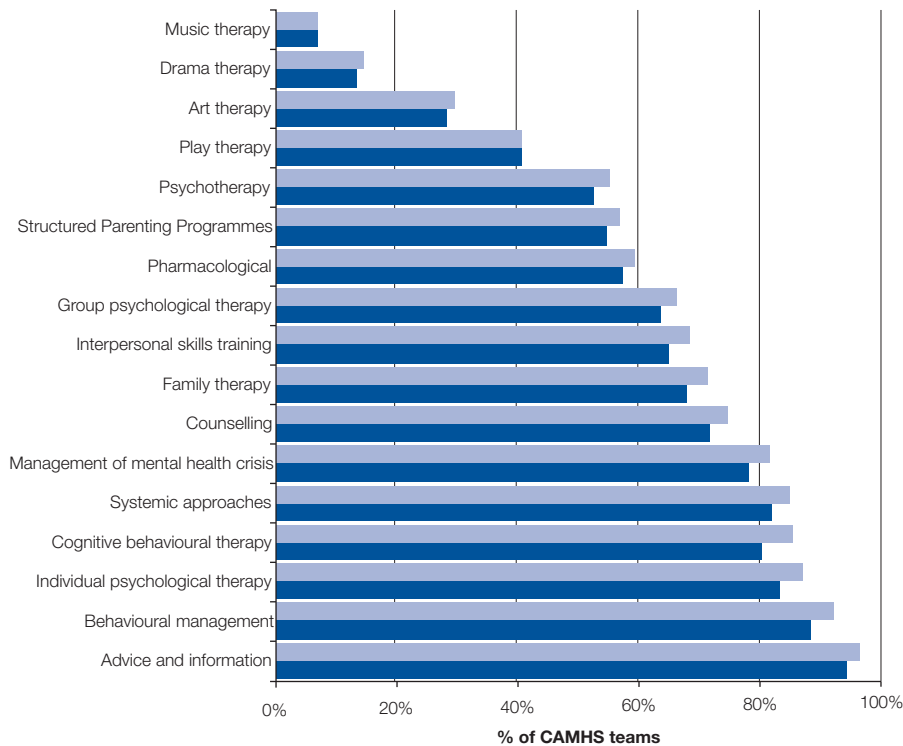
Fig. 12.9: Percentage of CAMHS teams providing assessment functions 2006 and 2007



Interventions

12.22 The majority of CAMHS teams were found to be providing the interventions listed in the mapping at least occasionally. The interventions were largely therapies or particular therapeutic orientations. Teams most commonly provided behaviour management, individual psychological therapy, systemic approaches, CBT and counselling on a regular basis (Fig. 12.10). 1,012 (97%) teams provided advice and information, 967 (92%) behavioural management, 915 (87%) individual psychological therapy and 895 (85%) cognitive behavioural therapy. Play, art, drama and music therapy were the least likely to be provided.

Fig. 12.10: Percentage of CAMHS teams providing a range of specific interventions 2006 and 2007



Outcomes measures

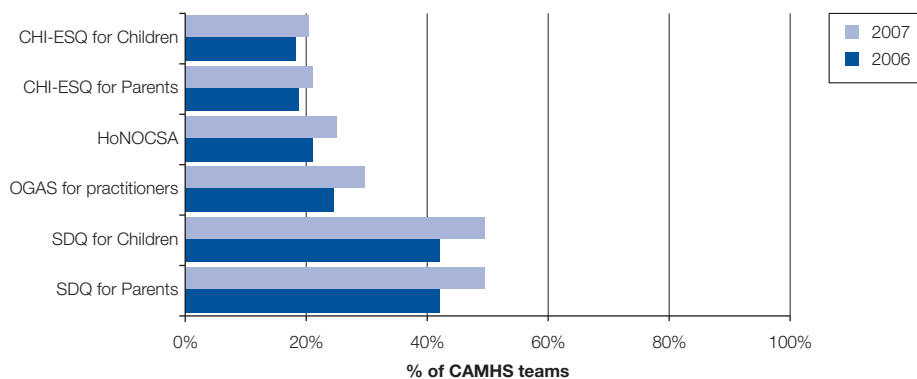
Use of outcome measures

12.23 In order to evaluate the outcome of CAMHS, teams are being encouraged and supported to use standard measures to routinely collect information about changes in children's emotional wellbeing and experience of services. The measures collect information from three perspectives, those of children and young people, parents and clinicians. Overall, 704 teams (67%) reported the use of at least one standard outcome measure, up from 623 teams (59%) in 2006. 130 teams (18%) used just one measure, 216 teams (31%) used 2 measures, 145 teams (21%) used 3 measures and 213 teams (31%) used 4 or more measures.

12.24 The outcome measures used were as follows:

- The SDQ for Parents and Children (Strengths and Difficulties Questionnaire) is used to assess change in the strengths and difficulties encountered by children. The children's questionnaire is used with 11 to 18 year olds and the parents' questionnaire with the parents/carers of children aged 3 to 16. In 2007, 518 teams (49%) used SDQ for parents, up from 445 teams in 2006. SDQ for children was used by 442 teams in 2006 rising to 514 (49%) in 2007 (Fig. 12.11).

Fig. 12.11: Use of outcome measures by CAMHS teams 2006 and 2007



- CGAS, the Children's Global Assessment Scale, is a measure completed by practitioners to capture change in difficulties. It can be used on children and young people of all ages and is a way of rating the extent of child and family difficulties at the start of contact and six months later in order to evaluate change. It was used by 259 teams (24%) in 2006 and 307 teams (29%) in 2007.
- Use of the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was reported by 221 teams (21%) in 2006 and 261 (25%) in 2007.
- CHI-ESQ, the Commission for Health Improvement Experience of Service Questionnaire, is a method of capturing the views of children and parents on their experiences of services. It is used with children and young people over the age of 9 and with the parents of younger children. Use with parents was reported by 198 teams (19%) in 2006 rising to 222 teams (21%) in 2007. It was used with children by 191 teams (18%) in 2006 and 214 (20%) in 2007.

CAMHS caseload

12.25 CAMHS mapping collects information on caseload looking at its size, the length of time cases have waited to be seen and the length of treatment. Data is also collected on key characteristics of the children and young people who make up the caseload but for a sample period only. Each year the data is collected for the calendar month of November for tier 2 and 3 teams and the 6-month period 1st June to 30th November for tier 4 teams.

Definitions for caseload

Cases: A 'case' is a child, or a young person, or a child / young person and their family, for which a referral has been received and with whom CAMHS staff have actively been working. Where separate referrals were received for one or more siblings in a family, each sibling was counted as a separate case.

Active work: Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion. The frequency with which cases were seen during the study period was not collected during the 2006 mapping exercise.

Consultation: A consultation requires a specialist CAMHS clinician to provide clinical advice or information for which they can be held accountable. This will usually infer that a record of the consultation will be recorded by at least one party.

Data collection period:

Tier 2/3 teams: caseload data were collected from the 1st to 30th November 2007.

Tier 4 teams: caseload data were collected for the six-month period June 1st to November 30th 2007.

Caseload: The caseload is a count of the total number of cases a team worked with in the data collection period. This is collected at the team level only. If a number of staff within a team work with the same case it should be counted once. The team caseload is effectively a head count of those active cases that have been worked with in the sample period.

Note: a number of services reported having teams with no caseload during the data collection period due to the newness of the team (staff were in post but the team was not yet operational), posts being vacant, staff being on long-term sick/maternity leave or the activities of the team excluded casework.

National summary and trends

12.26 A total of 109,131 active cases were recorded for the 2007 sample period. In addition, CAMHS staff carried out 50,596 consultations giving a total of 159,727 cases seen or consulted on. This was a slight increase on the 108,825 cases active cases seen in 2006 (Fig. 12.12) and 16% reduction on the number of consultations recorded. Although comparisons with previous years' findings should be treated with care as the distinction between active casework on the team caseload and consultations was only made for the first time in 2006, it is interesting to note that the total caseload (including consultations) in 2005 was 112,984. Looking further back, the magnitude of the improvement in the accessibility and capacity of CAMHS becomes apparent. There were 86,521 cases reported in 2003, giving a cumulative total increase of over 80% between 2003 and 2007.

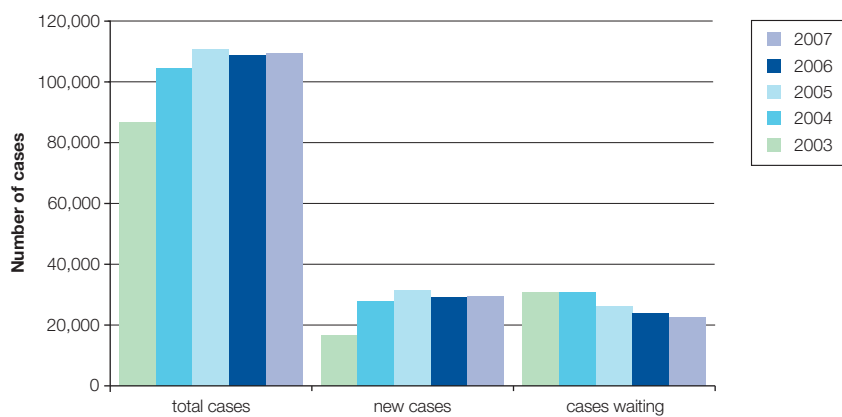
New cases seen

New cases: A new case was an active case that had been seen for the first time during the data collection period.

Length of Wait: Duration of wait is the interval between the receipt of the referral request and the time the case is first seen. In the case of DNAs (Did not attend) or cancellations, the wait is recorded from the most recent DNA or cancellation.

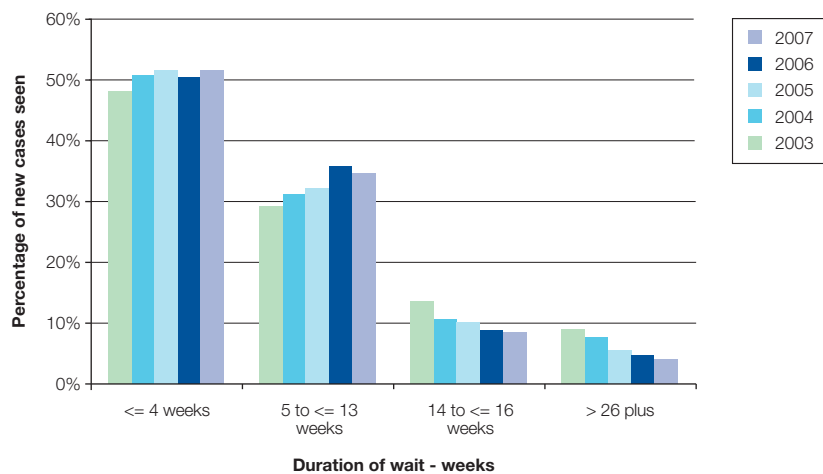
Fig. 12.12: Trends in cases seen, new cases and cases waiting 2003 to 2007

Note: This shows the active caseload in 2006 and 2007 excluding consultation.



12.27 In total there were 29,170 new cases recorded in 2007 compared to 29,078 in 2006. The overall change between 2003 and 2007 was of an 80% growth in new cases. The majority of new cases (53%) had to wait less than 4 weeks to be seen by a CAMHS team (51% in 2006). 32% of new cases waited for 5 to 13 weeks in 2007, 10% for 14 to 26 weeks and 4% for over 6 months. Overall, waits of more than 3 months have reduced steadily and in 2007 waits of 1 to 3 months were also down (Fig. 12.13).

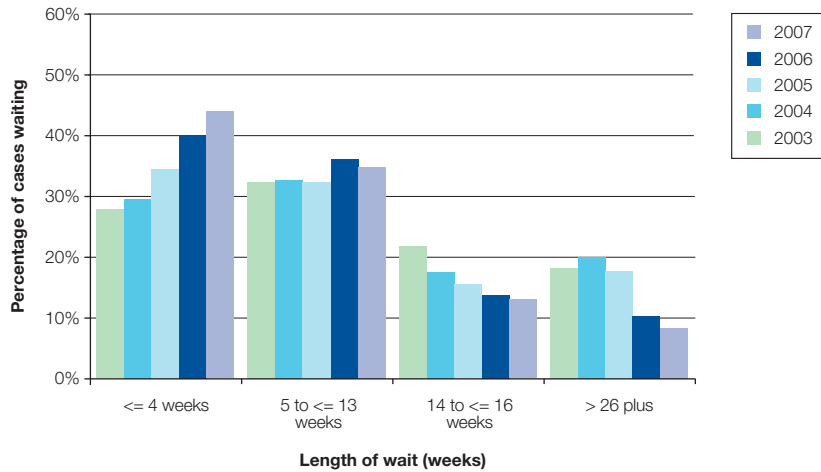
Fig. 12.13: Trends in percentage of new cases seen and the length of wait 2003 to 2007



Cases waiting and length of wait

12.28 The number of cases waiting at the end of the sample period (30th November) has fallen annually since 2004 (Fig. 12.12). It fell by 15% between 2004 and 2005, by 10% between 2005 and 2006 and by 5% between 2006 and 2007 to 22,592 cases (Fig. 12.14). As a proportion of the total number of cases still waiting to be seen, the number of cases waiting for 4 weeks or less continued to show an upward trend. The number of cases waiting longer than 4 weeks continued to fall.

Fig. 12.14: Trend in the length of wait of the cases still waiting 2003 to 2007



Chapter 13.

Delivering NSF Standard 10: Medicines for children and young people



Standard 10

Children, young people, their parents or carers, and health care professionals in all settings make decisions about medicines based on sound information about risk and benefit. They have access to safe and effective medicines that are prescribed on the basis of the best available evidence.

National Service Framework for Children, Young People and Maternity Services

Introduction

13.1 Standard 10 is concerned with the safe prescribing and management of medication for children and young people. It outlines the need for a partnership approach between health providers, children, young people and their parents or carers to ensure that families have the information that they need and that medication is given in the best way possible for each individual child.

13.2 This chapter reports the mapping findings most related to this theme, as follows:

- Nurse prescribing
- Parent and carer management of medication in hospital

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports

Nurse prescribing

Definitions

Independent prescribing: Prescribing by a practitioner (e.g. doctor, dentist, nurse and pharmacist) responsible and accountable for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is 'appropriate practitioner'²³.

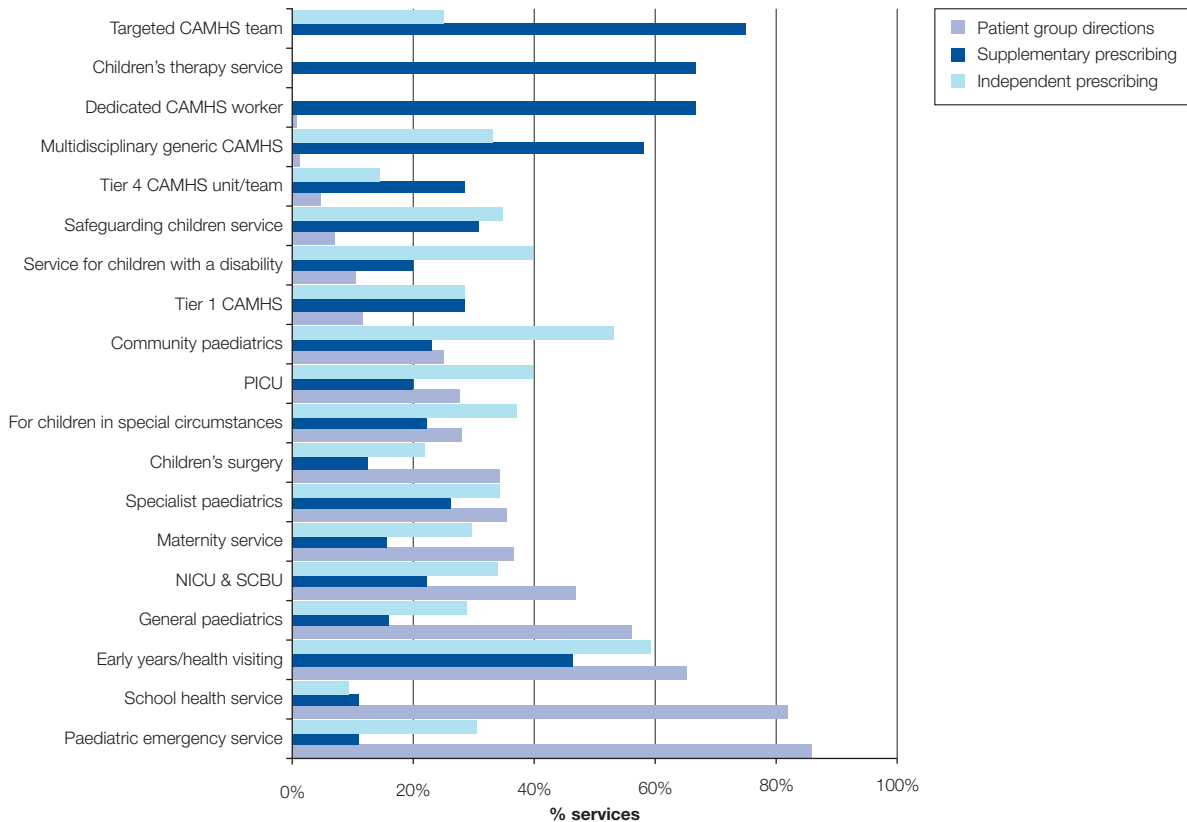
Supplementary prescribing: Prescribing in partnership with a doctor or dentist (the independent prescriber) to implement an agreed patient-specific Clinical Management Plan with the patient's agreement. Nurse and pharmacist supplementary prescribers are able to prescribe any medicine, including controlled drugs and unlicensed medicines, for the full range of medical conditions provided that are listed in an agreed Clinical Management Plan.

Patient group directions are written instructions for the supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Use of this should be reserved for those situations where this offers an advantage for patient care without compromising patient safety and where it is consistent with appropriate professional relationships and accountability.²⁴

13.3 Nurse prescribing was carried out by 1,580 services, 33% of all the services mapped. Prescribing under patient group direction was undertaken by 1,349 services (28%), including 145 (86%) paediatric emergency services and 242 (82%) school health services, reflecting their responsibilities in carrying out immunisation

programmes. It was also carried out by more than 50% of early years/health visiting and general paediatric services (Fig. 13.1). Supplementary prescribing was used by only 391 services (8%) overall, and was most often used by children's therapy services (67%) and CAMHS teams. Independent prescribing was used by 572 services (12%) but most commonly in early years and health visiting services (60%), community paediatric services (53%), PICU (40%) and services for children with a disability (40%).

Fig. 13.1: Services carrying out nurse prescribing 2007 (N=1,580)



Parent and carer management of medication in hospital

Now a parent's presence is recognised as a positive factor in aiding the child's recovery; and their practical contribution to care at the bedside is often essential. Encouraging parents and children to take responsibility for administering their own medicines in hospital, where appropriate, prepares for discharge home and allows health care professionals to assess the child's and parents' abilities to cope, for example, with inhalers or more complex therapies.

National Service Framework for Children, Young People and Maternity Services²⁵

- 13.4 Parents and carers often stay with their children in hospital and, in order to increase parent/carers autonomy and build their confidence in caring for their child, they are often encouraged to manage their child's medication. This may mean taking responsibility for administering the correct dose of medicines but it may also involve learning how to give injections or increasing skills in other ways to prepare parents and carers for caring at home. Overall, 148 general paediatric services reported the development of such services (61% of all general paediatric services).

Chapter 14.

Delivering NSF Standard 11: Maternity services



Standard 11

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

National Service Framework for Children, Young People and Maternity Services

Introduction

- 14.1 Standard 11 of the NSF addresses the requirements of women and their babies during pregnancy, birth and after birth through the provision of flexible and individualised services²⁶. The NSF follows a care pathway approach and emphasises the importance of women having choice and control in the planning of their care. This should be facilitated by easy access to services and continuity of support during pregnancy, childbirth and the postnatal period.
- 14.2 The importance of choice was reiterated in *Maternity Matters*²⁷ (DH, 2007) which further outlined local improvements to choice, access and continuity of care in maternity services. It set out four national guarantees for women concerning choice in: how to access maternity care; the type of antenatal care; the place of birth; and the place for postnatal care.
- 14.3 This chapter reports the mapping findings most related to this theme, as follows:
- Maternity service provision
 - Maternity services
 - Models of maternity care
 - Antenatal care
 - Intrapartum care
 - Participation in Managed maternity networks
 - Neonatal services
 - Neonatal service provision
 - Neonatal transfer

For details of the completion rates of the mapping exercise, please refer to Appendix 3. Also detailed tables of the data can be found and downloaded from the mapping website at www.childrensmapping.org.uk/reports

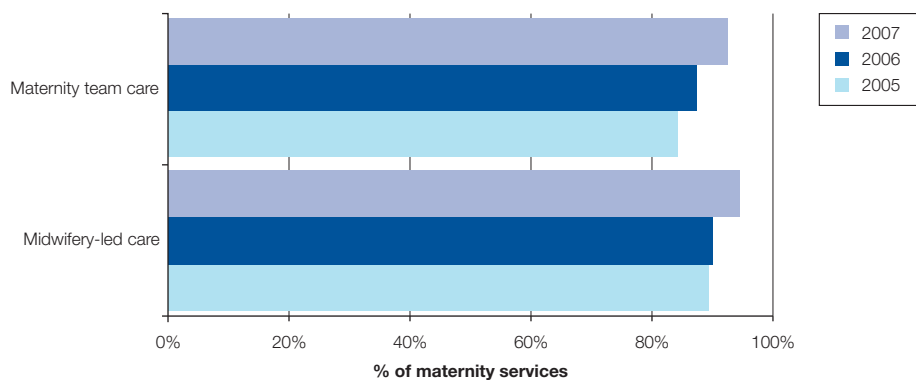
Maternity service provision

Maternity services

- 14.4 190 maternity services were reported in 2007, a reduction of 4 from the 194 services reported the previous year. This was probably due to consolidation in the way services were mapped as NHS providers tended to record their maternity provision as a single comprehensive service irrespective of how many sites and settings services were delivered in. Therefore almost all maternity services provided antenatal, intrapartum and postpartum care. The only exceptions to this were two community midwifery teams providing ante and postnatal care (one to teenage parents) which were mapped separately and were additional to comprehensive local maternity services.

14.5 For the majority of women pregnancy and childbirth are free of complications and require minimal medical intervention. In such cases, midwifery-led care, where the midwife is the lead professional, should be actively promoted. For women with complex pregnancies, care should be provided by a maternity team comprising midwives, obstetricians, anaesthetists, neonatologists and other specialists working in partnership. The mapping showed a steady increase in the provision of both care options (Fig. 14.1). Midwifery-led care was available in 175 services (90%) in 2006 rising to 180 services (95%) in 2007. 14 of these services were stand alone midwifery units which chose to be reported separately. Maternity team care was available in 170 services (88%) in 2006, increasing to 176 services (93%) in 2007. In all but 8 services both maternity team and midwifery-led care were available.

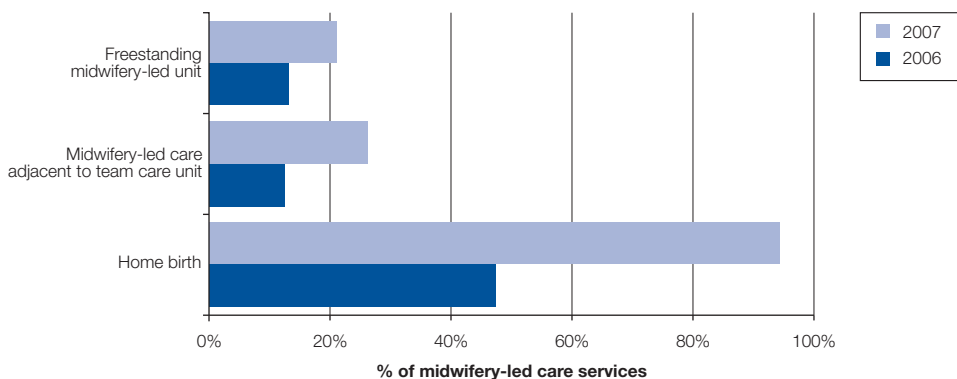
Fig. 14.1: Models of maternity care 2005 to 2007



Models of maternity care

14.6 There was significant improvement in the number of services with midwifery-led care that reported provision of home birth as a choice available to women (Fig. 14.2). In 2007, 171 services (94%) reported that they supported home births compared to 83 services (47%) in 2006. Free-standing midwifery units had been developed in 38 services (21%) in 2007 (compared to 13% in 2006) and midwifery units built alongside maternity team care units were available in 47 services (26%), up from 22 (13%) in 2006.

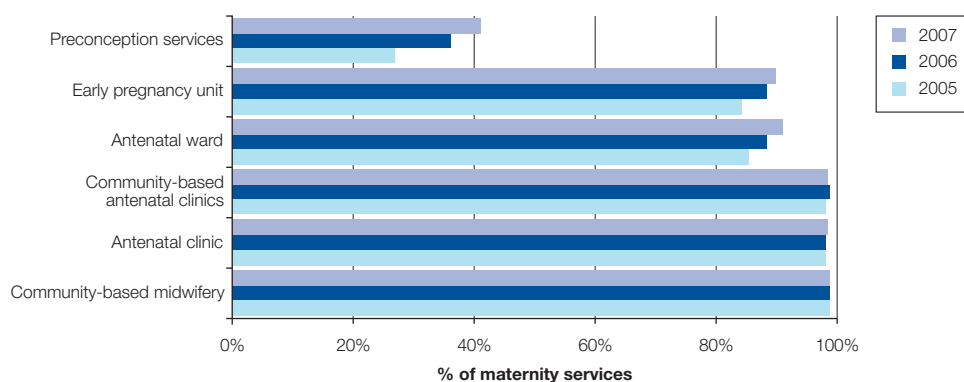
Fig. 14.2: Model of care in maternity



Antenatal care

14.7 A range of antenatal care was widely available. Community based midwifery and antenatal clinics were available in almost all maternity services. 170 services (90%) had antenatal inpatient beds and 168 services (90%) had an early pregnancy unit, both up from 159 services (88%) in 2006 (Fig. 14.3). Preconception services were less well developed but increasing, provided in 77 services (41%) in 2007, an increase from 65 services in 2006 and 41 services in 2005.

Fig. 14.3: Antenatal function in maternity services (N=180)



Involvement of mother's partner in antenatal education

14.8 The majority of maternity services routinely involved fathers and other partners of mothers in antenatal education. In 2007, 172 services (91%) reported that partners were fully involved (an increase of 26% from 2005) and in 14 services (7%) partners were offered partial involvement. Only one service did not involve partners.

Intrapartum care

14.9 Maternity services provided a total of 9,409 maternity beds in 2007, a 6% increase on the 8,886 beds provided in 2006 and a 28% growth since 2005 (Table 14.1). Of these beds, 2,294 (24%) were in birth rooms and 7,115 (76%) were maternity inpatient beds. There was an average of 3.7 birth room beds per 1,000 births in 2007 with an inter-quartile range of 2.88 to 4.30. This meant that each bed was used for an average of 0.74 births per day with an inter-quartile range of 0.66 to 0.97 births per day (Table 14.1). Change from the previous year was small. In 2006 the average birth room bed per 1,000 births was 3.74 with an inter-quartile range of 3.03 to 4.43. Bed use was 0.73 births per day with an inter-quartile range of 0.64 to 0.95.

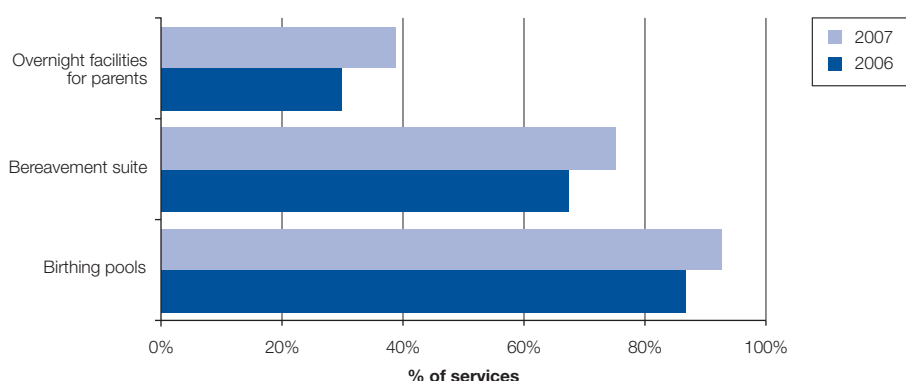
Table 14.1: Number of beds and births 2005 to 2007

	Total maternity beds	Number of birth room beds	Number of maternity inpatient beds	Births	Births per bed	Birth-room beds per 1000 births	Births per birth-room bed	Births per day per birth-room bed
2005	7,378	1,659	4,721	435,794	59	2.63	262.68	0.72
2006	8,886	2,174	6,712	581,427	65	3.74	267.45	0.73
2007	9,409	2,294	7,115	618,918	66	3.71	269.80	0.74

Note: Bed numbers are a snapshot taken on 30th November each year. Number of births is for the 12 months 1st April to 31st March.

14.10 The range of facilities in maternity units was improving (Fig. 14.4). For example, there was access to birthing pools in 176 services (93%), up from 87% in 2006. Bereavement suites were available in 143 services (75%) and overnight facilities for partners in 74 services (39%) but no information was collected on the nature of these facilities.

Fig. 14.4: Availability of facilities in maternity services



14.11 A range of options for pain relief were available in the majority of maternity services. Active birthing equipment was available in 177 services (93%) up from 165 (90%) in 2006. In 160 (91%) of the 176 maternity team care units in 2007, epidural pain relief was reported to be available on a 24/7 basis, up from 150 services (88%) in 2006.

Participation in Managed Maternity Care Networks

14.12 The purpose of Managed Maternity Care Networks is to ensure that health professionals and all agencies contributing to the provision of maternity services work together in a co-ordinated way, thereby ensuring equitable provision of high quality, clinically effective care²⁸. Only PCTs were asked about their involvement in Managed Maternity Networks and nationally 80 PCTs (53%) were found to participate, up from 59 PCTs (39%) in 2006.

Neonatal services

Neonatal services aim to offer high quality care for some of the most vulnerable babies in our society. Approximately 10 per cent of babies require some form of specialist support at birth with 1-3 per cent of these requiring Neonatal intensive Care.

Neonatal Intensive Care Review²⁹

14.13 The Neonatal Intensive Care Review recommended that the types of care that babies might require should be clearly defined in 3 levels:

- Level 1 - special care
- Level 2 - high dependency and
- Level 3 - intensive care³⁰.

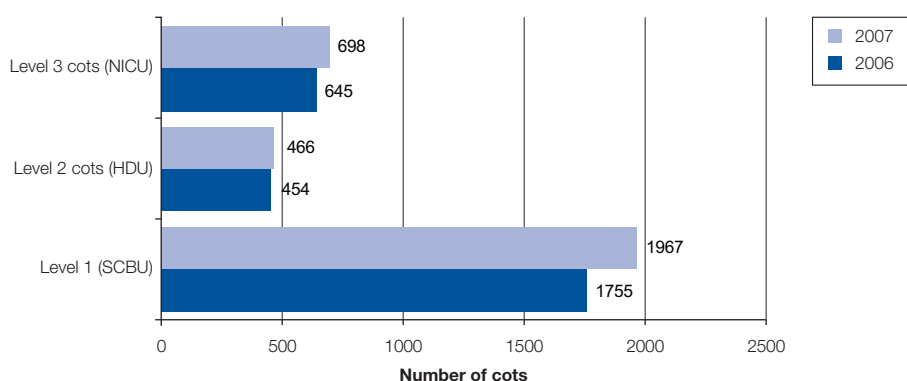
Neonatal intensive care units (NICU) may provide the full range of care but most would provide high dependency care and intensive care with special care baby units (SCBU) providing Level 1 special care. The review also recommended an increase in cot capacity and a strengthening of the role of SCBU to ensure the provision of high quality special care for babies.

Neonatal service provision

14.14 The number of neonatal intensive care units (NICU) increased from 109 in 2005 to 163 in 2006 and 166 in 2007. However, it should be noted that in 2006 the definition of NICU was extended to include special care baby units (SCBU).

14.15 The capacity of cots available in neonatal care was 3,131 in 2007, 10% growth on the 2,854 cots recorded in 2006. The strongest growth was in SCBU providing intensive care at level 1. The number of cots at this level rose by 12% from 1,755 in 2006 to 1,967 in 2007 (Fig. 14.5). High dependency cots providing care at level 2 increased 3% from 454 in 2006 to 466 in 2007 and NICU cots at level 3 rose 8% from 645 in 2006 to 698 in 2007.

Fig. 14.5: Number of NICU and SCBU cots 2006 and 2007

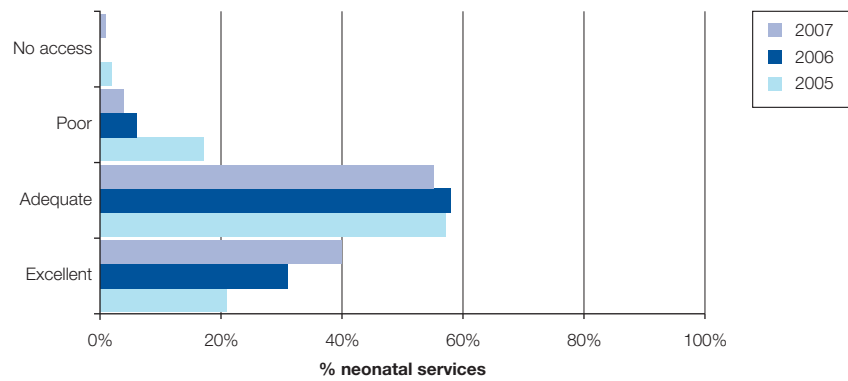


Neonatal transfer

14.16 The transfer of critically ill babies between units requires careful planning and co-ordination. Transport arrangements need to be in place both to support the movement of critically ill babies and also for babies being taken back to a unit near their homes³¹.

14.17 The majority of services considered their transfer arrangements between maternity and neonatal intensive care units to be adequate but the proportion of services giving an excellent rating had increased from 21% in 2005 to 31% in 2006 to 40% in 2007. Of the 166 NICU services in 2007, 91 services (55%) rated their transfer as adequate and 6 services (4%) felt their transfer arrangements were poor (Fig. 14.6).

Fig. 14.6: Adequacy of NICU access to neonatal transfer



Appendix 1:

Technical notes on the mapping exercise

This Appendix provides an outline of the child health, CAMHS and maternity service mapping methodology.

A1.1 Basic mapping concepts

Key characteristics of child health, CAMHS and maternity service mapping include:

- Annual data collection
- Online data collection input by all NHS trusts that provide or commission child health, CAMHS and/or maternity services in England
- Service provision is mapped to defined service/team types (Appendix 3)
- Services are mapped at the level of individual units of service delivered
- Expenditure on child health and maternity services entered by PCT commissioners and local authorities with regard to CAMHS commissioning
- All data publicly available in reports on www.childrensmapping.org.uk.

A1.2 Brief description of data collection process

- Introductory training delivered regionally
- Telephone/email helpdesk is provided throughout the data collection and reporting period
- Child health, CAMHS and maternity services and commissioner mapping leads are identified through previous mapping exercises and with the help of staff in Strategic Health Authorities, Government Offices and the National CAMHS Support Team
- Mapping Leads register on the website and obtain a unique password giving access to their NHS organisation or local authority's data set
- The Mapping Lead registers colleagues to support the mapping process as appropriate (as Assistant Mapping Leads or Service Group Heads) on the website to take responsibility for inputting specified areas of services or finances
- Service Group Heads review the data submitted in the previous year, making changes and revisions where necessary
- Service Group Heads either complete team data or 'delegate' completion to the appropriate team manager
- Commissioning Leads complete the commissioning data
- Data are collected on-line through the Internet
- Data are checked and confirmed correct by Chief Executive Officers (CEO) of NHS trusts and Directors of Children's Services (DCS) in local authorities
- Data was frozen on 28th February 2008 but corrections to the data were accepted beyond this date.

A1.3 Changes to the child health and maternity exercise in 2007

The mapping exercise is kept as similar to the previous year's data collection as possible. However, the changes below were put in place to improve the quality and consistency of the data collected and to support the merger of CAMHS mapping with the mapping of other child health and maternity services. Changes introduced in 2007 included:

- Enabling mappers to select more than one service type in order to reflect the plurality of service provision
- New questions were added to the PCT commissioner and provider organisation-wide questionnaire on NHS safeguarding provision
- All services were asked to indicate which of the Every Child Matters outcomes they were seeking to deliver

- Questions were introduced for all services on whether the whole or part of the service was targeted to particular groups of children and young people
- Services were asked to indicate if they routinely collected feedback from service users on their satisfaction with the service and if they encouraged users to participate in the design, development or delivery of services.
- Data was collected for the Healthcare Commission to contribute to the Annual Health Check. This concentrated on a number of indicators arising around from the 2006 review of children's hospital services.

A1.4 Changes to the child health and maternity exercise in 2006

The changes that were introduced in 2006 included:

- New mapping structure
- Integration of the mapping of spend on child health, CAMHS and maternity services
- Maternity services were changed to include NICU and SCBU as separate service types
- Definitions and questions were revised
- Some additional policy questions were added at the organisation level
- The provision of help and guidance on the use of the website was substantially improved
- 'Do-it-yourself' manuals were placed on the website to be downloaded
- A sandbox was introduced to enable questionnaires to be explored without damage to the datasets
- A pilot data collection was carried out for the Healthcare Commission. This picked up a number of indicators around areas that has raised concern in the recent review of children's hospital services.

A1.5 Checks and reliability

- Summary reports automatically screen data for completeness and plausibility
- Standardised codes and selection from pre-defined lists wherever possible
- Summaries giving overall view of the data entered and are signed off by the organisation's Chief Executive Officers (CEO) of NHS trusts and Directors of Children's Services (DCS) in local authorities
- Data scrutinised by Durham team during preparation of atlas and problems checked with local informants.

Appendix 2:

CAMHS technical notes

A2.1: Changes introduced in 2007

- CAMHS commissioners were asked to distinguish between expenditure on tier 2/3 CAMHS and tier 4 services
- The integration of the programming of CAMHS, child health and maternity service mapping was completed with the result that:
 - The questions on ECM outcomes, targeted provision, service user involvement in services and the collection of feedback were asked of CAMHS as well as child health and maternity services
 - A single staff list was used merging CAMHS staff types with child health and maternity staff categories
 - Workforce grades were removed to bring CAMHS data in line with all child health data.

A2.2 Changes introduced in 2006

- CAMHS mapping was moved to the child health mapping website and a single process of registration was introduced for PCTs and other NHS trusts
- Workforce grades were reintroduced to reflect the implementation of Agenda for Change
- A clear separation was introduced to distinguish the active caseload from consultations in team activity. There would be no expectation that clinicians collected full details of the child or young person consulted about during the caseload data collection periods
- New questions were introduced to explore which teams delivered assessments, consultation and liaison, training and particular interventions
- Teams were asked if they used outcome measures and, if so, which ones
- No data was required by the Healthcare Commission for performance purposes but the mapping continued to collect data for the PAF A70 indicator for Ofsted.

A2.3 Changes introduced in 2005

- Workforce grades were removed until the full implementation of Agenda for Change was complete
- The facility for commissioners to register on the mapping website independently was introduced. A specific log in was set up for each commissioning organisation
- Guidance was strengthened around the inclusion of consultation numbers within caseload data
- New local authority questions were introduced linked to performance indicators carried out by the Commission for Social Care Inspection.

A2.4 Changes introduced in 2004

- Individual staff questionnaires dropped
- Commissioners reported and signed-off investment data directly but were contacted initially by service providers
- Previous year's data presented as a starting point
- Caseload data was collected for teams not individual staff
- A new question was introduced to clarify whether teams being mapped for the first time were new investment or just previously unmapped.

A2.5 Checks and reliability

- Summary reports automatically screens data for completeness and plausibility
- Standardised codes and selection from pre-defined lists wherever possible
- Summaries giving overall view of the data entered and are signed off by Chief Executive Officers (CEO) of NHS trusts and Directors of Children's Services (DCS) in local authorities
- Data scrutinised by Durham team during preparation of atlas and performance indicator tables; problems checked with local informants.

Appendix 3:

Completion rates 2006 and 2007

A3.1 Completion rates

Child health, CAMHS and maternity service mapping (referred to below as child health mapping) is a voluntary data collection exercise in which all PCTs and NHS child health CAMHS and maternity services providers are invited to participate. Overall, a very high participation rate is achieved but response rates vary each year both in the number of agencies entering data and the completeness of the data reported.

There are 3 measures which indicate the completeness of data entry:

1. rate of registration on the mapping website
2. rate of sign-off by the Chief Executive Officer of NHS trusts and Directors of Children's Services (DCS) in local authorities to confirm agreement with the data reported
3. rate of sign-off of each individual service questionnaire and finance spreadsheet to confirm that it is complete.

Rates of response against each of these measures are given below for the 2006 and 2007 mapping exercises. No completion rates have been given for 2005 as that was the first year of the exercise for child health and maternity services and before PCT reorganisation.

A3.2 Completion rate 1: Registration rate

Registration indicates that the organisation has knowledge of the exercise, has nominated a Mapping Lead who has accessed the website, completed the registration process and received a password enabling them to enter and revise data. The rates of completion are shown in Table 1.

Table 1: Rates of registration for the mapping exercise 2006 and 2007

	2006			2007		
	Total in England	Number registered	Registration rate	Total in England	Number registered	Registration rate
PCTs	152	152	100%	152	152	100%
NHS Provider Trusts	211	210	99.5%	213	209	99.5%
LAs	150	150	100%	150	150	100%
Total	513	510	99.8%	515	514	99.8%

A3.3 Completion rate 2: CEO/DCS sign off rate

Every year, Chief Executive Officers (CEO) of NHS trusts and Directors of Children's Services (DCS) in local authorities are asked to 'sign off' the mapping data that is being reported by their agency. This signifies that the CEO/DCS has been presented with a report of the data (set up on the mapping website for this purpose) and confirms the data as a description of the organisation's relevant service provision and investment. Separate sign off reports are prepared for finance, child health and maternity services provision, CAMHS provision and performance indicators. The rates of sign-off in 2006 and 2007 are shown in Table 2.

Table 2: Rates of sign off by CEO and DCS 2006 and 2007

	2006			2007		
	Number of agencies registered	Number signed off	Sign off rate	Number of agencies registered	Number signed off	Sign off rate
PCT finance data	152	132	87%	152	144	95%
Child health and maternity service data	316	267	84%	316	292	96%
CAMHS data	110	95	86%	110	101	92%
LAs - CAMHS finance	150	132	88%	150	143	95%
LA PAF 70 proxy indicator	150	107	71%	150	106	71%

A3.4 Completion rate 3a and b: Questionnaires and spreadsheets confirmed complete

At the end of each service questionnaire and finance spreadsheet, data inputters are asked to tick a box to indicate completion of data inputting. As service data is migrated from one year to the next to avoid the need for repeat data entry, this confirmation gives confidence that the data has been reviewed in the current year. Rates of finance spreadsheet sign-off are given in Table 3a. In Table 3b, rates of service questionnaire sign-off are presented for each of the service types mapped.

Table 3a: Rates of sign-off of finance spreadsheets by PCT and LA 2006 and 2007

	2006			2007		
	Number spreadsheets completed	Spreadsheets confirmed complete	% confirmation rate	Number spreadsheets completed	Spreadsheets confirmed complete	% confirmation rate
PCT	1639	1575	96%	1888	1786	95%
LA	212	186	88%	233	217	93%
Total	1851	1761	95%	2121	2003	94%

Table 3b: Rates of sign-off of service questionnaires by service type 2006 and 2007

Service Type	2006			2007		
	Number services mapped	Services confirmed complete	% confirmation rate	Number services mapped	Services confirmed complete	% confirmation rate
School health service	334	294	88%	295	276	94%
Early years and health visiting service	477	415	87%	427	407	95%
Children's therapy service	488	452	93%	494	468	95%
Disabled children's services	391	354	91%	396	366	92%
Safeguarding children service	303	278	92%	277	254	92%
Services for children in special circumstances	282	257	91%	265	245	92%
Tier 1 CAMHS	58	47	81%	42	40	95%
Community paediatrics	466	426	91%	394	360	91%
Children's surgery	213	185	87%	203	191	94%
Specialist paediatric service	188	150	80%	177	170	96%
Paediatric intensive care unit	33	26	79%	29	27	93%
General paediatrics	246	224	91%	242	231	95%
Paediatric emergency service	169	153	91%	169	161	95%
NICU and SCBU	163	146	90%	166	157	95%
Maternity service	194	170	88%	190	181	95%
CAMHS Team	1055	1011	96%	1047	973	93%
Total	5060	4588	91%	4813	4507	94%

Appendix 4:

Service categories and types 2007

A4.1 Universal child health services

- School health service
- Early years and health visiting service

A4.2 Child health targeted services

- Community paediatric service
- Children's therapy service
- Service for children with a disability or complex needs
- Service for children in special circumstances
- Tier 1 CAMHS

A4.3 Children's hospital service

- Children's surgery
- Specialist paediatrics
- Paediatric intensive care
- General paediatrics
- Paediatric emergency

A4.4 CAMHS (specialist tiers 2-4)

- Multidisciplinary generic CAMHS
- Single disciplinary generic CAMHS
- Targeted CAMHS
- Dedicated CAMHS worker in a non-CAMHS team
- Tier 4 CAMHS unit

A4.5 Maternity and neonatal services

- Neonatal intensive care unit and special care baby unit
- Maternity service

Appendix 5:

Working definition of CAMHS tiered system

Mental health services for children and adolescents have been described according to a four-tier framework.

Tier 1

The phrase primary care is used to describe agencies that offer first-line services to the public and with whom they make direct contact. This includes interventions by:

- GPs
- Health visitors
- Residential social workers
- Juvenile justice workers
- School nurses
- Teachers
- Family aides, carers and support workers offer various types of assistance that help to prevent family breakdown.

All of these primary care workers regularly encounter early manifestations of difficulty, problems and disorder in children. Complex and serious problems require immediate referral to tier 2 or 3 (specialist) level of CAMHS. The bulk of more minor problems is, and should be, handled within the primary care sector through discussion, and counselling.

Role of **Primary Mental Health Workers (PMHWs)**: PMHWs are tasked with supporting and enabling tier 1 professionals and improving the links between the primary and specialist tiers of service. These professionals would need to be integrated into a specialist community CAMHS.

The roles of PMHWs include:

- identifying mental health problems early in their development – early intervention
- offering general advice – and, in certain cases, treatment for less severe mental health problems
- pursuing opportunities for promoting mental health and preventing mental health problems.

Tier 2

A level of service provided by professionals working on their own who relate to others through a network rather than within a team:

- Clinical child psychologists
- Educational psychologists
- Paediatricians – especially community
- Community child psychiatric nurses or nurse specialists
- Child psychiatrists

Tier 2 services offer:

- training and consultation to other professionals (who might be within tier 1)
- consultation for professionals and families
- outreach to identify severe or complex needs where children or families are unwilling to use specialist services
- assessment which may trigger treatment at this level or in a different tier

The purpose of tier 2 services is to:

- enable families to function in a less distressed manner,
- enable children and young people to overcome their mental health problems,
- diagnose and treat disorders of mental health,
- enable children and young people to benefit from their home, community and education,
- enable children, young people and their families to cope more effectively with their life experiences.

Tier 3

A specialist service for the more severe, complex and persistent disorders. Because of the complexity of the work that they undertake, staff usually work in a multidisciplinary team or service working in a community child mental health clinic or child psychiatry outpatient service. Tier 3 services might have input from the following professionals:

- Social workers
- Clinical psychologists
- Systematic family therapists
- Community psychiatric nurses
- Child and adolescent psychiatrists
- Art, music and drama therapists
- Child psychotherapists
- Occupational therapists.

In addition to those of tier 2, the tasks of tier 3 services are:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in tier 2 because of the complexity, risk, persistence and interference with social functioning and normal development, and the consequent need for specialist skills.
- To act as gatekeepers, with clearly agreed criteria, for the assessment for referrals to tier 4.
- To have relationships which ease the passage of children and young people into such care
- To contribute to the services, consultation and training at tiers 1 and 2
- To ensure smooth transition of individual cases or families to tiers 2 and 1 before completion of the involvement of tier 3 service
- To participate in research and development projects.

Tier 4

Tier 4 should be seen as part of a continuum of care for clients and families. They are essentially tertiary services such as day units, highly specialised outpatient teams, and inpatient units for older children and adolescents who are severely mentally ill or at suicidal risk.

Tasks undertaken in tier 4 involve:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in tier 3 because of their complexity, risk, persistence and interference with social functioning and normal development, consequently requiring very specialised skills.
- Provisions of interventions that require such a level of skill.
- Provision of services that would not be cost effective in every locality because of sporadic demands for them in smaller populations.
- Provide support to staff working in tiers 1, 2 and 3, where they are engaged in complex cases that might otherwise require management in tier 4.

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Appendix 6:

Child Health, CAMHS and Maternity Service Mapping Steering Group 2007-2008

Remit:

To oversee the development of all children, young people and families related mapping projects. This includes;

- CAMHS mapping (sixth year);
- Child Health and Maternity Services (second year);
- Children's services mapping (pilot phase).

Membership:

Hilary Samson-Barry (CHAIR)	Department of Health
Fiona Smith	Royal College of Nursing
David Vickers	South Cambridgeshire PCT
Kamini Gadhok	Royal College of Speech & Language Therapists
Maddie Blackburn	Healthcare Commission
Bob Foster	CSIP
Barbara Hearn	National Children's Bureau
Jane Held	Local Government Association
Jacky Tiott	Department of Children, Schools and Families
Prof. PMS O'Brien	Royal College of Obstetricians & Gynaecologists
Jake Abass	Yorkshire & Humber PHO
Kim Bromley-Derry	South Tyneside Metropolitan Borough Council
Rose Collinson	Medway District Council
Adam King	Ofsted
Dave Smith	Government Office North East
Paul O'Sullivan	Plymouth PCT
Keith Brumfitt (represented by Ivy Papps)	Children's Workforce Development Council
Helen Thompson	Leicester City PCT
Hilal Barwarny	Leicester County Council

Note:

Full terms of reference are available from the project management team.

Appendix 7:

Child Health, CAMHS and Maternity Service Mapping Expert Reference Group 2007-2008

Remit:

To support the development of the children's health and maternity service mapping, the Expert Reference Group's remit is to:

- Provide general support to the Mapping Team through the provision of expert advice;
- Contribute to the quality assurance of the mapping data collected by helping the Mapping Team to recognise possible errors and interpret the results;
- Ensure the mapping reflects stakeholder needs, including the needs of policy-makers, service commissioners and providers, service managers, planners and practitioners. The views of users of services will not be represented on this group but work to ensure their views are heard will be carried out separately and in addition to the work of the ERG;
- Advise the Mapping Team on areas of the mapping that need improvement, identifying developments that will help in data collection or reporting;
- Act as a sounding board for the mapping team on issues connected to the mapping.

Membership:

Alcuin Edwards	Department of Health
Amanda Robson	George Elliot Hospital
Ann Marshall	Sue Start Leicester *
Ashley Wyatt	Leeds Primary Care Trust
Bob Butcher	Northampton General Hospital NHS Trust
Carole Murrish	James Cook University Hospital
Cath O'Kane	Northumbria Healthcare NHS Trust
Chris Scarborough	Birch Hill Hospital *
Cliona Ni Bhrolchain	Clatterbridge Hospital
Dasha Nicholls	Great Ormond Street Hospital
David Shortland	Poole Hospital
Dr Edward Wozniak	Department of Health
Dr Fawzia Rahman	Central Derby Primary Care Trust
Heather Sahman	CSIP – East Midlands
Jan Gunter	East Lincolnshire Primary Care Trust
Jane Wiles	James Cook University Hospital
Jill Demilew	Department of Health *
Julia Stallibrass	Department of Health
Kathryn Halford	Department of Health
Dr Lynda Brook	Alderley Hey Hospital
Lynne Leyshon	South Devon Healthcare NHS Trust
Mark Cain	County Durham Primary Care Trust
Mohammed Kibirige	James Cook University Hospital
Paula Carr	North Stoke Primary Care Trust
Sue Welsh	Northumberland, Tyne and Wear SHA
Sue Youngusband	County Durham Primary Care Trust *

Note: Full terms of reference are available from the project management team.

* indicates members who are no longer part of the group, but contributed for 2006/7 mapping.

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- ³⁰ As above Section 8.
- ³¹ As above Section 38.

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