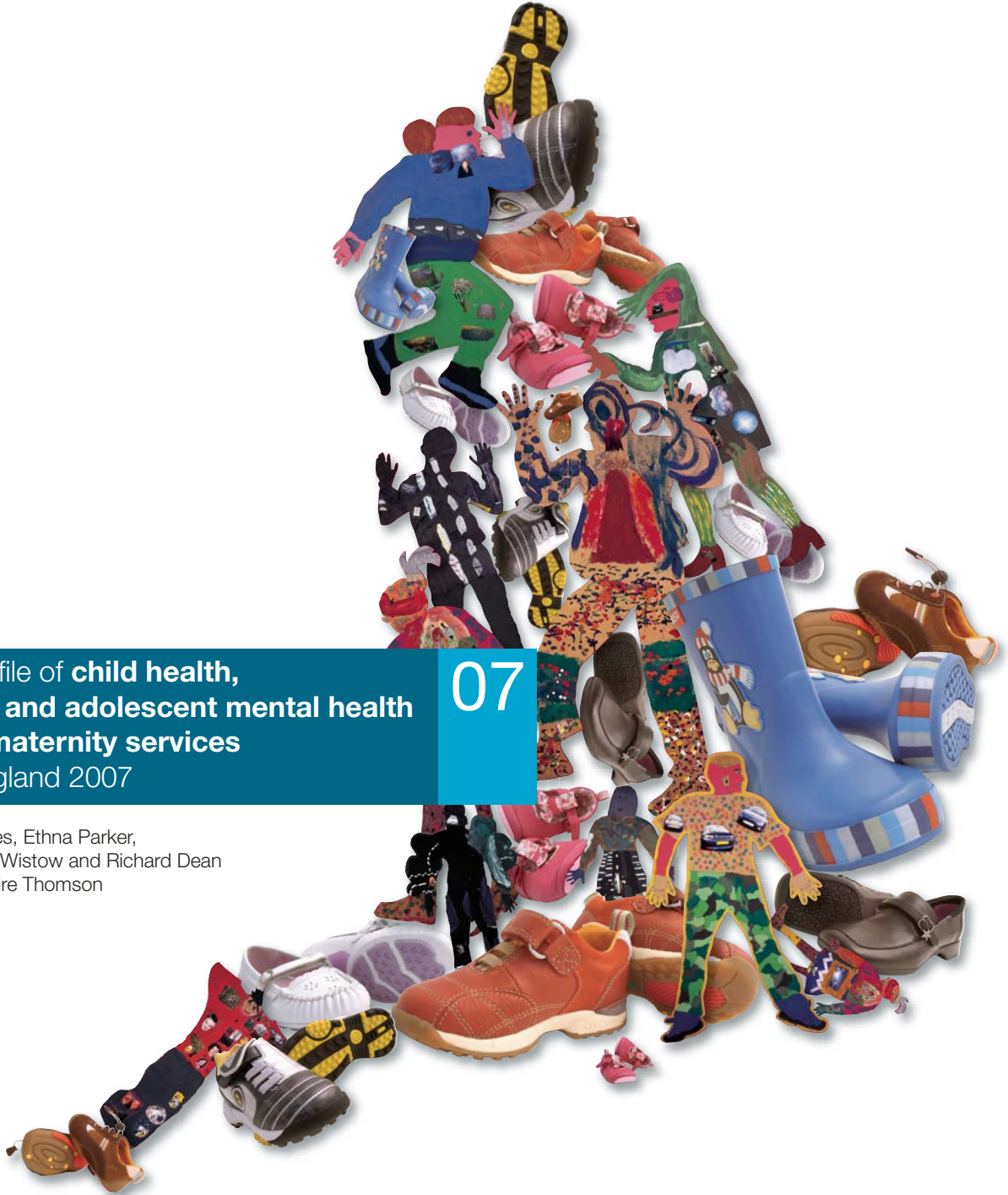A profile of **child health,
child and adolescent mental health**
and **maternity services**
in England 2007

07

Di Barnes, Ethna Parker,
Richard Wistow and Richard Dean
with Claire Thomson

Foreword

This is the second report of the national child health and maternity services mapping exercise, providing the results of information collected by local authorities and the NHS between November 2006 and March 2007. Importantly, this years report includes data from the more established child and adolescent mental health services mapping exercise. The integration of all results into one atlas, organised around National Service Framework standards aims to further support the local development and improvement of children's services.

Local support for a tool which has the ability to track changes over time as national policy is implemented and raise the profile of children's services by highlighting gaps and resource issues has continued this year. The response rate from services has improved further, from 96% to 99%. This is despite the significant restructuring within the NHS and the non mandatory nature of the child health and maternity service questionnaires this year. Please maintain this enthusiasm so that robust trend data can be built upon year on year.

The mapping exercises have always had a close relationship to performance improvement with the data providing a useful source of information for the Healthcare Commission and Ofsted. For the period of this report, only CAMHS data was formally performance monitored by Ofsted. It may be useful to note though that this will change in 2007/8 as children's hospital services data is used as part of the Healthcare Commission's review. Details are available on their website: www.healthcarecommission.org.uk.

The ability to access the data and utilise the reports to understand the nature and extent of your local provision and pinpoint areas for attention is critical. Reports are available locally, regionally and nationally at www.childhealthmapping.org.uk. In particular, at a local level, staff new to children's services may find the local PCT profiles a useful starting point for understanding the overall position of your PCT.

This paper-based atlas provides a national position statement and can be used to understand how different regions compare in terms of progress made against national policy. For this reason it is of particular use to national and regional policy leads and inspectors, leads in professional organisations, SHA children's leads, CSIP staff, Children's Services Advisors and their teams at government offices. Please remember though that all of the data can be drilled down to the original questionnaire it came from so the detail is readily available on the website.
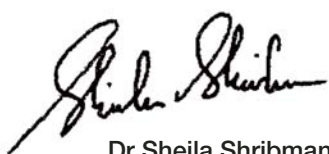
In terms of the key messages from this report, you will find a very useful summary in the 'Key Messages' document. However, there are some interesting early trends that will be helpful to follow up now and in the future such as:

- 25% increases in workforce and investment, partly accounted for by the increase in response rate and numbers of services mapped but also due to improved knowledge of mapping
- A national spend figure of £5B with 64% taken up by hospital and maternity services and just 13% on universal services

- Commissioners taking their planning responsibilities seriously with improvements in both leadership arrangements for children's services and planning activities such as the completion of locality wide health needs assessments
- A significant change in the way in which services are delivered between reporting years with big increases in outreach working taking place in non health settings
- Some concerns in the reduction of school nursing resources per cluster of schools and the marginal improvement in services for adolescents
- The delivery of the PSA targets for CAMHS across all CAMHS partnerships.

In terms of the next steps, improvements to the way in which data is reported will continue with on-line portals dedicated to each PCT being available in the New Year. In addition, the Child Health and Maternity Intelligence Unit (CHIMAT) is under development and will provide a range of commissioning tools to support you in your work over the next 18 months.

Once again, without your support none of this would be possible, so many thanks for your commitment to this important way of understanding children's services and the opportunities arising to improve delivery and better outcomes.

Dr Sheila Shribman
National Clinical Director for Children
Department of Health

Contents

Chapter 1.

Introduction

Overview

1.1 This is a report of the 2006/7 national child health, child and adolescent mental health service (CAMHS) and maternity services mapping exercise. This was the second year that child health and maternity service data was collected and the fifth year that the CAMHS exercise had been carried out. For the first time, data collection in these three areas was combined, underlining their joint aim 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.

1.2 The mapping exercise results in a national service overview, indicating what is provided, where and with what levels of investment. In 2006 details of 5,057 child health, CAMHS and maternity services/teams were mapped employing almost 107,612 whole time equivalent (wte) staff and investment in the services exceeded £4.5B. With the quantity of data collected, it is not possible to report all the findings in a single report and so this atlas presents data at a national and strategic health authority level only. More local findings can be found on the mapping website and reference is made to this within each chapter of the report.

Mapping management

1.3 The mapping exercise was undertaken by the Durham Mapping Team under the management of the former National Child Health Mapping Lead Bob Foster, now led by Claire Thomson. The Durham Mapping Team is based in the School for Applied Social Sciences at Durham University. The team first developed the service mapping methodology in 2000 to monitor progress in the implementation of the Mental Health NSF and since then annual mapping exercises have been introduced for CAMHS, child health and maternity services and older people's mental health services.

1.4 Currently a national pilot of the mapping of children's social care and education services is being undertaken. This will complete the picture of children's services provided by the statutory sector in England and will mean that service mapping can inform the planning of all children's services that will be commissioned through children's trusts.

1.5 The mapping exercise was developed in partnership with the children's policy branch at the Department of Health and the Durham Mapping Team continues to work in close collaboration with staff in the Care Services Improvement Partnership (CSIP) and the National CAMHS Support Service (NCSS).

1.6 Governance arrangements are provided through the National Children's Services Mapping and Information Steering Group chaired by the Director of Children and Families at the Department of Health. An Expert Reference Group made up of child health, CAMHS and maternity service practitioners, managers and policy makers provides expert advice on the definitional aspects of the exercise.

1.7 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 were:
- CAMHS 2006 - ROCR/OR/016/002 - SUB204/017.
- National Child Health and Maternity Services Mapping - ROCR/OR/0170.

Mapping process

1.8   The 2006/7 mapping exercise was carried out between November 2006 and March 2007. It contained three elements:
- Service mapping which built up an inventory of services and teams and was completed by NHS trusts that provide child health, CAMHS or maternity services
- Financial mapping which was completed by PCT commissioners who were asked to record their actual spend on child health, CAMHS and maternity services for the last financial year (April 2005 to March 2006) and their predicted budget for the current year (April 2006 to March 2007)
- Local authority mapping of CAMHS only which required a parallel finance mapping exercise and information on four CAMHS performance indicators for Ofsted, the inspection body for children's services.

1.9   In addition to monitoring NSF and ECM outcomes, the mapping exercise aims to:
- Act as a source of data for national, regional and local performance measurement and monitoring
- Assist in the bid for resources
- Support local service development and gaps analysis
- Facilitate local benchmarking.

1.10   As child health and maternity service mapping was in its second annual cycle and CAMHS mapping in its fifth, the web-based mapping process had become familiar to the majority of services involved. By and large, services/teams were on the system and data inputting required only revisions and updates. However, the work involved in data update was considerable as staffing information had to be checked, CAMHS caseload numbers had to be collected and details of the type of service delivered had to be revised. The success of the mapping owes a great deal to the thorough way that this data has been submitted each year.

1.11   For the child health, CAMHS and maternity service mapping in 2006, the key stages in the mapping process were as follows:

- Each NHS trust providing or commissioning child health, CAMHS or maternity services were required to nominate a lead manager to take responsibility for seeing that the data collection was completed. The mapping lead had to co-ordinate the exercise but could request colleagues to take on sections of the mapping, such as, the mapping of CAMHS tier 2 to 4 teams. Lead mappers were asked to register on the mapping website, identify the catchment/partnership area for their local services, co-ordinate data entry and ensure the exercise was signed off as complete.

- For all teams and services, details of their provision, function, specialisation, staffing and activity were requested. Some details of the characteristics of the children and young people using CAMHS were also needed. All data was input on-line and the website provided reports that could be examined and printed to enable the data to be interrogated. Please refer to Annex 3 for the definition of the CAMHS tiered system of provision.

- All data had to be entered between 1st November 2006 and 31st March 2007 and 'signed off' as correct by the Chief Executive of the NHS trust.

- PCT commissioners were required to register on the website and submit data on their child health, CAMHS and maternity service budget for the last and current financial year, distinguishing how much of the budget was spent with each of their service providers.

- Local authority CAMHS commissioners were identified with the help of Ofsted and the Department for Children, Schools and Families (DCSF). They also registered directly on the website and provided financial data on local authority CAMHS budgets and information on their progress in meeting national targets on CAMHS provision (PAF A70 indicators). The performance data was sent to Ofsted to be used in local authority performance rating.

- A helpdesk operated throughout the mapping period and could be contacted by telephone or email. Very good use was made of this facility and valuable feedback was received by the Durham University Mapping Team which informed improvements to the system to be introduced for the 2007/8 collection.

Using this atlas

1.12   The structure of this report is new to take account of the combined approach to the child health, CAMHS and maternity service mapping exercise. This was also more reflective of national policy such as the NSF and ECM, making the document more appropriate for its use in monitoring the implementation of policy change. The emphasis on ECM will increase in future years since additional questions have been included for 2007/8.

The structure of the atlas is as follows:

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

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

Chapter 3: Workforce describing the make up of the child health, CAMHS and maternity service workforce and its vacancy rates.

Chapters 4 to 13: Delivering NSF standards, these chapters connect the mapping to the NSF standards and report the findings most relevant to each standard.

Chapter 11: NSF standard 9 contains the report of the CAMHS mapping exercise.

Annexes: Technical aspects and governance arrangements providing explanations of the technical aspects of the exercise including quality checks and membership of steering and expert reference groups.

1.13   Please note that the content of chapters 4 to 13, Delivering NSF standards will change as NSF and ECM continues to be rolled out. It is important that conclusions are not drawn about the relative importance of different service types by the length of chapters. This is usually due to the fact that some areas have more easily measurable issues. A group of clinicians, managers and policy makers continue to advise the mapping exercise ensuring that key issues facing stakeholders are captured and that the data collected is:
- measurable through this form of national data collection
- referenced in at least one national policy document
- deemed to be of importance by the field.

1.14   Where information was gathered in the 2005/6 mapping exercise, trends in findings are provided and they will continue to be tracked over time in order to monitor progress in achieving targets.

1.15   It is important to stress that this was the first joint child health, CAMHS and maternity mapping exercise and it remains a learning exercise for everybody involved.   Data may not be complete and detailed results should be read with care. We advise commissioners and providers to use the information as a tool to identify areas for follow up and further investigation.

Local access to data

1.16   The Durham Mapping Team is continuing to develop the ways it reports mapping data and provides tools for data interrogation. Currently on the mapping website there are national, regional and local reports, a service directory facility and a comparator tool for setting up customised reports. The website address is: www.childhealthmapping.org.uk/reports.

1.17   If you have any difficulty accessing these, contact our helpdesk on 0191 334 1489.

Chapter 2.

Commissioning, expenditure and leadership

Introduction

2.1   This chapter reports the findings of the finance mapping that was completed by PCTs, and local authority CAMHS commissioners, to describe investment in child health, CAMHS and maternity services for the financial year April 2005 to March 2006.

2.2   In addition to reporting current investment, the finance mapping enables trends in expenditure to be calculated. Information on the actual expenditure in the previous financial year (2005/6) and the predicted budget for the current year (2006/7) was collected. By comparing the two figures, predicted changes in investment can be calculated from the data supplied in a single year.

2.3   The chapter reports the finance mapping results as follows:

- All child health, CAMHS and maternity services expenditure
  - Overview
  - Commissioning arrangements
  - Total spend
- Child health and maternity service expenditure
  - Budget change
  - Spend per child
  - Spend on maternity services per birth
- CAMHS expenditure
  - CAMHS change in spend
  - PCT and LA share of CAMHS investment
  - Source of funding
  - Spend per child
- Individual care expenditure
- PCT leadership for children's issues and involvement in planning fora.

2.4   As finance mapping is complex, requiring the identification of investment in a range of services by both commissioners and providing agencies, it is very difficult to confirm the accuracy of the data submitted. Details of the data checks made by the Durham Mapping Team are described in Annex 1 but localities also continue to check the data submitted and may request changes to be made. Therefore it is possible that the published data may be different from that on the website.

2.5   Detailed tables of the data used can be found and downloaded from the mapping website at: www.childhealthmapping.org.uk/reports

# An overview of spend on child health, CAMHS and maternity services

2.6   The aim of the finance mapping is to identify annual national spend on child health, CAMHS and maternity services, to distinguish investment on particular categories of service and to track changes in expenditure. This was a challenging exercise in the winter of 2006/7 because of the changing environment in which commissioners were operating, as described below.

2.7   The implementation of key aspects of 'Commissioning a patient-led NHS'[3] were having an impact. These included not only the reconfiguration of PCTs and SHAs but also the emergence of practice based commissioning, the full-scale development of foundation trusts across England and the introduction of payment by results. In addition, changes were being introduced in the commissioning of children's services through the creation of children's trusts. As required by the Children's Act (2004), children's trusts should be in place in every local authority by April 2008 and these were at varying stages of development.

2.8   The identification of funding for children's health services remained difficult as:
   • Hospital-based services were often wrapped up in single service level agreements between PCTs and acute providers which did not specify the child specific elements of the contract
   • Initiatives, such as payment by results, which were beginning to address this, were still at an early stage of implementation
   • Separating out children's services from generic all age services could be a complicated task requiring a drill down to the constituent parts of a service.

2.9   Data was collected at PCT level but it has been aggregated to SHAs for the purpose of this report. Services have also been aggregated into the three broad categories:
   • Universal, targeted and hospital children's health services
   • Maternity services
   • CAMHS.

2.10   PCTs, as commissioners, were asked to complete on-line financial spreadsheets providing information on the predicted budget for the current financial year (2006/7) and the actual spend for the previous year (2005/6). Spend included staff, non-staff costs and a proportion of overhead costs. 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. It is hoped that estimates will become less used as familiarity with the mapping process develops and PCTs set up systems to respond. The feasibility of removing the estimate option will be reviewed on an annual basis.

2.11   Finance data was submitted by 96% of PCTs (146 PCTs) but 11% of PCTs submitted partial data, providing no expenditure figures on at least one category of service. Overall, the response rate was much higher than the previous year with 88% of PCTs' data being 'signed off' by their chief executive in 2007 compared to 66% in 2006. Because of the improvement in reporting in 2006/7, comparisons with the 2005/6 finance mapping returns have been kept to a minimum and care should be taken in interpreting these results.

Commissioning arrangements

2.12 PCTs were asked to identify whether they undertook commissioning as a single agency, through specialist commissioning arrangements or as part of a group of PCTs and/or local authorities that commissioned jointly.

2.13 The majority of child health, CAMHS and maternity services were commissioned through single PCT commissioning arrangements (Fig. 2.1). This accounted for 87% of the reported child health budget. Joint commissioning accounted for only 4% of the total budget while specialist commissioning for regional and sub-regional specialties was reported for 7% of the budget. 'Spot' commissioning accounted for only 2% of the budget. 'Spot' commissioning 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.

Fig. 2.1: Commissioning arrangements for 2006/7 child health, CAMHS and maternity service budget
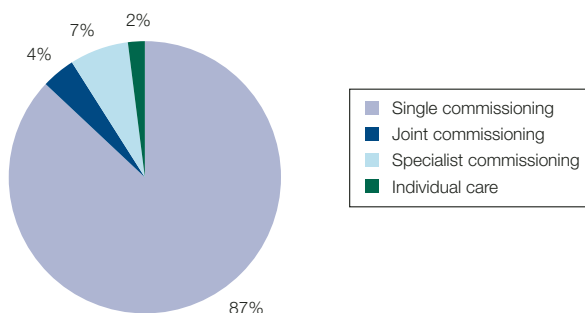
2.14 Between 2005/6 and 2006/7 the main changes in commissioning arrangements were a decline in joint or group commissioning because of the merger of PCTs that led to a corresponding increase in single agency commissioning (Fig. 2.2). The proportion of the budget spent on specialist commissioning rose by 2%, largely due to participation in the mapping by specialist commissioning teams. The proportion of the budget spend on individualised care remained at 2%.

Fig. 2.2: Change in commissioning arrangements 2005/6 and 2006/7
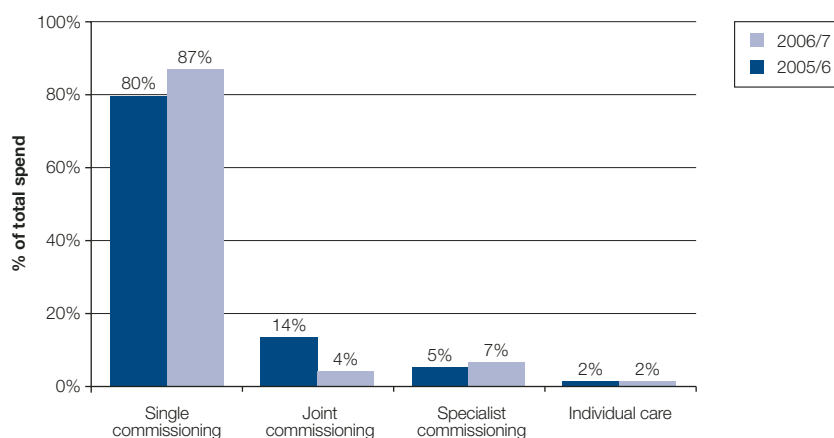
2.15 Commissioning arrangements differed considerably between SHAs (Fig. 2.3) with joint/group commissioning developed in only a minority of areas. This is likely to reflect historical differences in commissioning and changes will be mapped with interest over the next few years. It is also important that the finance mapping exercise is adapted to ensure joint commissioning with local authorities can be accurately reflected.

Fig. 2.3: Commissioning arrangements for 2005/6 child health, CAMHS and maternity service budget by SHA
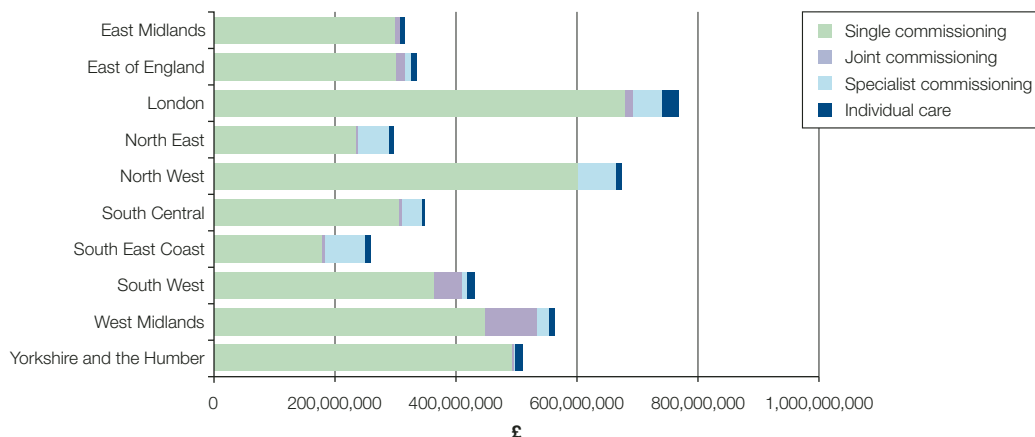
Total spend

2.16 Total reported spend on child health, CAMHS and maternity services in 2005/6 was £4,504M. As this was submitted by 96% of PCTs only and included some partial data, it is estimated that the total spend on children's health services in 2005/6 was in the order of £5B. In 2004/5 the reported figure was £3,600M but two factors should be noted when making comparisons:
- Improved data capture in 2005/6 can account for increased total expenditure
- The introduction of payment by results has led to more accurate reporting.

2.17 Out of a total reported expenditure of £4,504M in 2005/6, £1,502M (33%) was spent on hospital services, £1,372M (31%) on maternity services, £563M (13%) on universal services, £496M (11%) on targeted services and £461M (10%) on CAMHS (Fig. 2.4). Spot purchasing for individual care accounted for an additional £110M (2%).

Fig. 2.4: Reported child health, CAMHS and maternity service expenditure by service category 2005/6
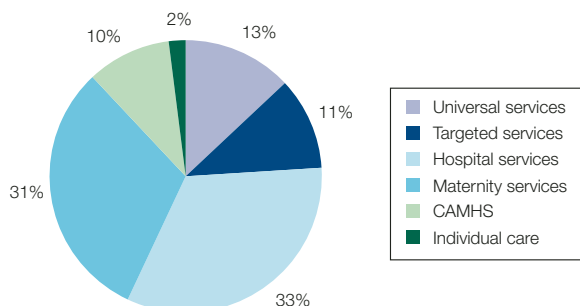
Child health and maternity service expenditure

Change in expenditure – actual versus predicted

2.18 In 2004/5, the actual spend on child health and maternity services was £3,119M and the predicted budget for 2005/6 was £3,381M, an expected increase of 8%. In fact the mapping recorded an overall increase of 26% in actual spend between 2004/5 and 2005/6 (Fig. 2.5). As explained above, this was due largely to improved data collection and understanding of expenditure brought about through the development of payment by results. A number of PCTs explained that their estimates of spend in 2004/5 had been over optimistic and, although the figures were lower in 2006/7, they were more accurate.

Fig. 2.5: **Trends in actual and predicted budget for child health and maternity services 2004/5 and 2005/6**
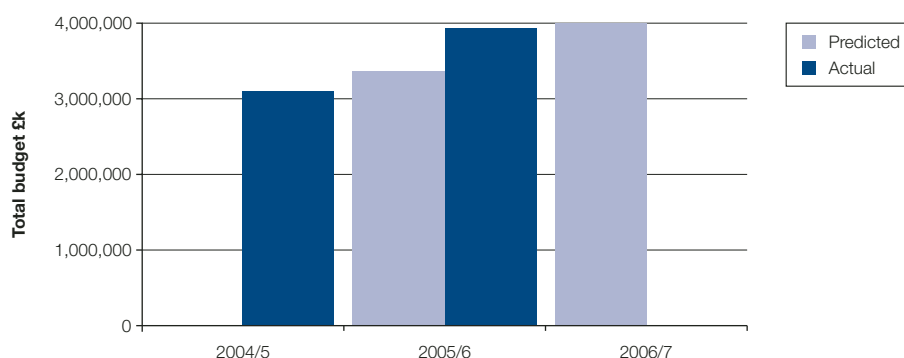
2.19 In the 2005/6 mapping exercise, the expected change in spend on child health universal, targeted and hospital services ranged from 5% to 10% but by 2006/7, predicted growth was considerably reduced and only a negligible increase of spend on hospital services was expected (Fig. 2.6). In 2005/6 the expected growth of spend on maternity services was 9% but this had dropped to 2% in 2006/7.

Fig. 2.6: **Changes in child health and maternity services budget predicted in 2005/6 and 2006/7 by service categories**
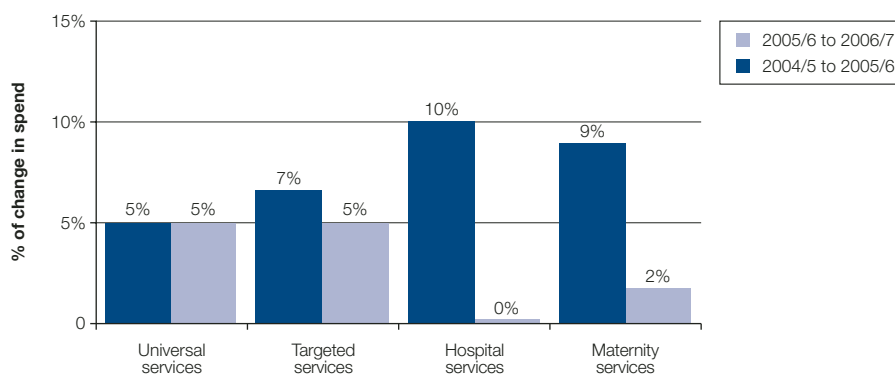
Spend per child on children's health services

2.20   The national spend per child aged 0 to 17 years of age was £232 in 2005/6 compared to £180 in 2004/5. The regional variation ranged from £155 to £323 (Fig. 2.7).

Fig. 2.7:   Spend per child aged 0 to 17 on child health services 2005/6
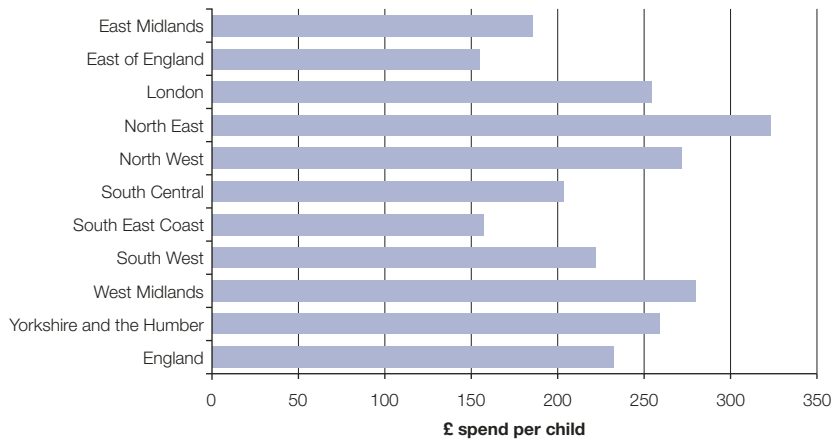
Expenditure on maternity services per birth

2.21   National spend on maternity services per birth was £2,360 in 2005/6 compared to £2,584 in 2004/5. Regional variation ranged from £1,465 to £2,992 (Fig. 2.8).

Fig. 2.8:   Spend per birth on maternity services 2005/6
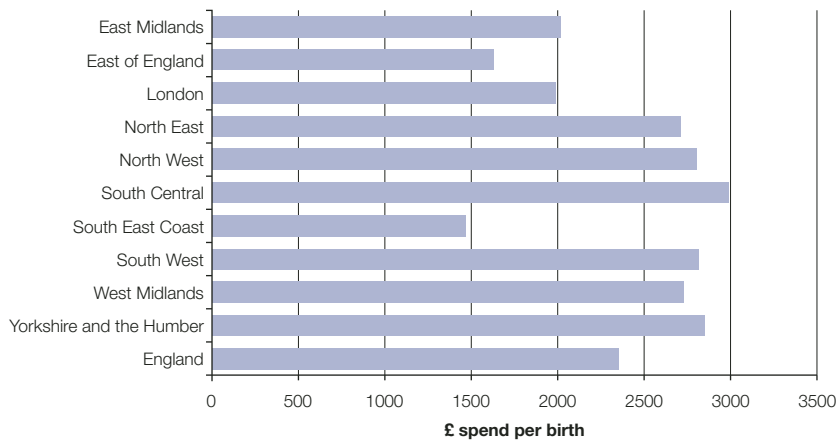
CAMHS expenditure

Change in expenditure – actual versus predicted

2.22   In the financial year 2005/6, total investment in CAMHS tiers 2 to 4 was £461M and the predicted budget for 2006/7 was £508M, an increase of 10%. This indicated a slight increase in growth in CAMHS investment from the 7% growth reported in 2005. As very strong growth of 34% had been reported between 2003/4 and 2004/5, the overall increase in actual investment in CAMHS between 2003 and 2006 was 43% (Fig. 2.9).

2.23   However, direct comparisons of spend year on year are problematic because of changes to the way finance data has been collected. Of particular importance was the introduction of CAMHS finance mapping by local authorities in 2004/5 when it could be seen that actual spend rose to £431M, exceeding the PCTs predicted budget for that year.

2.24   In 2005/6 the actual spend had again increased to £461M but this increase was considerably lower than the £513M spend predicted. Although further growth has been predicted in 2006/7, it will be interesting to compare this to the actual data reported in next year's exercise.

Fig. 2.9:   Trends in CAMHS commissioning budget 2003 to 2007
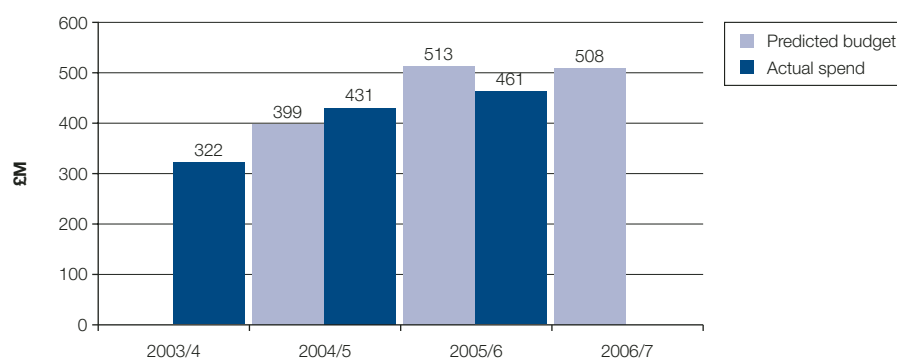
2.25   The change predicted in the CAMHS budget between 2005/6 and 2006/7 showed that all SHAs expected an increased spend on specialist CAMHS in the financial year 2006/7 but this increase ranged from 7% at the lowest to 21% at the highest (Table 2.1).

Table 2.1: Total CAMHS budget change 2005/6 to 2006/7 by SHA

Strategic Health Authority	Total Spend 2005/6 Child and Adolescent Mental Health Services	Budget 2006/7 Child and Adolescent Mental Health Services	Budget change (£k)	% change in budget
East Midlands	36,515,912	39,790,569	3,274,657	9.00%
East of England	43,399,312	52,370,278	8,970,966	20.70%
London	101,433,200	110,917,567	9,484,367	9.40%
North East	32,934,503	35,292,102	2,357,599	7.20%
North West	53,766,243	58,168,825	4,402,582	8.20%
South Central	31,734,063	35,061,858	3,327,795	10.50%
South East Coast	35,229,534	39,129,586	3,900,052	11.10%
South West	40,223,325	45,452,908	5,229,583	13.00%
West Midlands	43,183,649	46,191,213	3,007,564	7.00%
Yorkshire and the Humber	42,450,298	45,779,807	3,329,509	7.80%
Total	**460,870,038**	**508,154,714**	**47,284,676**	**10.26%**

PCT and LA share of CAMHS expenditure

2.26   In the 2006/7 CAMHS mapping exercise, PCTs reported £372,613k actual spend in 2005/6 and a predicted budget of £404,928k for 2006/7, predicting a 10% increase in investment. This represented an 81% and 80% share of the CAMHS budget in the respective financial years and a reduction in the PCT share of total investment in CAMHS for the fourth consecutive year (Fig. 2.10).

2.27   Local authorities reported expenditure of £88,257k in 2005/6 and a predicted budget of £103,227k in 2006/7, an increase of 17%. This represented a 19% and 20% share of the CAMHS budget in the respective financial years (Fig. 2.10).

Fig. 2.10: Trends in total CAMHS expenditure and budget (PCT/LA)
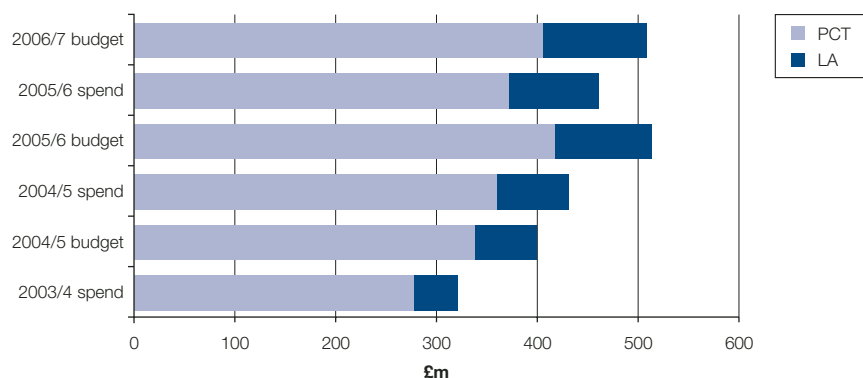
Source of funding

2.28 CAMHS investment from mainstream sources in 2005/6 was £435,955k. This accounted for 94% of total CAMHS spend in 2005/6; the same proportion as the previous year. Other key sources were the Children's Fund, Drug and Alcohol Teams, Sure Start/Children's Centres and Youth Offending funding. When examined alongside the predicted budget for the financial year 2006/7, Children's Fund and Sure Start funding was expected to reduce but growth was expected in all other funding sources although this growth was often small (Fig. 2.11).

Fig. 2.11: Trends in CAMHS income sources
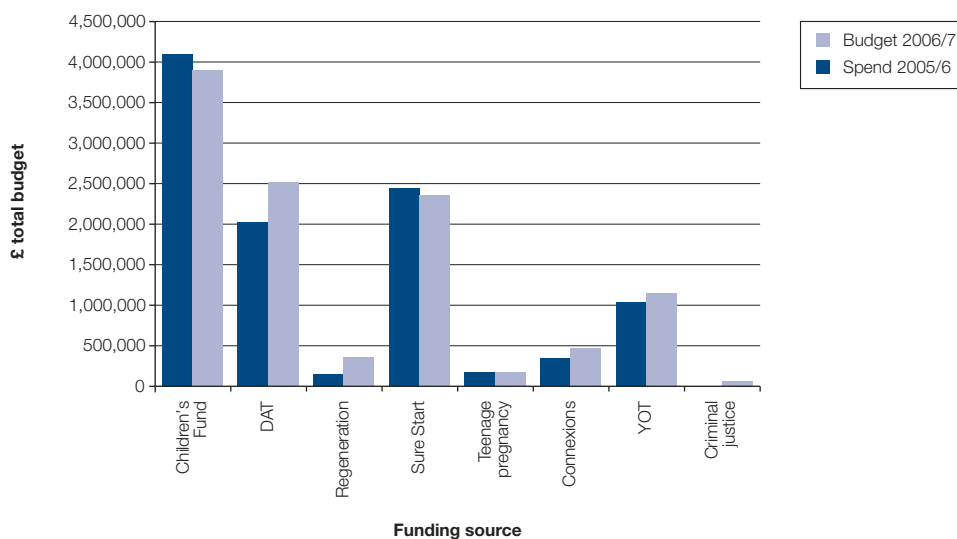
CAMHS spend per child

2.29 The average spend per child aged 0 to 17 nationally was £42 in 2005/6, an increase from the £39 reported for 2004/5. Throughout SHAs a large variation was found, ranging from £31 to £62 (Fig. 2.12).

Fig. 2.12: CAMHS spend per child aged 0 to 17 by SHA 2005/6
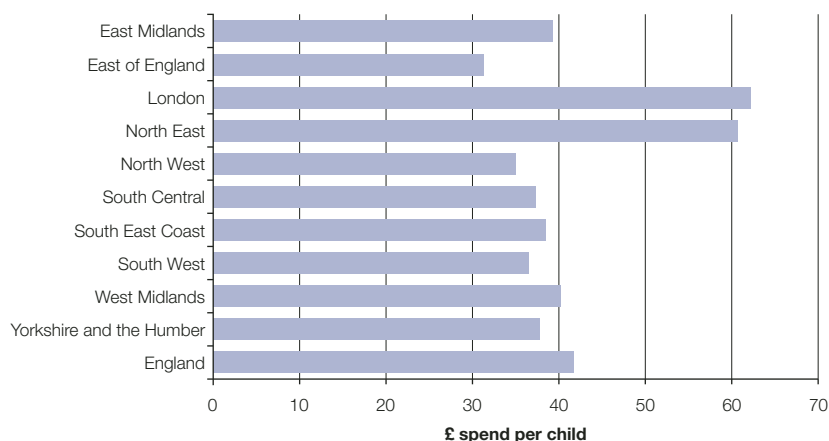
Individual care expenditure

2.30 At the request of commissioners the mapping exercise collected information on expenditure on individual care packages, often termed 'spot' purchasing. Whilst the majority was for out of area placements, some complex care packages were provided within localities. A total spend of £110,496k was reported of which £51,596k (47%) was spent on CAMHS provision set out in NSF Standard 9. £24,121k (22%) was spent on Standard 8 services - those providing care and treatment for children who are disabled, have complex needs or need palliative care (Fig. 2.13). £10,037k (9%) 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 £24,522k (22%) of the individual care budget as it supported children and young people whose needs crossed a number of categories.

Fig. 2.13: Use of the individual care budget by NSF standards 2005/6
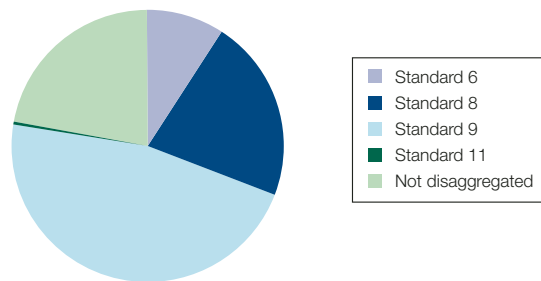
2.31 Looking at the distribution of spend on individual care by SHA, there was considerable variation (Fig. 2.14).

Fig. 2.14: Individual care spend on services defined by NSF standards by SHA 2005/6
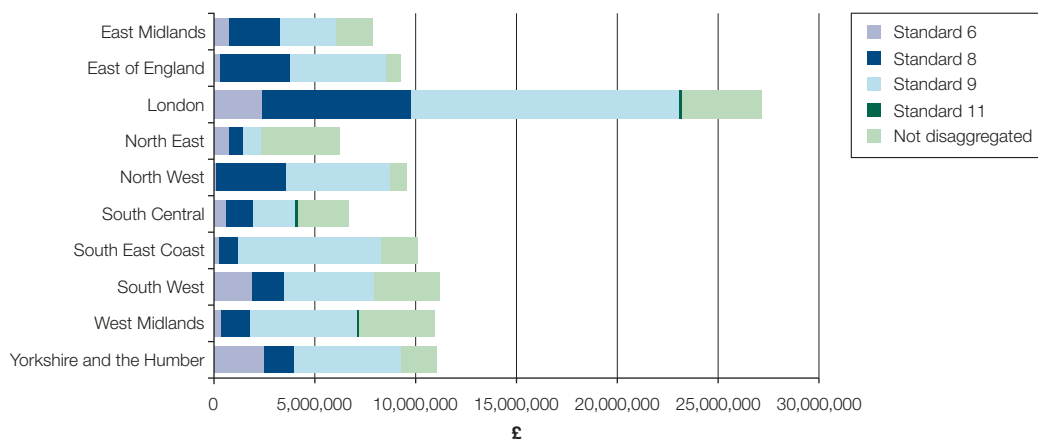
PCT leadership for children's issues and involvement in planning fora

2.32   Enquiries were made about PCT leadership and management arrangements for children's services through questions on whether PCTs had dedicated child health leads in place and if they participated in a range of planning fora. Inevitably responses to these questions were affected by the major reorganisation of PCTs that took place in autumn 2006 which had disrupted the running of some PCT planning groups. Despite this, only slight changes were recorded from the previous year.

2.33   In 2006/7, 93% of PCTs reported having a dedicated child health lead compared to 98% of responding PCTs in 2005/6. This was explained by some PCTs being in the process of appointing staff to senior positions in new enlarged organisations when the mapping was carried out.

2.34   Reported involvement in children's planning fora had reduced overall but 93% of PCTs were maintaining involvement in the local Children and Young People's Strategic Partnerships (Fig. 2.15).   The proportion of PCTs running PCT-based children's planning groups had declined from 80% in 2005/6 to 64% in 2006/7, because planning groups had been suspended during reorganisation. Involvement in locally managed children's clinical networks had increased slightly while participation in Managed Maternity Care Networks had declined.

Fig. 2.15: Trends in PCT participation in planning fora and clinical networks
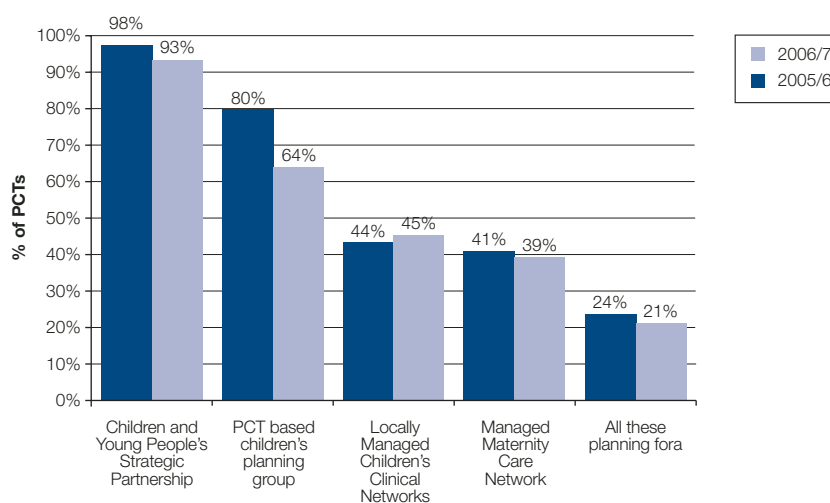
Chapter 3.

Children's workforce

Introduction

3.1   Every service or team was asked to explain their workforce, identifying the professional make-up of the team, the whole time equivalence (wte) of the resource and the number of staff involved.

3.2   This chapter reports the workforce mapping results as follows:

- Summary of the children's workforce
  - Child health and maternity service workforce
  - Trends in professional staff
  - Workforce by service category
  - Doctors in the child health and maternity service workforce
  - Nurses in the child health and maternity service workforce
  - Allied health professionals
  - Maternity workforce

- CAMHS workforce
  - Overview
  - Variations on workforce by SHA
  - Professionals in the CAMHS workforce
  - Workforce in local and wider teams
  - Workforce in local teams
  - Workforce in wider than local teams
  - Specialist CAMHS support to tier 1
  - Care staff.

3.3   Detailed tables of the data used can be found and downloaded from the mapping website at:
www.childhealthmapping.org.uk/reports

Summary of the children's workforce

3.4   The child health and maternity service workforce showed an overall increase of 25% from 93,714 wte in 2005/6 to 117,317 wte in 2006/7 but it should be stressed that this change was largely due to improved data capture as a result of more children's NHS provider trusts taking part in the mapping exercise. The highest reported increase was in hospital services with an increase of 41% (Fig. 3.1) encouraged by this being collected for a pilot exercise by the Healthcare Commission. The maternity service workforce rose by 33%, universal service staffing by 17% and targeted service staffing by 9%. The total CAMHS workforce was 9,705 wte in 2006, falling by 2% to 9,876 wte in 2005. This was the first fall after 3 years of growth which saw an overall increase of 25%.

Fig. 3.1:   Trends in total workforce
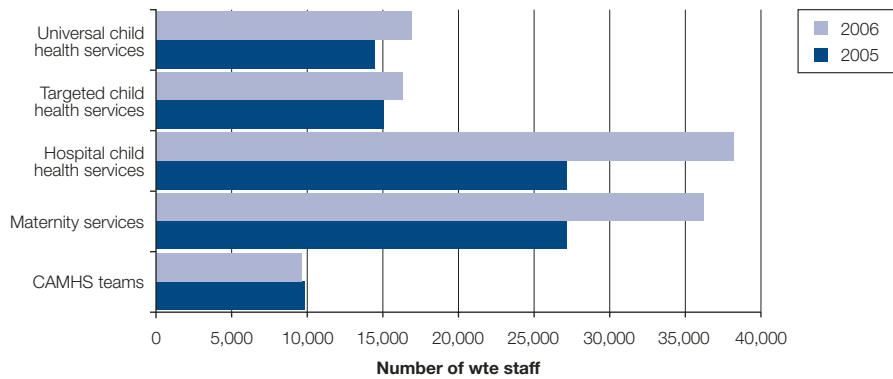
Child health and maternity service workforce

Trends in professional staff

3.5   Increases were recorded in all professional groups (Fig. 3.2) in the child health and maternity service workforce, but again it should be noted that this was probably due to the increase in the number of services mapped rather than a growth in the workforce. The largest increase was recorded in the number of nurses which rose from 30,321 wte in 2005 to over 37,554 wte in 2006, an increase of 24%. The number of midwives increased from 14,328 in 2005 to 18,237 in 2006, a growth of 27%. Doctor numbers increased from 12,703 wte in 2005 to 16,765 wte in 2006, a growth of 32%. The key professional staff groups are examined in more detail below.

Fig. 3.2:   Trends in child health and maternity service workforce by profession
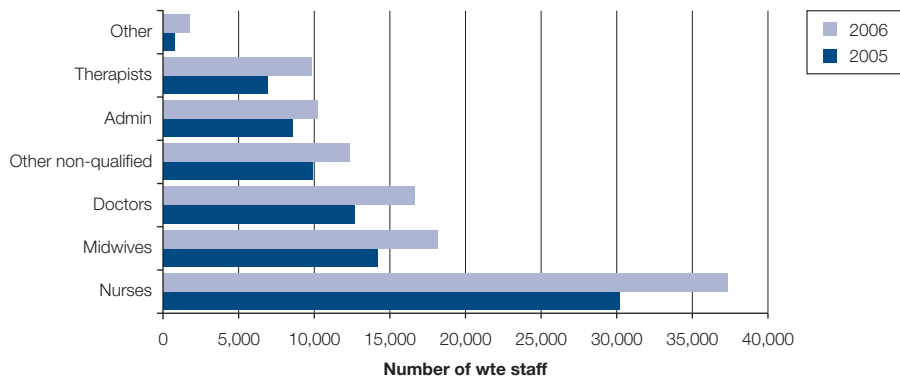
Workforce by service category: universal, targeted and specialist services

3.6   Universal services (early years and health visiting and school health services) accounted for 24% of the child health workforce. Nurses (including health visitors) were the largest professional group with 11,617 wte employed, representing 69% of the universal services workforce. They were supported by 3,003 wte (19%) non-qualified staff and 1,942 wte (12%) administration staff (Fig. 3.3). In total there were 64 wte doctors attached to these services (0.4% of the universal services workforce).

Fig. 3.3:   Professional make-up of the workforce of universal services 2006

Number of wte staff in universal services
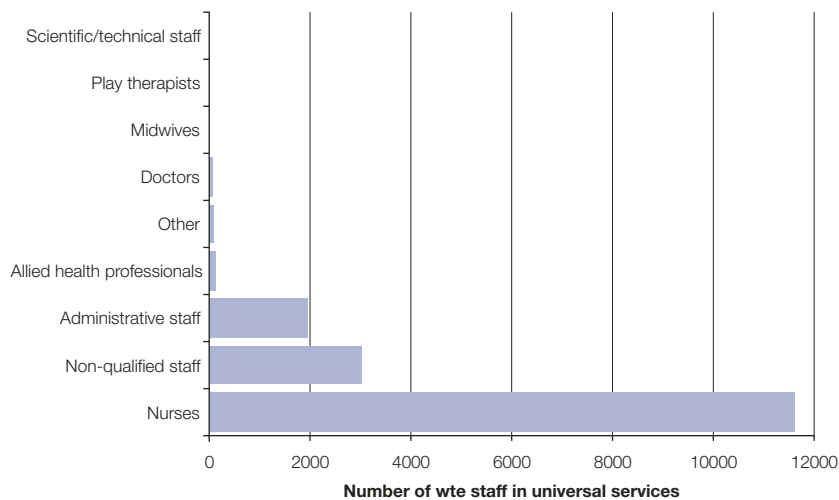
3.7   Targeted services included children's therapy services, community paediatric services, safeguarding services, CAMHS tier 1 support, services for disabled children/children with special needs and services for children in special circumstances. These services accounted for 23% of the child health workforce. Allied health professionals made up 41% of targeted service staffing (6,698 wte). 21% of the workforce were nurses (3,396 wte) and 8% (1,310 wte) were doctors. 17% of the workforce (2,828 wte) were administration staff but this included staff involved in maintaining childhood health surveillance records (Fig. 3.4).

Fig. 3.4:   Professional make-up of the workforce of targeted services 2006

Number of wte staff in targeted services
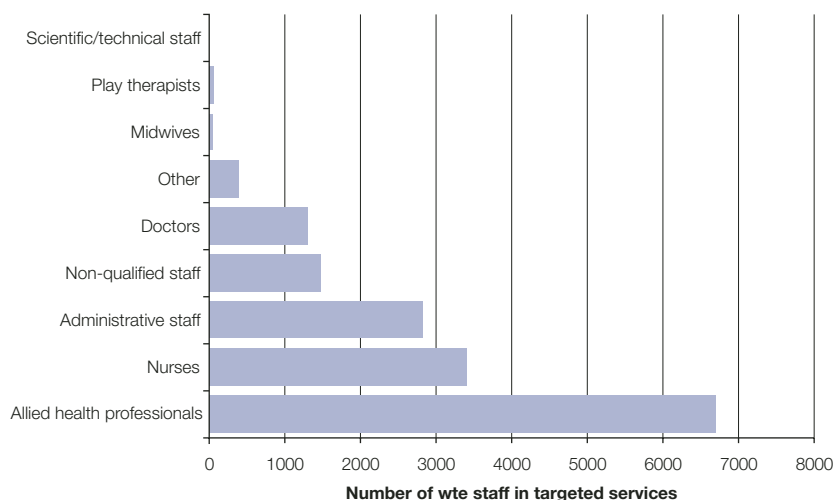
3.8   Hospital services included emergency care, children's surgery, specialist children's services, general
       paediatrics and paediatric intensive care. These services accounted for 53% of the child health workforce.
       Nurses were the largest professional group with 17,402 wte, representing 46% of the hospital services
       workforce (Fig. 3.5). Doctors were the next largest group with 10,279 wte, 27% of the workforce. Non-
       qualified staff accounted for 2,880 wte (8% of the workforce), allied health professionals for 1,909 wte (5%)
       and play therapists for 476 wte (1%).

Fig. 3.5:   Professional make-up of the workforce of hospital services 2006

Number of wte staff in hospital services
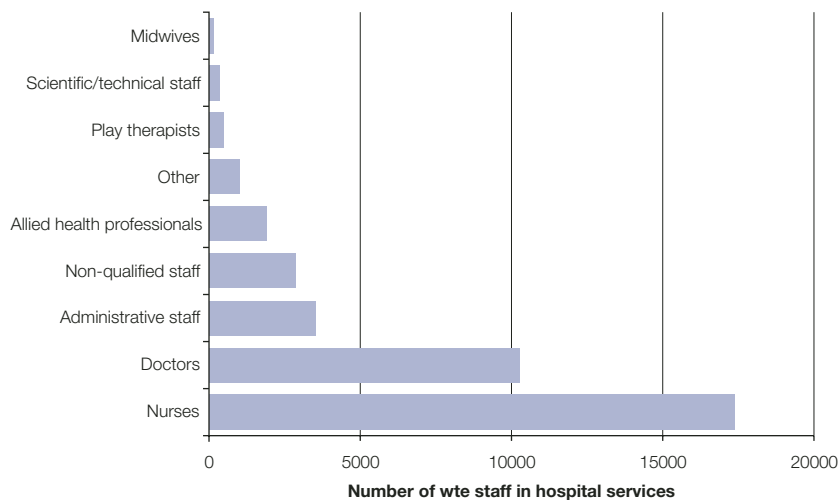
3.9   Maternity services included the wide range of maternity provision, neonatal intensive care units (NICU) and
       special care baby units (SCBU). Half of the workforce were midwives including 165 wte heads of midwifery
       and 17,841 wte midwives (Fig. 3.6). Nurses made up 14% of the workforce with 5,139 wte but 96% of
       these worked in NICU services. A further 14% of the workforce was made up of doctors. Of the 5,112 wte
       doctors, 66% worked in maternity services and 34% in NICU. Maternity support workers made up 8% of
       the workforce with 2,793 wte and 2,184 wte other unqualified workers were also employed.

Fig. 3.6:   Professional make-up of the workforce of maternity services 2006

Number of wte staff in maternity services
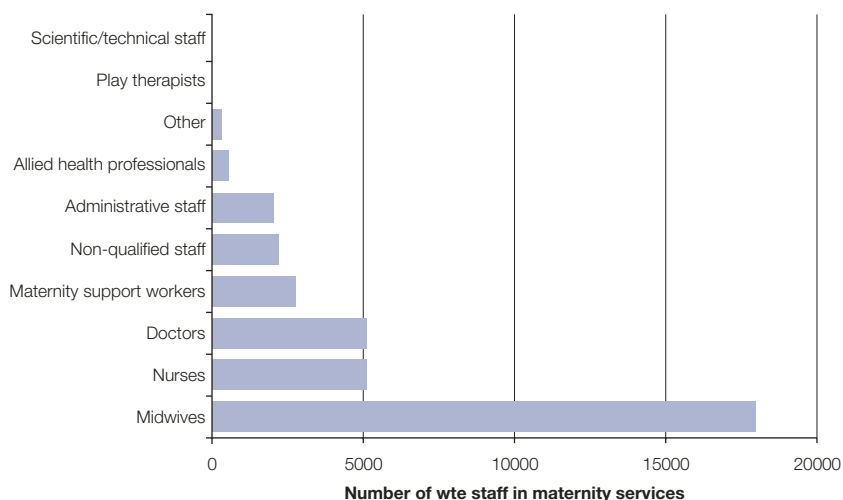
Doctors in the child health and maternity service workforce

3.10 Four categories of medical staff were identified in the mapping exercise. Child health and maternity services employed 5,829 wte consultants (35% of medical staff), 3,085 wte career grade doctors (18%), 7,815 wte trainee doctors (47%) and 35 wte GPs with a special interest in paediatrics.

3.11 The medical workforce was largely concentrated in 3 types of services; maternity, general paediatrics and children's surgery (Fig. 3.7). 20% of medical staff worked in each of these three services. A further 11% of doctors worked in specialist paediatric services, 10% in paediatric intensive care and 9% in children's emergency care services emphasising the concentration of doctors in hospital services.

Fig. 3.7:   Distribution of doctors in the workforce 2006

Number of wte doctors in child health and maternity workforce
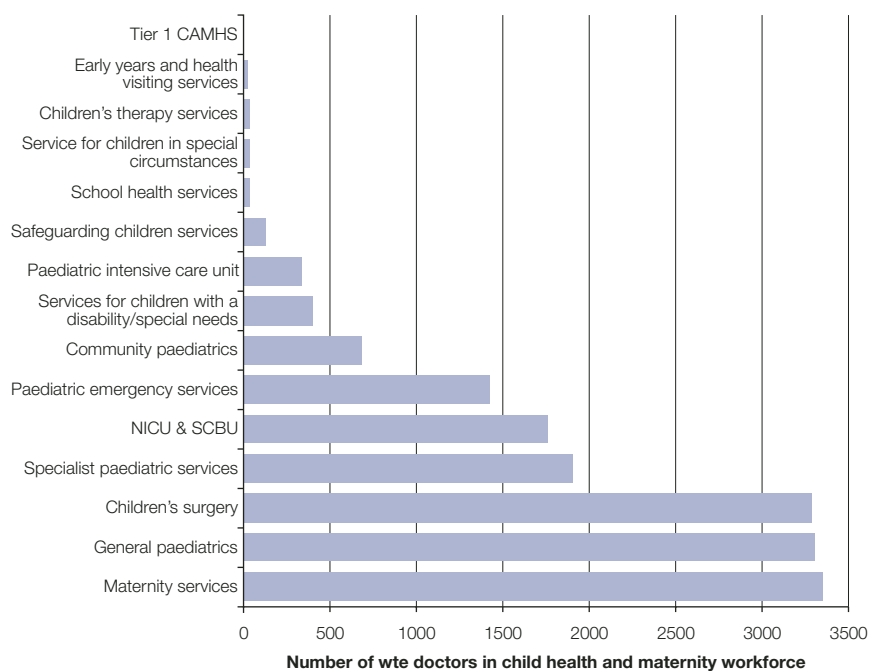
Nurses in the child health and maternity workforce

3.12 The total nursing workforce (excluding midwives) in child health and maternity services was 37,554 wte. Of this workforce, 44% (16,328 wte) were registered children's nurses (Fig. 3.8), 24% (8,964 wte) were health visitors, 22% (8,288 wte) were registered adult nurses and 6% (2,414 wte) were school nurses. Registered learning disability nurses made up 2% of the workforce (604 wte) and registered mental health nurses >1% (176 wte). 2% of the workforce (780 wte) were designated nurses for looked after children. No information was gathered on other named and designated nurse roles.

Fig. 3.8: Breakdown of nursing workforce 2006
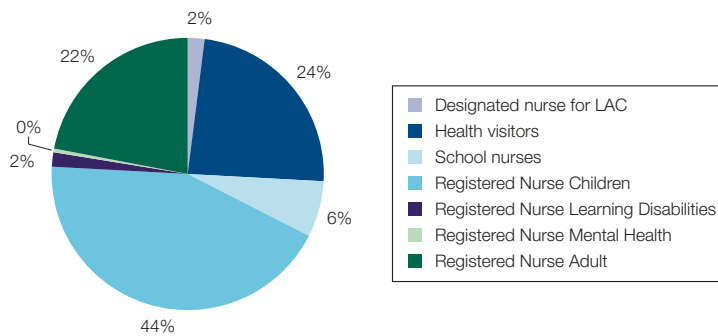
3.13 Early years and health visiting services employed 23% of this workforce, general paediatric services a further 18% and NICU/SCBU 13% (Fig. 3.9). Specialist paediatric services accounted for 8% but over 90% of the staff of both general paediatric and specialist paediatric services was made up of registered children's nurses. School health services accounted for 9% of the total child health nursing workforce.

Fig. 3.9:   Distribution of nursing workforce in child health and maternity services 2006 (excluding midwives)
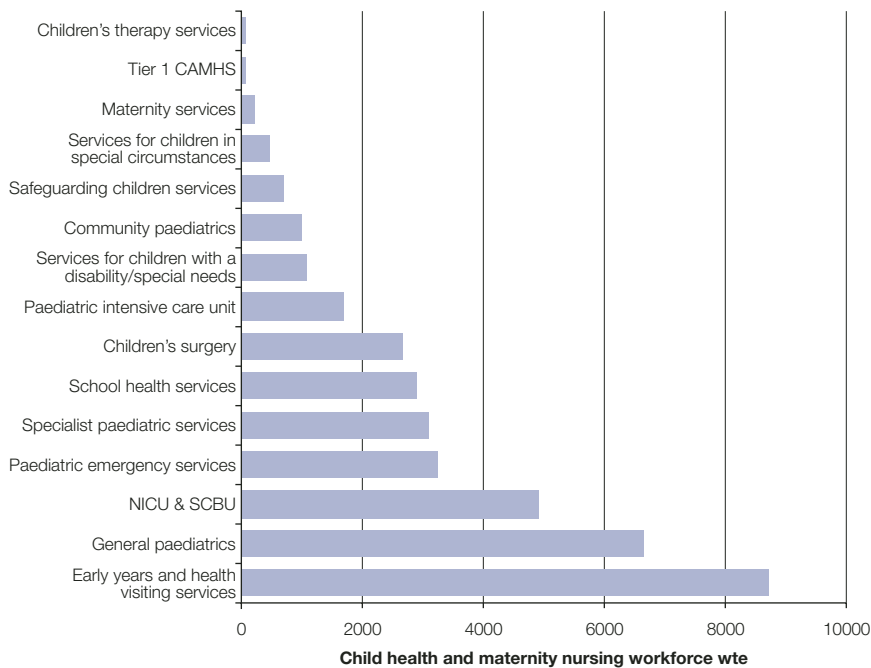
Allied health professionals

3.14 In total the child health and maternity services workforce included 9,310 wte allied health professionals. Looking in detail at this workforce, there were 3,117 wte speech and language therapists (33% of the allied health professional workforce) and 475 wte (5%) assistant speech and language therapists (Fig. 3.10). 1,606 wte were physiotherapists (17% of the workforce) and 296 wte (3%) were physiotherapy assistants. Occupational therapists accounted for 1,024 wte (11%) of the workforce with an additional 218 wte (2%) provided by occupational therapy assistants. Overall there were 364 wte dieticians (4%), 279 wte audiologists (3%) and 160 wte (2%) orthoptists. In total there were 235 wte (3%) clinical psychologists and 31 wte psychology assistants. There were 32 wte child psychotherapists.

Fig. 3.10: Allied health professional workforce 2006

Number of wte staff in AHP workforce
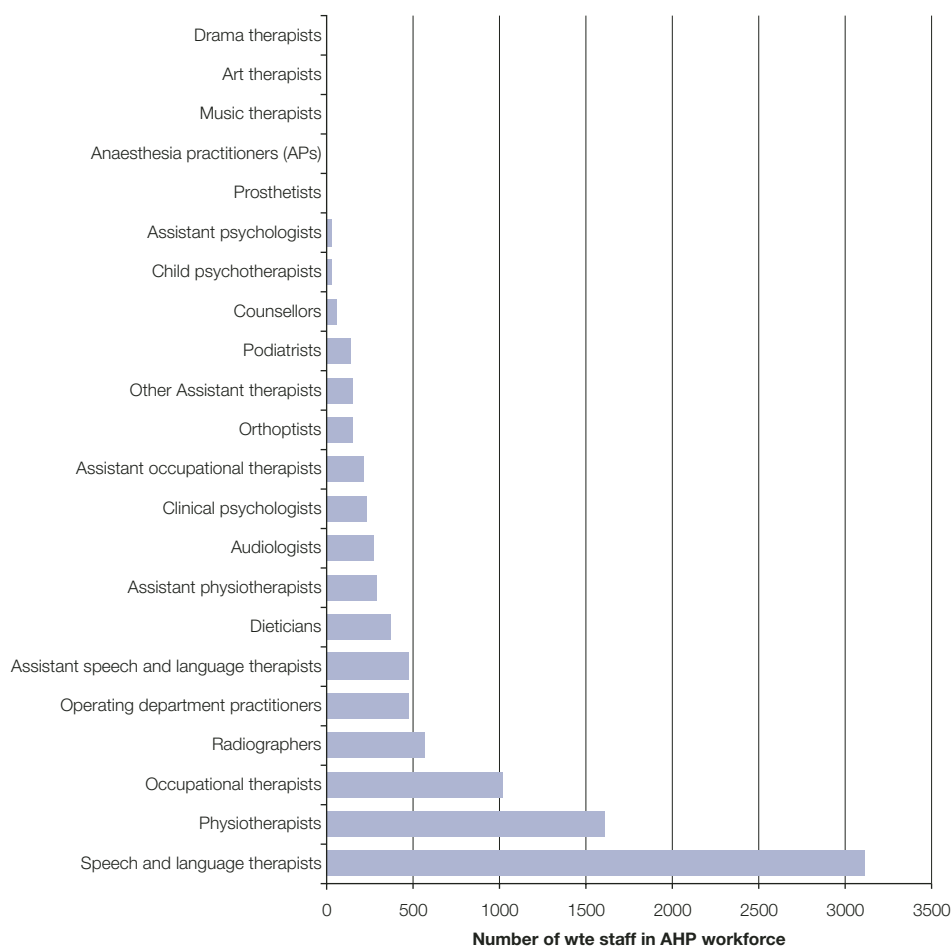
3.15 The majority (62%) of allied health professionals worked in children's therapy services (Fig. 3.11). 7% worked in general paediatric services, 7% in specialist paediatric services and 6% in services for children with a disability or complex needs.

Fig. 3.11: Distribution of allied health professionals 2006
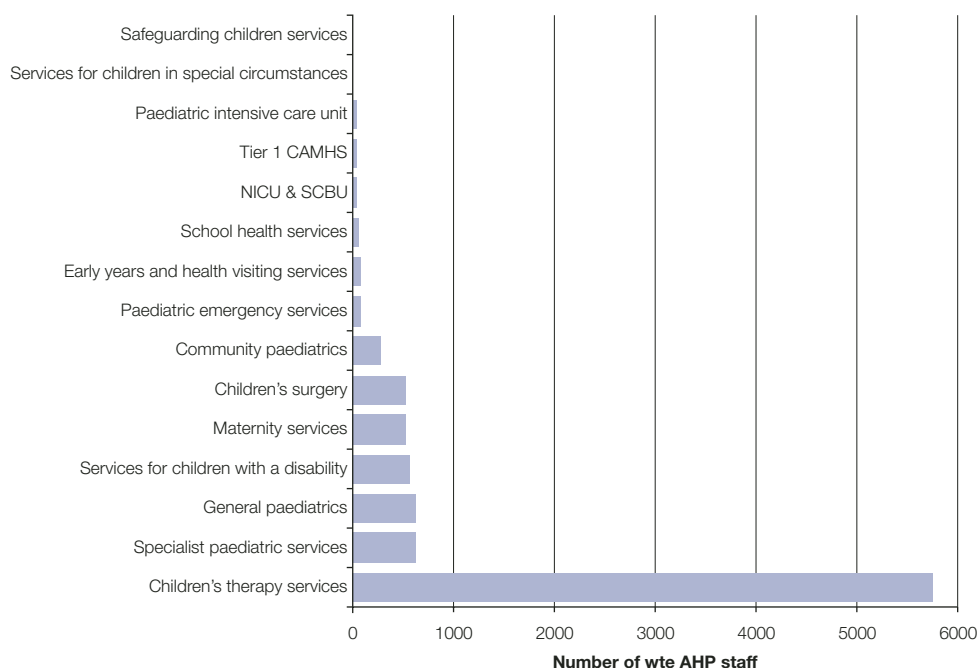
Maternity workforce

3.16 A total of 18,059 wte midwives were recorded in the mapping exercise, 98% of whom worked in maternity services, 1% in neonatal services and 1% in general paediatrics (Table 3.1). In addition, a small number of midwives worked in safeguarding services, early years and health visiting services, community paediatrics and services for children in special circumstances. Of the 2,821 maternity support workers in the workforce, 99% worked in maternity services.

Table 3.1: Maternity workforce by service type 2006

Service Type	Head of midwifery wte	Midwifery wte	Maternity support workers wte
Maternity services	155	17608	2792
NICU and SCBU	10	233	1
General paediatrics	3	157	-
Safeguarding children services	7	17	-
Early years & health visiting services	1	17	20
Community paediatrics	0	14	7
Services for children in special circumstances	1	13	2
Total	**177**	**18059**	**2821**

CAMHS workforce

Overview

3.17 The 2006/7 mapping exercise showed a marginal reduction in the CAMHS workforce for the first time. There are four possible factors that should be considered when viewing this data:

- The mapping exercise found evidence of the pressures being placed on some NHS budgets. Reductions in CAMHS budgets were reported in some localities and PCT spend on CAMHS in 2005/6 was often found to be lower than the predicted budget for that year. When data checks were made, it was found that some areas had had to reduce spend on CAMHS, whilst others were unable to expand at a sufficient rate to create new posts as well as meet wage inflation.

- In 2006/7, the mapping exercise was not accorded the level of importance it had been given in previous years as it was not used as a source of data for NHS performance rating. Therefore it was suspected that less effort was put into ensuring staffing was accurately mapped. When a 10% increase in staffing was being sought year on year, understandably great care was taken to include all possible posts and service expansions.

- As staffing categories were changed in 2006/7 to take account of 'Agenda for Change' (DH), every team had to remap their staff whereas previously they only had to check that the data entered the year before was correct. Therefore staff may have been omitted in error.

- The merger of CAMHS mapping with the broader child health and maternity service exercise required that registration was carried out by each NHS organisation. Previously CAMHS mapping had allowed for a degree of flexibility in how registrations were organised, and many returns covered local CAMHS partnerships and the full range of multi-agency provision within this area. The move to a single registration by each NHS provider organisation led to some agencies only mapping what they were directly responsible for and not teams provided by partner agencies within their area. This seems to have particularly affected the number of social workers reported within the 2006 mapping.

3.18 The total CAMHS workforce reported in 2006 was 9,705 wte. This was a decrease of 2% from the 9,876 wte reported in 2005 but given the 15% increase in staffing between 2003 and 2004 and the 11% growth between 2004 and 2005, the overall change between 2003 and 2006 was a 25% increase (Fig. 3.12).

Fig. 3.12: Percentage change in overall CAMHS workforce 2003 to 2006
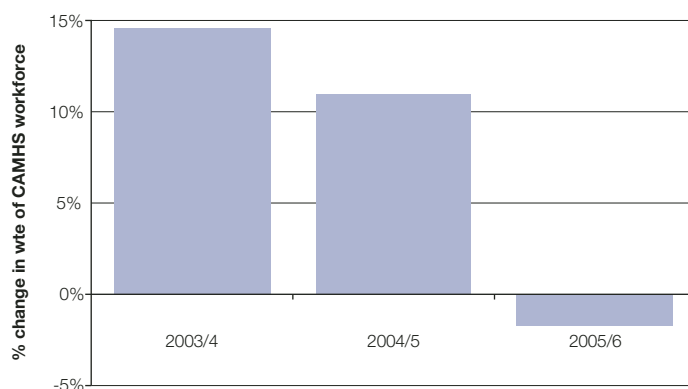
Variation in CAMHS workforce by SHA

3.19   When linked to the population of children and young people, there was an average of 87.8 wte CAMHS staff per 100k population of 0-17 year olds in 2006. This had fallen from an average of 89.1 wte in 2005 but remained higher than the average of 80.4 wte per 100k in 2004. However, distribution across the country was uneven (Fig. 3.13).   Local variation across SHAs ranged from 54 wte per 100k to 163 wte per 100k.

Fig. 3.13: CAMHS workforce wte per 100k 0 to 17 population by SHA 2006
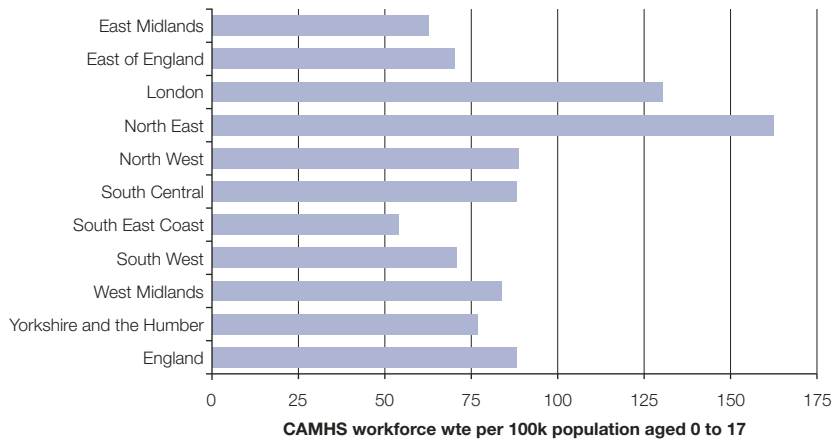
Professionals in the CAMHS workforce

3.20   CAMHS were staffed by a wide range of professionals in order to meet the diverse and specialist needs of children and young people (Fig. 3.14). Nurses were the largest professional group, accounting for 28% of the workforce in 2006 (26% in 2005 and 28% in 2004). The other main professions that made up the workforce were doctors (11% of the workforce in 2006, 10% in 2005 and 11% in 2004), clinical psychologists (12% of the workforce in 2006, 13% in 2005 and 15% in 2004), and administrators (16% of staff in 2006, 2005 and 2004).

Fig. 3.14: Total CAMHS workforce by profession 2006
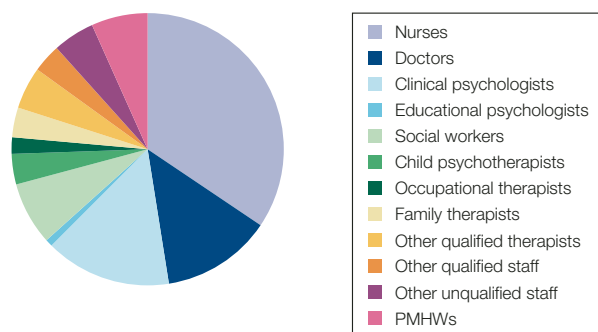
3.21   Despite the overall growth in the CAMHS workforce since 2003, the size of some professional groups has
        declined (Fig. 3.15).

Fig. 3.15: Changes in CAMHS workforce by professional group 2003 to 2006
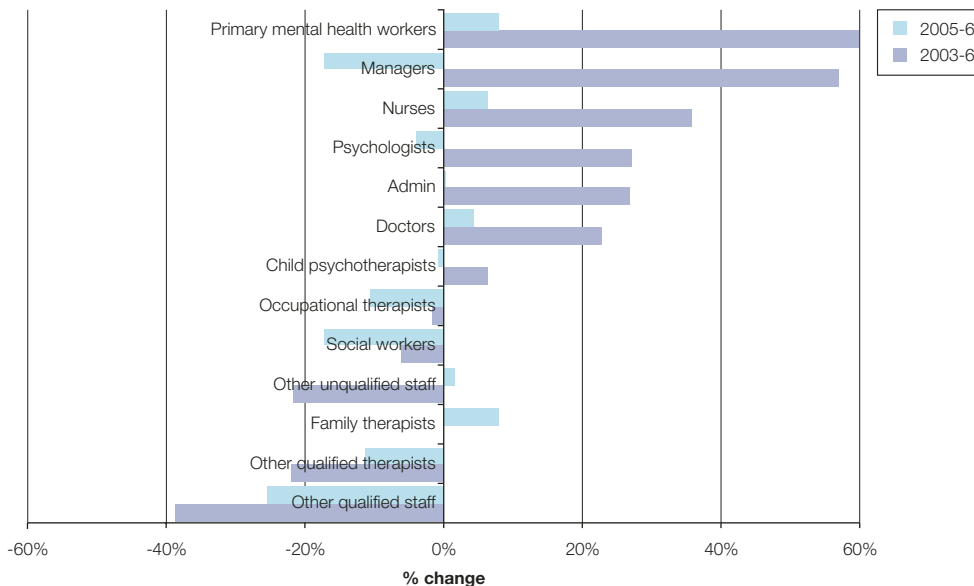
3.22   The principal areas of growth have been in the traditional professions of medicine, nursing and psychology.
        Growth can also be seen in the number of primary mental health workers (PMHW) which is a relatively new
        role (see para 3.28 below). Other interesting points to note about the CAMHS workforce (Fig. 3.15 and
        Table 3.2) include:

        •   The 17% reduction in the number of social workers recorded in 2006 could in part be caused by
             changes in mapping structure. With the merger of CAMHS and child health mapping there was some
             confusion over the participation of CAMHS partnerships with the result that some social services teams
             were not recorded. Attention will be paid to this issue in the 2007/8 data collection as it will be
             important to identify if there is a net loss of social workers in CAMHS provision.
        •   Family therapists were mapped separately for the first time in 2005, and increased by 8% in 2006. Prior
             to 2005, they were included in the category of other qualified therapists and their removal from this
             group accounts in part for the 22% reduction in other qualified therapists between 2003 and 2006.
        •   The other qualified staff workforce has varied considerably each year. This tends to be a workforce
             holding short term, or time limited contracts, and it is therefore vulnerable at times of financial pressure.
        •   Although the number of managers has increased by 57% since 2003, their numbers declined in the last
             12 months. It is unclear if this drop was caused by changes to data collection, service redesign or other
             factors.
        •   Primary mental health workers (PMHW) were not identified as a professional category in 2003. Instead
             they were mapped by the profession in which they qualified. Therefore the real growth in their numbers
             will exceed the 33% growth from 2004 to 2006 shown in Fig. 3.15.

Table 3.2: Change in professional make up of CAMHS staff 2003-2006

	wte 2003	wte 2004	wte 2005	wte 2006	Change 2003-4	Change 2004-5	Change 2005-6	Change 2003-6
Nurses	2038	2517	2600	2770	24%	3%	7%	36%
Admin	1230	1393	1552	1559	13%	11%	0%	27%
Psychologists	997	1320	1320	1269	32%	0%	-4%	27%
Doctors	866	1008	1019	1064	16%	1%	4%	23%
Social workers	638	640	722	599	0%	13%	-17%	-6%
Primary mental health workers		382	506	548		33%	8%	
Other unqualified staff	511	219	394	400	-57%	80%	2%	-22%
Other qualified therapists	507	522	477	396	3%	-14%	-11%	-22%
Family therapists			274	296			8%	
Child psychotherapists	270	312	289	287	16%	-7%	-1%	7%
Other qualified staff	426	254	352	262	-40%	38%	-25%	-38%
Managers	120	161	227	188	34%	41%	-17%	57%
Occupational therapists	159	165	176	157	4%	6%	-11%	-2%

Workforce in local and wider teams

Definitions

Local teams:

A local team is one that has been commissioned to serve a defined local area. These are usually made up of a single, or small number of PCTs and/or local authorities. Almost all children and young people using a local team will come from this area but it is acknowledged that local teams will also occasionally support clients from further afield.

Wider than local teams:

A wider than local team will have commissioning arrangements to serve an area best described in terms of Strategic Health Authorities (SHAs). These can be national services providing specialist provision for the whole of England.

3.23   In CAMHS mapping, a distinction has been made between local and wider teams (see definitions). These categories are particularly useful with reference to workforce as they can be used to distinguish staff that work in teams providing for a local defined population from those that work in teams which serve larger catchment areas, such as a number of SHAs or regions. For wider teams, no population can be identified with any accuracy and therefore it is not possible to map workforce to population.

3.24   As wider than local teams tend to be tier 4, there were key differences in the staffing of local and wider teams. This was particularly evident with respect to nurses, who dominated the staffing of wider teams (58%) (Fig. 3.16). In order to explore these differences, local and wider team workforces will be examined in turn.

Fig. 3.16: Percentage of workforce in local and wider teams by profession 2006
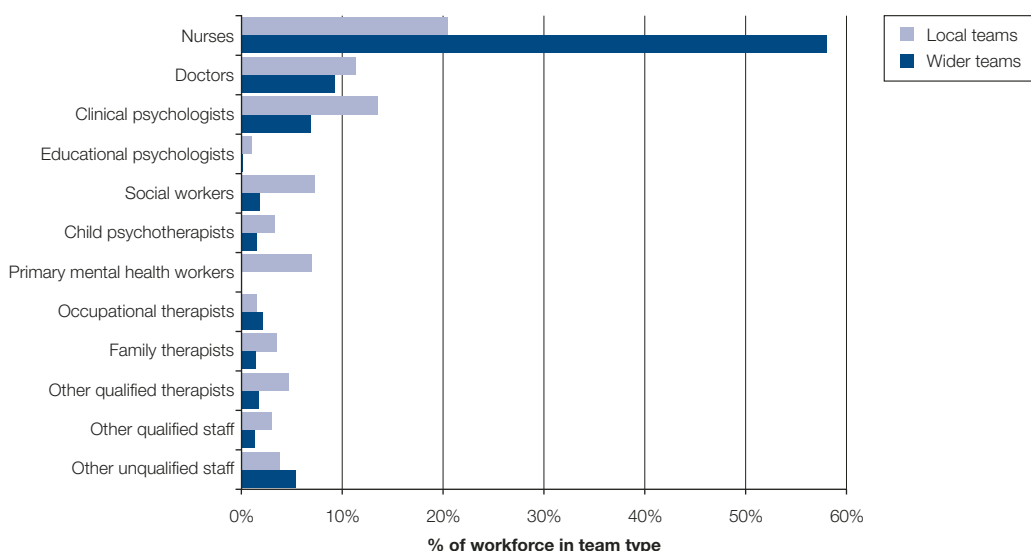
Workforce in local teams

3.25   Staff employed in local teams accounted for 79% of the CAMHS workforce. This remained constant from 2005, but was an increase from 76% of the workforce in 2004. In total, 7,665 wte staff were employed in local teams distributed as follows:

- Nurses made up 20% of the local team workforce but there was considerable variation nationally (see Fig. 3.17). On average there were 14 wte nurses per 100k population (aged 0-17) but the variation in SHA ranged from 9 to 26 wte nurses per 100k population aged 0-17.
- Clinical psychologists made up the next largest professional staff group in local CAMHS teams providing 14% of the workforce. Overall there were 9.5 wte clinical psychologists per 100k population but this ranged from 6 to 14 in SHA areas.
- Doctors made up 11% of the local team workforce with 877 wte in total. Provision varied from 6 to13 per 100k population. On average there were 8 doctors per 100k population.
- The social work workforce was considerably smaller at 562 wte. This was 7% of the total staffing of CAMHS local teams. There was a national average of 5 wte social workers per 100k population.
- There were 256 child psychotherapists who made up 3% of the local team workforce. Their numbers varied considerable between SHA. On average there were 2 wte child psychotherapists per 100k population but provision was concentrated in London and the south.
- In total, 542 wte PMHWs were reported in local CAMHS teams, accounting for 7% of the workforce. Overall there were 5 wte PMHWs per 100k population, ranging from 2 to 9 in SHA area.

Fig. 3.17: Local teams - staff per 100k 0 to 17 population by profession 2006
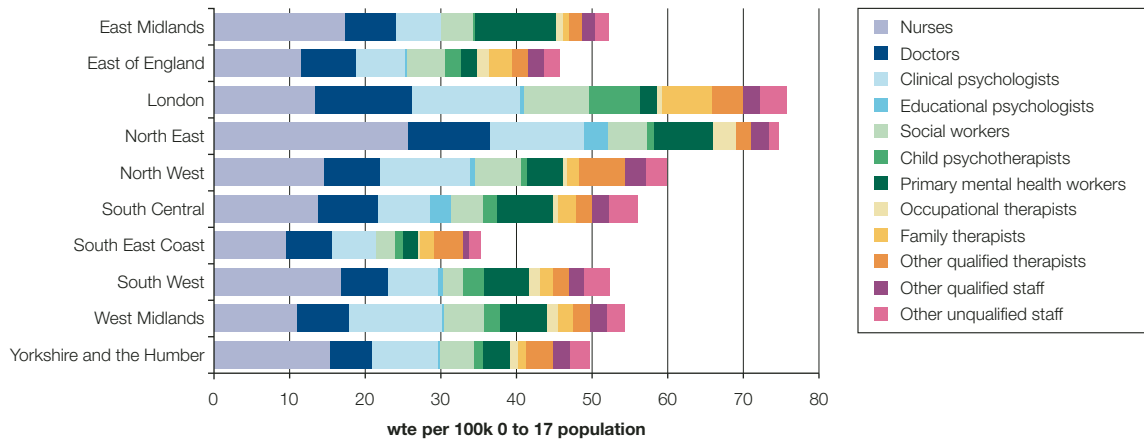
Workforce in wider than local teams

3.26   The majority of wider than local teams were small specialist units delivering tier 4 services. Owing to the specialist nature of the provision, wide variations were seen in the staff employed but, overall, staffing levels in these teams fell from 2,123 wte in 2005 to 2,040 wte in 2006. The variation across the country was very marked (Fig. 3.18).

3.27   As staffing of wider than local teams cannot be examined against specified populations, the professional make-up of the workforce has been examined in terms of percentages of total staffing. Overall, 58% of the workforce were nurses, reflecting the dominance of inpatient provision. Doctors made up 9% of the workforce, clinical psychologists 7%, and child psychotherapists 2%. Social workers were just 2% of the staff group.

Fig. 3.18: Workforce in wider teams 2006
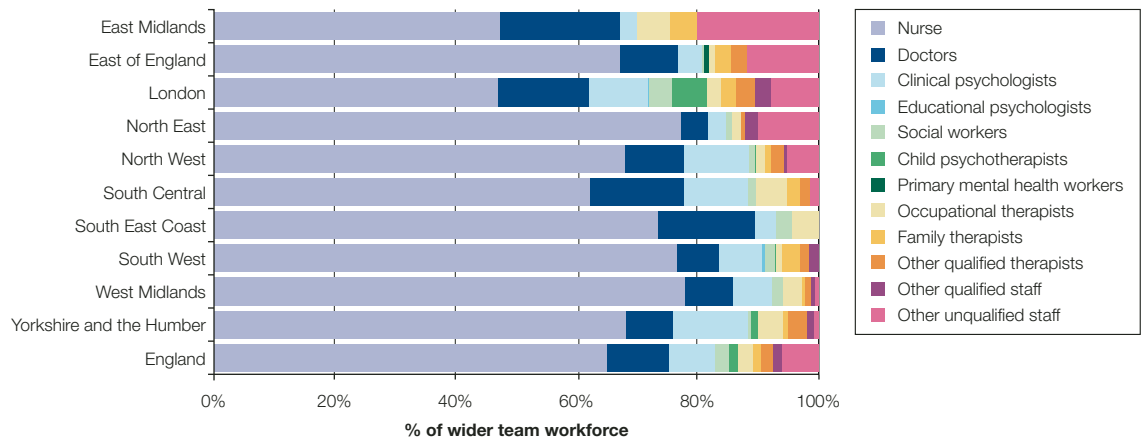
Specialist CAMHS support to tier 1

Definitions:

PMHW:
Primary Mental Health Workers (PMHW) are specialist child and adolescent mental health workers, providing an early intervention interface between tier 1 and specialist CAMHS. They also work on the promotion of mental health in children and provide direct intervention with children, young people and families, usually working jointly with tier 1 professionals.

Support to tier 1:
All staff were asked to record time spent in working with tier 1. This includes workers providing a combination of support, advice, consultation, supervision and training to tier 1 professionals on emerging mental health needs in children and young people.

3.28   Support to tier 1 CAMHS work was investigated in the mapping in two ways. Firstly through the work of primary mental health workers (PMHW) and secondly by asking all clinical staff to estimate the time spent supporting tier 1 work.

3.29   2006 was the third year that PMHWs were identified as a professional group in the CAMHS mapping exercise. The number of these workers was found to have grown from 382 wte in 2004 to 506 wte in 2005, and 549 wte in 2006, an increase of 33% between 2004 and 2005, 9% between 2005 and 2006 and 43% between 2004 and 2006.

3.30   The time spent by clinical staff in supporting tier 1 was 11% in 2006, 10% in 2005 and 9% in 2004. Fig. 3.19 shows which professional groups this support came from. Primary mental health workers estimated that 59% of their time was spent supporting tier 1 staff while educational psychologists estimated that 38% of their time was spent in this way. The amount of time dedicated to tier 1 by other professionals was much lower. Clinical psychologists spent 8%, child psychotherapists 7%, nurses 3%, social workers 6% and doctors 2%.

Fig. 3.19: Time spent by clinical staff supporting tier 1 work 2006
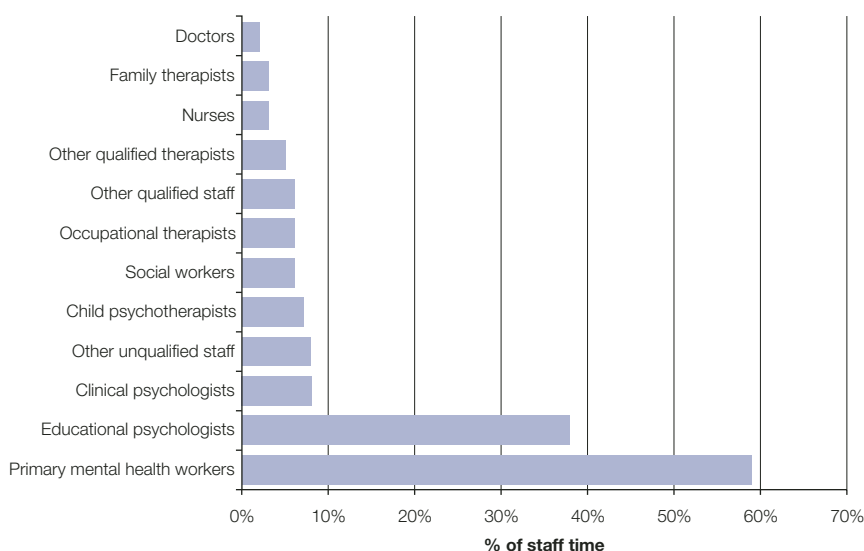
Care staff

3.31   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 staff. 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.

3.32   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 of them deliver elements of tier 3 and they all deliver to a defined local population.

3.33   Counting care staff only, the number of staff per 100k population in local CAMHS teams was 10.2 wte in 2004. This increased to 11.7 wte per 100k in 2005 and 12.2k in 2006. There is a large degree of variation across SHA area, ranging from 8.3 to 16.7 wte per 100k (Fig. 3.20).

Fig. 3.20: Care staff in local teams per 100k total population for comparison with NSF estimates of tier 3 requirements 2006

Number of care staff in CAMHS teams per 100k population
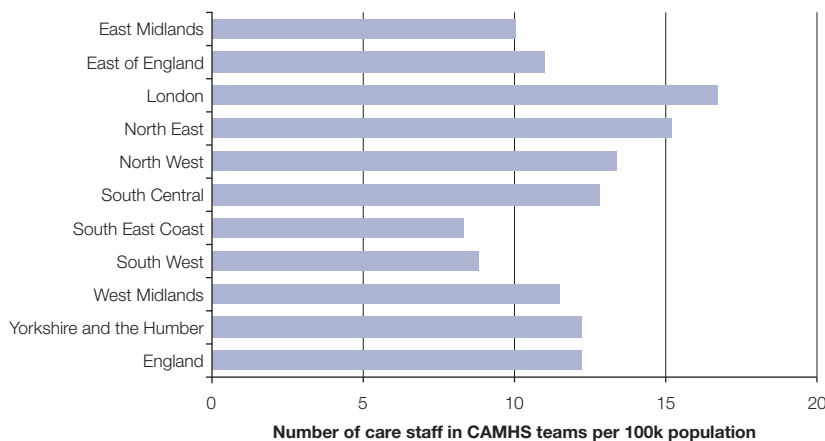
Chapter 4.

Delivering NSF Standard 1:
Promoting health and
well-being, identifying needs
and intervening early

Introduction

4.1 Standard 1 of the National Service Framework for Children, Young People and Maternity Services states:
"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."

4.2 In addition to Standard 1 of the NSF, other key policy of relevance includes the White Paper, Choosing Health[4], the Chief Officers Nursing Review[5] and Every Child Matters, in particular the 'Being Healthy' outcome. All emphasize 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.

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

- PCT provision of public health strategy
- Completion of child health needs assessments
- Universal and targeted children's health services
- PCT child health promotion programme
- Time spent on public health activities
- Public health advice and immunisation
- Qualified school nurse provision
- Support for children in special circumstances.

4.4 Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

PCT provision of public health strategy

4.5 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 well-being 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 Health[4]. In 2005, 64% of responding PCTs had a public health strategy in place. In 2006, this proportion had declined to 52% (80 PCTs) but these public health strategies covered the whole PCT area. Due to restructuring, for many PCTs this was work in progress at the time of the mapping exercise.

Completion of child health needs assessments

4.6   Only half of PCTs reported having completed a fully comprehensive child health needs assessment but considerable progress was reported from the previous year on inclusion of a range of measures of need (Fig. 4.1). The best covered elements were population, 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. 4.1:   Percentage of PCTs completing elements of child health needs assessment

% of PCTs completing needs assesment
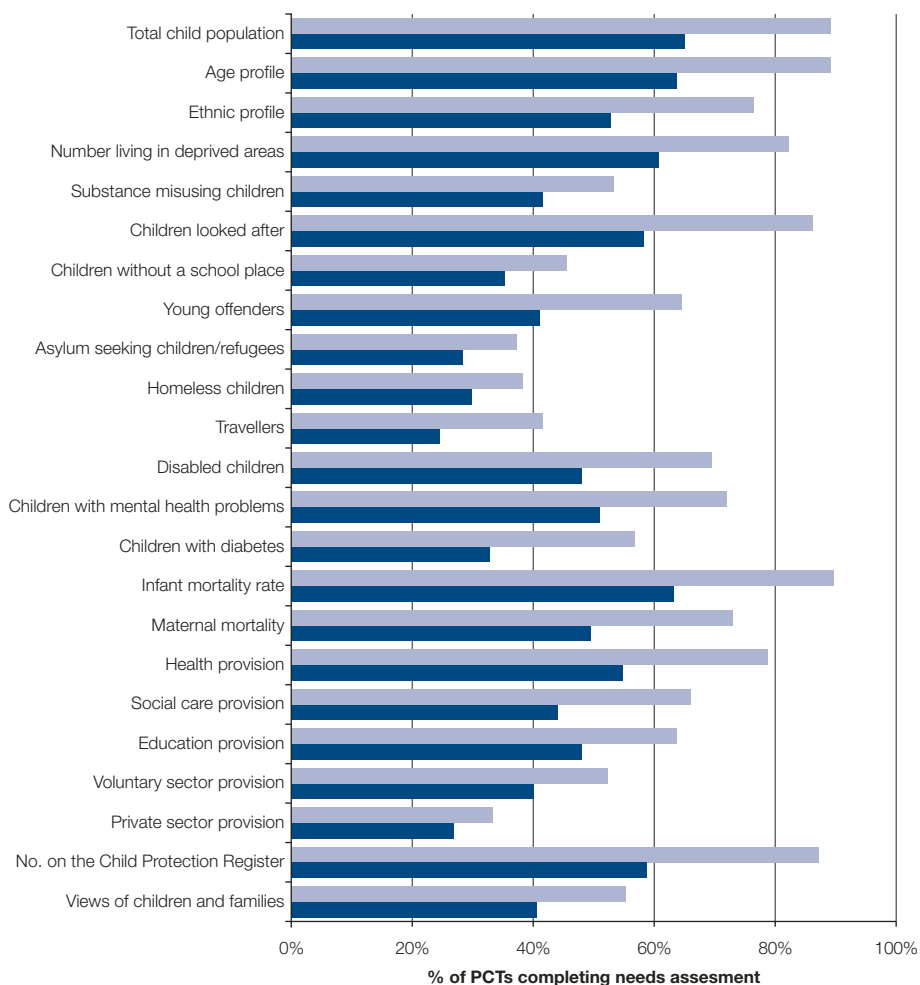
Universal and targeted children's health services

4.7   The main service types aligned to this standard in the mapping exercise were the universal services of early years and health visiting and school health. To a lesser extent targeted services such as services for children with disabilities, safeguarding services and community paediatric services also fulfil valuable public health functions.

4.8   Little change was observed in the number of universal services between 2005 and 2006 (Fig. 4.2) but the workforce of school health services increased by 19% and the workforce of early years and health visiting services by 16% (Fig. 4.3).

Fig. 4.2:   Trends in the number of universal services
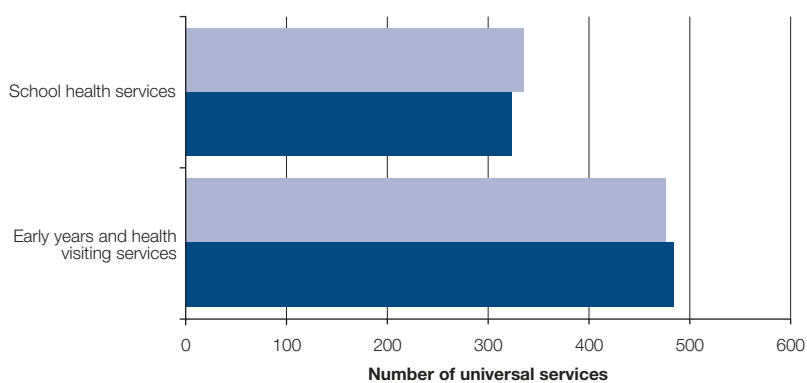
Fig. 4.3: Trends in the workforce of universal services
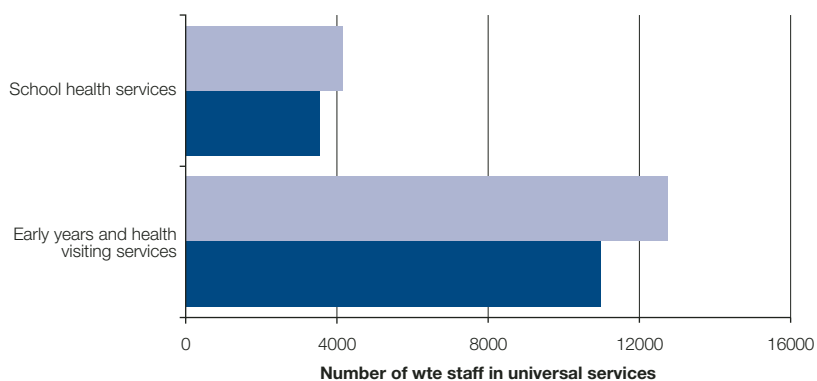
4.9   There were greater increases in the number of targeted teams reported between 2005 and 2006. The number of community paediatric services increased by 18% and their workforce by 22% (Fig. 4.4). Children's therapy services increased in number by 15% and staffing by 17%. The number of services for children in special circumstances rose by 14% and staffing by 24%. Although there were 8% more safeguarding services in 2006, the workforce declined by 13%, perhaps as a result of named nurses and doctors not being recorded. There was also a 10% drop in the staffing of services for children with disabilities while the number of services increased by 12% (Fig. 4.5).

Fig. 4.4:   Trends in the number of targeted services
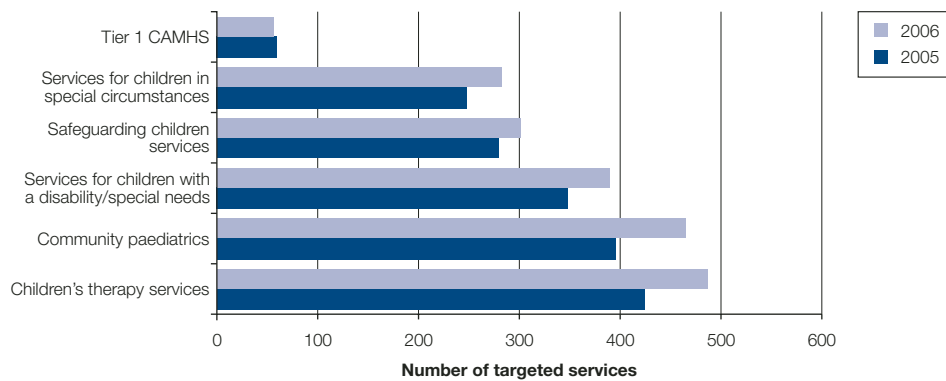
Fig. 4.5:   Trends in the workforce of targeted services
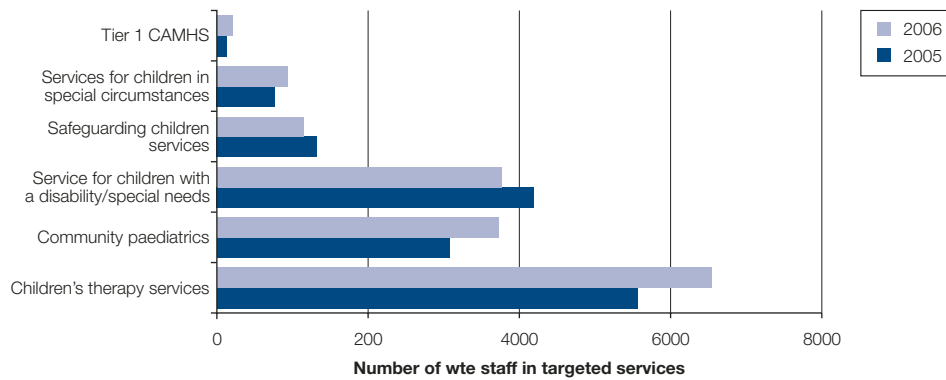
PCT child health promotion programme

4.10   The NSF requires that PCTs ensure a Child Health Promotion Programme is offered to all children that is personalised as appropriate to meet the needs of the child and family. This should acknowledge 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.

4.11   With this policy framework in mind, PCTs were asked if they commissioned appropriate screening and other programmes for their whole population. Of the PCTs that responded to the question, 92% had arrangements for the examination of newborns, 90% for neonatal hearing screening and over 80% for birth visits, antenatal screening, the 6-8 week check and the measurement of height and weight when children enter school (Fig. 4.6). However, only 47% of PCTs had arrangements in place for a vision screening programme for 4 to 5 year olds and 58% for Sweep hearing tests for this age group.

Fig. 4.6: PCTs reporting childhood screening programmes in place
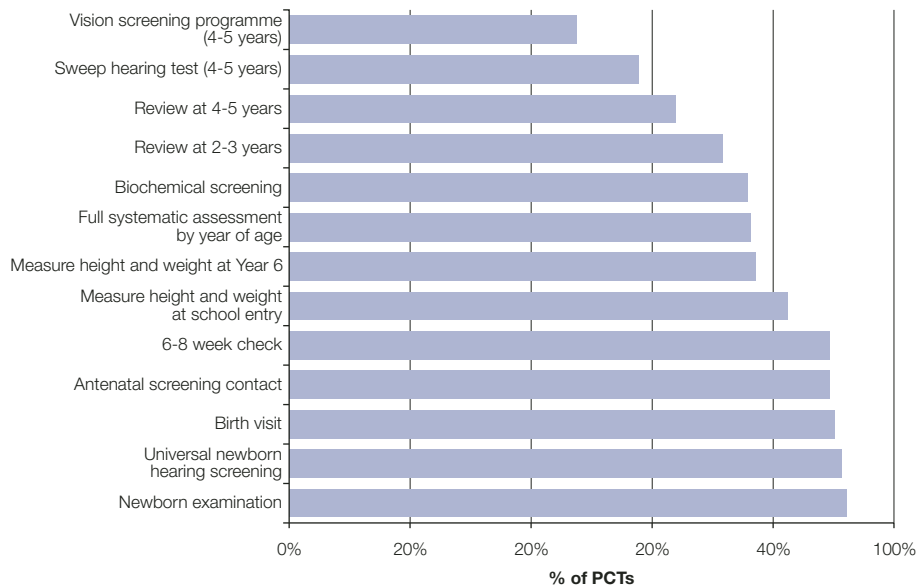
Time spent on public health activities

4.12 Early years and health visiting and school health services play a key role in the delivery of health promotion programmes, lifestyle and public health advice and support to children and families. These services were asked to identify the amount of time spent on activities linked to the public health agenda. The majority of early years and health visiting services (78%) reported that over 50% of their time was directed towards public health. 44% of services estimated that they spent between 50% and 75% of their time on public health while 34% of services spent over 75% on this work. In school health services, a similar balance was reported (Fig. 4.7); 38% spent from 50% to 75% of their time on this work and 30% spent over 75% of their time on it.

Fig. 4.7: Time spent on public health activities by universal services (N=811)
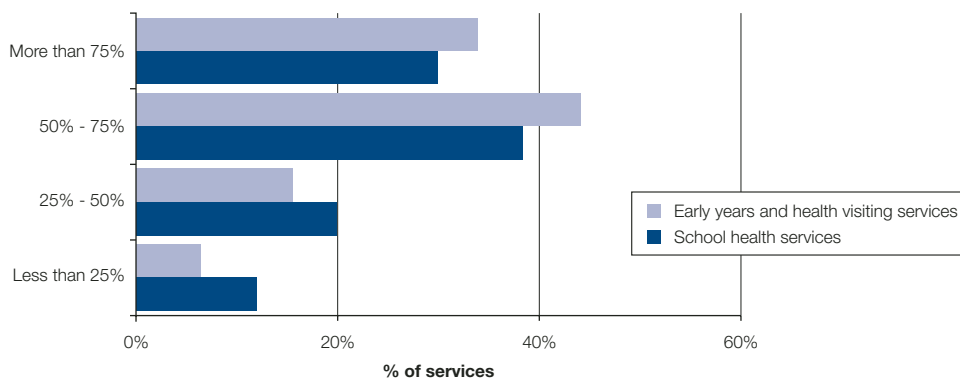
Public health advice and immunisation

4.13 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. 4.8). In targeted teams a focus on these activities was less common but this varied according to the type of service. 91% of services for children in special circumstances indicated they had a public health focus while only 33% of safeguarding teams recorded this.

Fig. 4.8: **Percentage of universal and targeted services reporting a focus on public health, health promotion and immunisation**

Qualified school nurse provision

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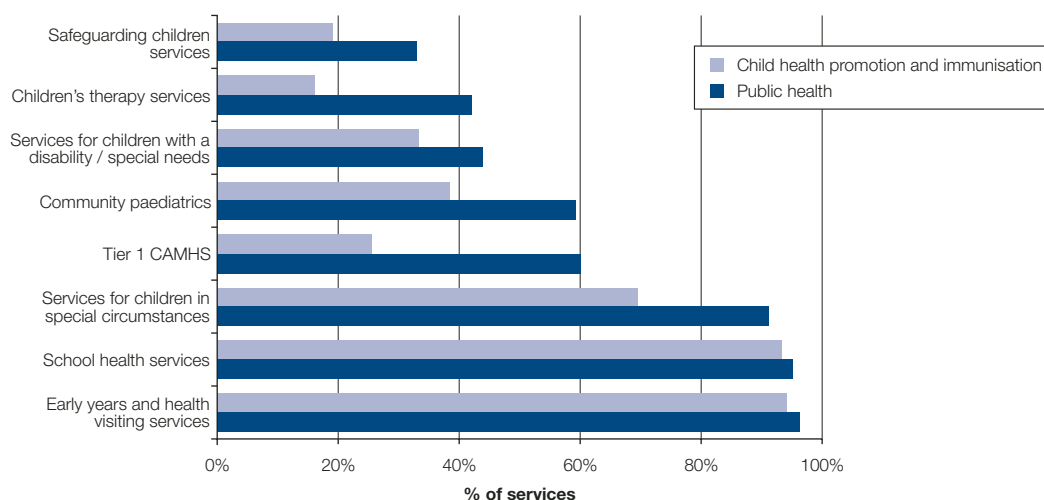are encouraged to work towards having at a minimum, one full-time, all year round, qualified school nurse for each school cluster or group of primary schools and its secondary school taking account of health needs and school population."

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

4.14 To estimate how well school health services were achieving the target of 1 wte qualified school nurse for each school cluster (group of primary schools with their associated secondary school), services were asked to identify how many school clusters they covered. This question was answered by 263 (79%) of the school health services mapped. Of the services responding, 16 (6%) services reported over 2 wte school nurses per cluster, 67 (25%) reported between 1 and 2 wte per school cluster and 180 (68%) services provided less than 1 wte school nurse per cluster. Altogether, 295 school health services employed 1,976 school nurses, an increase from 2005 of 307 school nurses. The national average per cluster was 0.4 wte and ranged from 0.2 to over 1 in SHA regions (Fig. 4.9).

Fig. 4.9: School nurses per school cluster by SHA
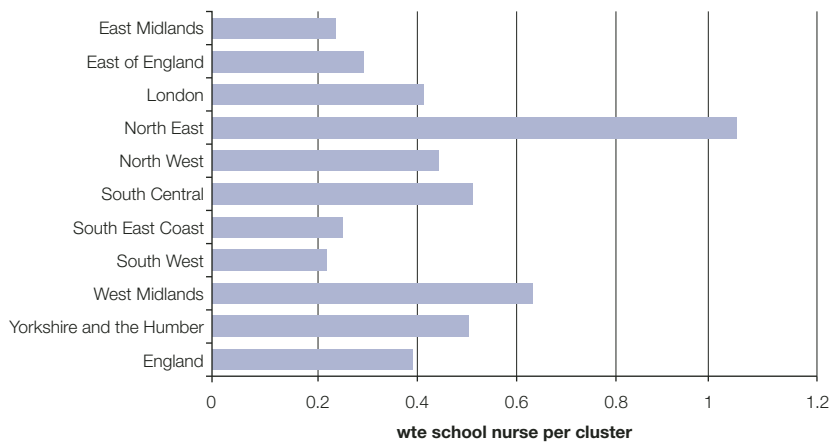
Support for children in special circumstances

4.15   The NSF stresses the need for support to children in special circumstances including targeted health promotion interventions[6]. The number of services for children in special circumstances recorded in the 2005/6 mapping exercise was 247 and this rose to 282 services in 2006/7. Of the 282 services, the most frequent focus of their work was support to looked after children (71%), teenage parents (54%) and asylum seekers, travellers and homeless young people (52%) (Fig. 4.10). Very little change was recorded from the previous year.

Fig. 4.10: Focus of services for children in special circumstances (N=282)
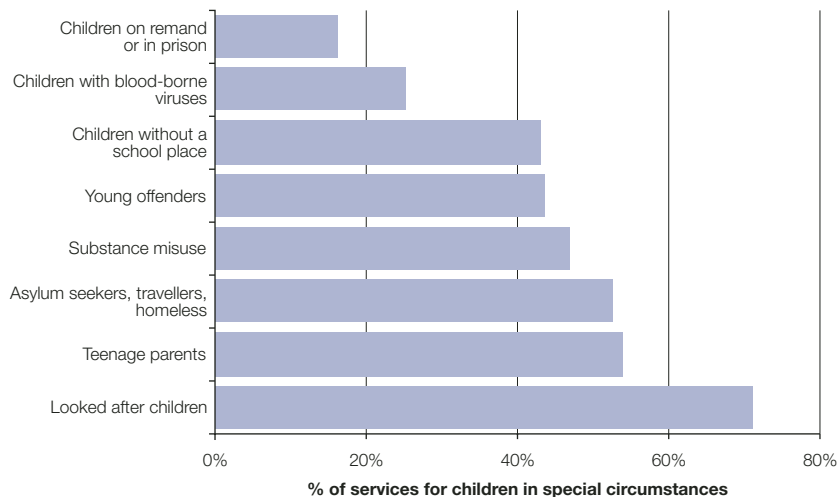
Chapter 5.

Delivering NSF Standard 2:
Supporting parenting

Introduction

5.1   Standard 2 of the National Service Framework for Children, Young People and Maternity Services states:
"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."

5.2   This chapter reports mapping findings most related to this theme, as follows;

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

5.3   Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

Provision of parenting programmes

5.4   The provision of parenting programmes by universal and targeted services was still relatively under-developed. The most frequently used programme was Webster Stratton which was used by 355 universal or targeted services. The Family Caring Trust programme was used by 85 services, Triple P by 81 services, Mellow by 62 services and the Strengthening Families programme by 53 services. Parenting programmes were most likely to be used by CAMHS teams – these accounted for 60% of the services delivering Webster Stratton (Table 5.1). Early years and health visiting services were also more likely to use parenting programmes but the numbers were low.

Table 5.1: Parenting programme provision (number of teams/services)

	Nurturing	Strengthening families	Family Caring Trust	PIPPIN	Mellow	Webster Stratton	Triple P	Strengthening families strengthening communities	PEEP Learning Together	Parents as first teachers
CAMHS tier 2 to 4 teams	17	20	11	1	36	213	50	5	1	-
Children's therapy services	-	-	-	-	-	1	-	-	7	1
Early years and health visiting services	12	18	43	7	14	71	22	5	15	8
Community paediatrics	-	-	1	-	-	4	2	-	-	-
Safeguarding children services	4	4	4	1	1	6	-	-	-	1
School health services	4	2	11	-	1	27	2	-	-	-
Services for children in special circumstances	3	4	6	-	1	8	4	3	-	-
Services for children with a disability/special needs	2	3	5	-	6	14	1	-	1	2
Tier 1 CAMHS	2	2	4	1	3	11	-	-	1	-
Total	**44**	**53**	**85**	**10**	**62**	**355**	**81**	**13**	**24**	**12**

Health and lifestyle advice for parents

5.5   The work of early years and health visiting services is as much to support the parents of young children as to ensure the safety and development of the children themselves. A key role for these services is to provide parents with public health and lifestyle information and advice. 97% of services reported that a focus of their work was on ensuring the safety of children and parents and on accident and injury prevention. 95% of services focused on the mental health and emotional well-being of children and parents, particularly of mothers with young babies. Helping parents stop smoking was a focus for 93% of services and 89% provided advice on nutrition, weight and exercise. Support with breastfeeding was provided by 76% of services. 76% provided advice on reproductive and sexual health (Fig. 5.1). Another area of support was for parents who had lost a child. 77% of services participated in SIDS (sudden infant death syndrome) / CONI (care of the next infant) schemes.

Fig. 5.1:   Health promotion for parents provided through early years and health visiting services

% of early years and health visiting services
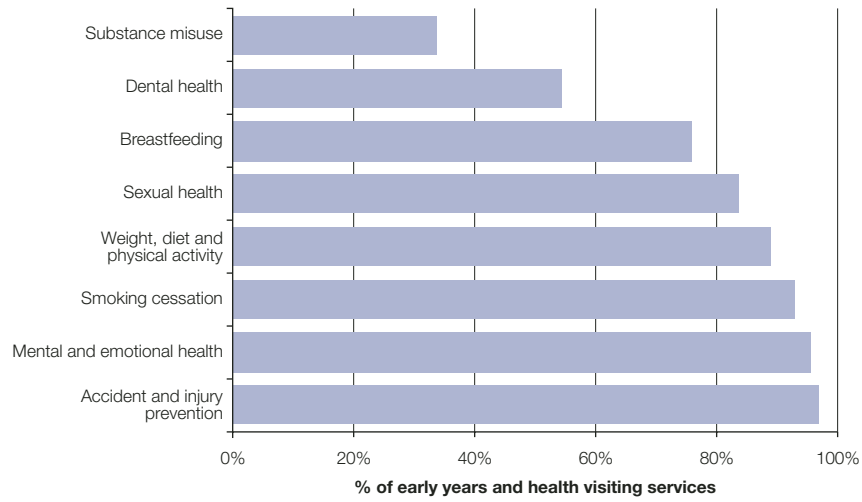
Chapter 6.

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

Introduction

6.1   Standard 3 of the National Service Framework for Children, Young People and Maternity Services states: **"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."**

6.2   This chapter reports mapping findings most related to this theme, as follows;

- Improving access to children's health services.

6.3   Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

Improving access to children's health services

6.4   Good progress was recorded in increasing the provision of children's health services in settings that are convenient to children, young people and their families. When the findings of the 2006/7 mapping exercise was compared to those of the previous year, little change was found in the location of the administrative base of services but services were found to be working in a wider range of settings. The proportion of services that were delivering services in extended mainstream schools increased by 105% between 2005 and 2006. The proportion working into extended schools within special schools increased by 90% and the proportion working in children's centres grew by 76% (Fig. 6.1). In 2006/7, 34% of child health services provided home visits.

Fig. 6.1: Trends in use of selected service settings
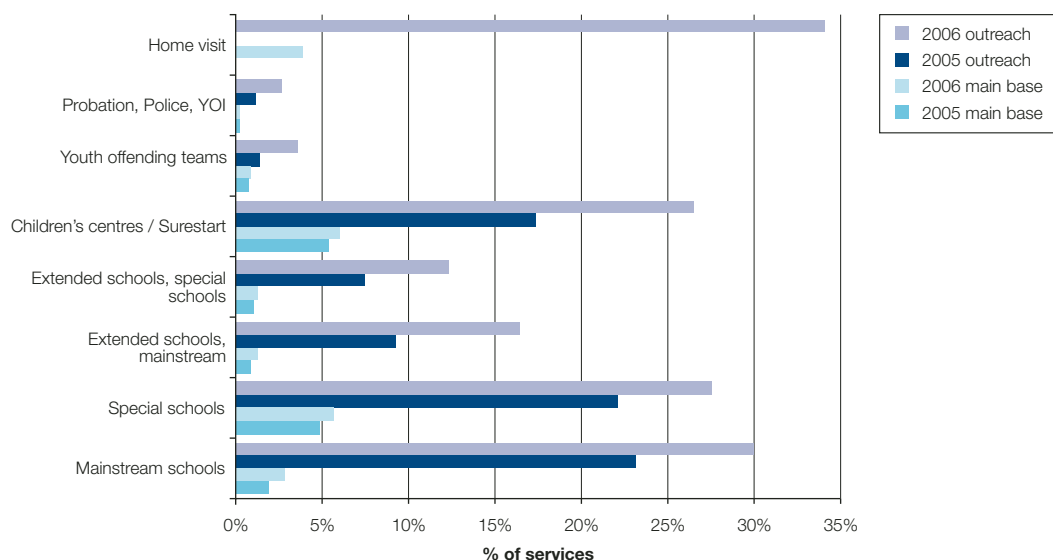
Chapter 7.

Delivering NSF Standard 4:
Growing up into adulthood

Introduction

7.1   Standard 4 of the National Service Framework for Children, Young People and Maternity Services states: **"All young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood."**

7.2   This chapter reports mapping findings most related to this theme, as follows;

- Services for adolescents and young people
- Promoting a healthy lifestyle for young people.

7.3   Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

Services for adolescents and young people

7.4   Adolescents and young people were a focus of work for 87% of school health services showing they work across all school age children. 74% of services for children in special circumstances reported a focus on young people, many of which were supporting looked after children and children leaving the care system. Comparing the proportion of services reporting a focus on working with young people, the trend was a general increase (Fig. 7.1).

Fig. 7.1:   Provision of services for adolescents and young people
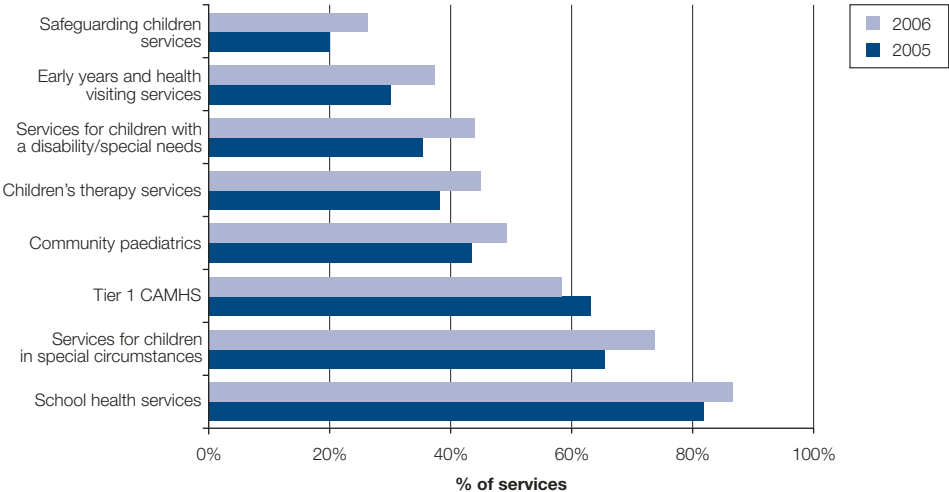
Promoting a healthy lifestyle for young people

7.5   Services were asked if their provision for children, young people and their families had a focus on promoting a healthy lifestyle. As has been seen in paragraph 5.3, health promotion delivered by health visitors is likely to be targeted at parents but school health services and other targeted services that focus on lifestyle issues such as substance misuse, smoking cessation and sexual health are delivering services to adolescents and young people. While Table 7.1 reports health promotion work carried out with children of all ages, sexual health and the prevention of teenage pregnancy was a concern of 97% of school health services, 90% of services for children in special circumstances and 73% of safeguarding services. Help with smoking cessation was provided by 90% of school health services and 75% of services for children in special circumstances. Support and advice on substance misuse was provided by 51% of school health services and 48% of services for children in special circumstances.

Table 7.1: Percentage of school health and targeted services with a focus on promoting a healthy lifestyle for young people

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	8%	96%	97%	90%	90%	51%	97%
Services for children in special circumstances	23%	88%	90%	71%	75%	48%	74%
Safeguarding children services	11%	70%	73%	70%	27%	44%	39%
Services for children with a disability/special needs	5%	84%	48%	70%	27%	7%	75%
Community paediatrics	10%	57%	46%	45%	32%	16%	57%
Tier 1 CAMHS	3%	97%	45%	32%	23%	26%	23%
Children's therapy services	9%	26%	1%	33%	7%	1%	70%

Chapter 8.

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

Introduction

8.1 Standard 5 of the National Service Framework for Children, Young People and Maternity Services states: **"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."**

8.2 Policy emphasises the importance of high priority being given to the resources and processes established to deliver NHS responsibilities in relation to child protection and the safeguarding of children. In 2006/7 the mapping exercise collected information on the availability of dedicated safeguarding services, the level of access to advice and assessment 24 hours a day, 7 days a week and the focus given to safeguarding work by other child health services. The mapping exercise did not deal with other broader processes/system issues concerning child protection as these are audited through other means.

8.3 This chapter reports mapping findings most related to this theme, as follows;

- Provision of dedicated safeguarding services
- Focus of work on safeguarding children
- Features of safeguarding children's services.

8.4 Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports
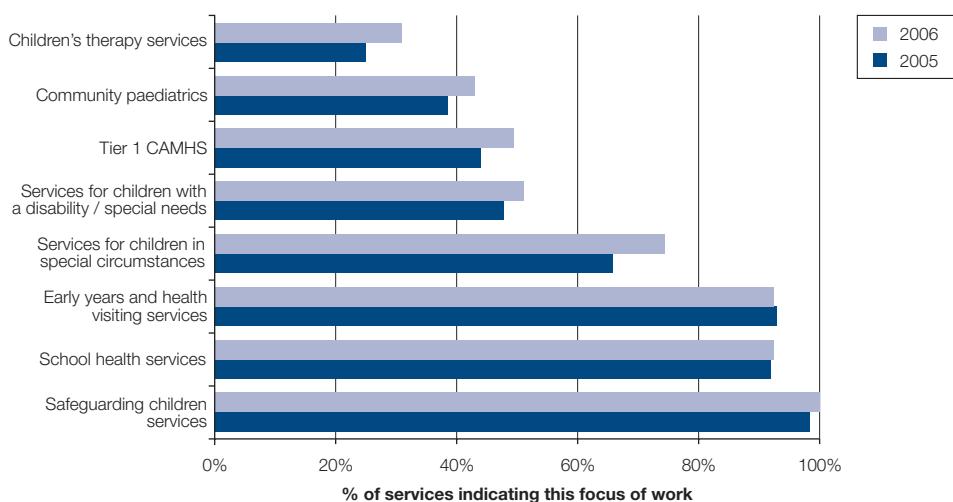
Provision of dedicated safeguarding services

8.5 There were 303 dedicated safeguarding services mapped in 2006/7, an increase of 23 from 2005/6. Safeguarding services had a workforce of 1,151 wte giving an average of 3.8 wte per service.

Focus of work on safeguarding children

8.6 Safeguarding children was reported as a focus of work in all universal and targeted service types to varying degrees. As would be expected, all safeguarding children's services identified this focus. Over 90% of early years and health visiting and school health services also saw this work as a core function. Almost 75% of services for children in special circumstances reported safeguarding as a focus as it is strongly linked to their responsibilities for looked after children. The proportion of services indicating this focus of work increased in the 12 months between the 2005/6 and 2006/7 mapping exercises (Fig. 8.1).

Fig. 8.1: Focus on safeguarding in universal and targeted services

% of services indicating this focus of work

Features of safeguarding children's services

8.7   Safeguarding services were asked about features of provision that were available on a 24 hour, 7-day a week basis. Ideally all features should be in place in all safeguarding services. 61% of services offered child protection medical examinations 24/7, a significant improvement on the 47% of services providing this in 2005/6 (Fig. 8.2). 68% of services offered a next day response for urgent assessment, up from 45% in 2005/6. Staff in 57% of services had access to the Child Protection Register in 2006/7 (this question was not asked the previous year).

Fig. 8.2: Provision of 24/7 response in safeguarding children services

% of safeguarding services
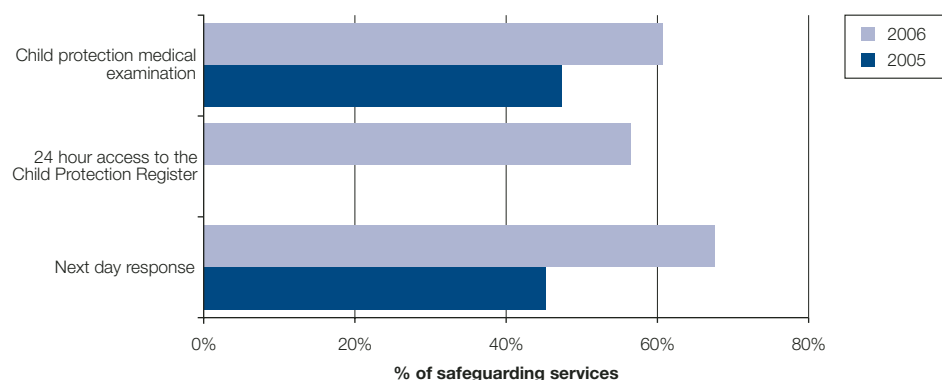
Chapter 9.

Delivering NSF Standards 6 and 7:
Children and young people who are ill and children and young people in hospital

Introduction

9.1   Standard 6 of the National Service Framework for Children, Young People and Maternity Services states: **"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."**

9.2   Standard 7 of the National Service Framework for Children, Young People and Maternity Services states: **"Children and young people receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings."**

9.3   In addition to the NSF, other policy that has influenced hospital care includes the Kennedy Report[7], the NSF for Long Term Conditions[8], the Children Act (1989 and 2004), Paediatric and Congenital Cardiac Services Review[9] and Neonatal Intensive Care Review - Strategy for Improvement[10]. 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.

9.4   This chapter reports the mapping findings related to this theme, as follows;

- Overview of children's hospital service provision
- Characteristics of paediatric emergency care services
- Models of care in general paediatric services
- Diabetes services delivered through general paediatrics
- Paediatric surgery
- Network of care for critically ill children.

9.5   Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

# Overview of children's hospital service provision

9.6   Children's hospital services saw considerable growth in the 2006/7 mapping exercise because services were more thoroughly mapped. This was as a result of improved response rates to the mapping exercise as a whole and the piloting of data provision for the Healthcare Commission as a follow-up to their 2005/6 Children's Hospital Review. Therefore the increase in both the number of services and their staffing seen in Figures 9.1 and 2 should be read with care as the apparent growth is likely to be due to improved mapping and not to change on the ground.

9.7   Nevertheless, a total of 246 general paediatric services were recorded with a workforce of 14,965 wte. There were 210 children's surgery services staffed by 7,435 wte and 188 specialist children's services staffed by 7,837 wte (Figs. 9.1 and 2). The number of children's emergency care services had risen to 169 services staffed by 5,689 wte and there were 33 paediatric intensive care units (PICU) with a workforce of 2,239 wte.

Fig. 9.1:   Trends in the provision of children's hospital services
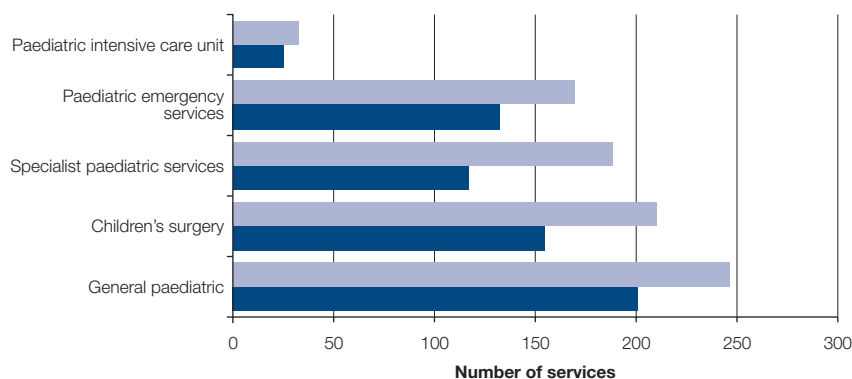
Fig. 9.2: Trends in the workforce of children's hospital services
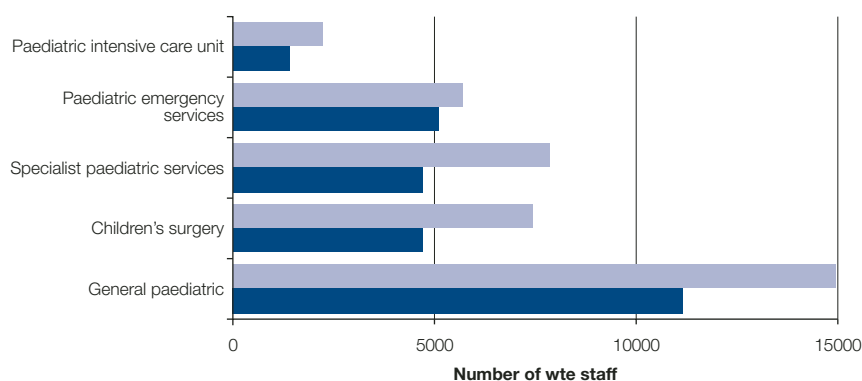
Characteristics of paediatric emergency care services

9.8   Of the 169 paediatric emergency care services reported in 2006, 34 (20%) were dedicated stand alone emergency care units designed specifically for children with their own reception and pathways of care. This was an increase from 17% stand alone paediatric A&E services in 2005/6. 118 services (70%) were part of A&E but had a separate waiting area for children and 114 services (67%) had separate areas for the assessment and treatment of children (Fig. 9.3). 106 services (63%) reported 24/7 access to staff trained in paediatrics.

Fig. 9.3:   Trends in the development of paediatric emergency services

% of paediatric emergency services with this characteristic
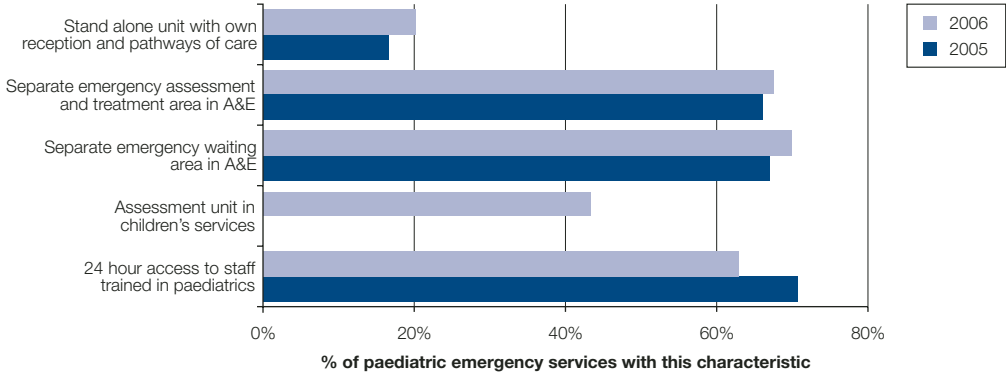
Models of care in general paediatric services

9.9 Key policy emphasises the importance of bringing services closer to the child and family in relation to hospital services, this means increasing the accessibility of general paediatric services through extending them into the community and ensuring better links between hospital and home. The mapping exercise tried to understand progress by requesting data about inpatient versus outpatient care and the range of alternatives to hospital admissions.

9.10 Of the 246 general paediatric services mapped, 184 (73%) provided inpatient care, 209 (85%) provided outpatient services and 154 (63%) offered day case care. Overall, 160 (65%) services provided all three types of care. 9 services were inpatient units only, 30 (12%) were exclusively outpatient teams and 6 were day patient units.

9.11 Services were asked to identify the models of care they currently provided (Fig. 9.4). These questions were answered by 193 of the 246 general paediatric services mapped (78%). The different models of service reported included the provision of:
- Specialist nurses in 157 general paediatric services (95%)
- Specialist assessment units in 138 services (83%)
- Community nurses attached to inpatient units in 109 services (66%) to make links between home and hospital for children and their families
- Hospital at home services by 102 services (61%). These were home nursing teams supporting children with acute, long term or complex health care needs who traditionally would have been cared for in hospital
- Home care for children with life threatening illnesses in 98 services (59%) to enable children to stay at home when they might previously have been admitted to hospital.

Fig. 9.4: **Trends in models of care in general paediatrics**
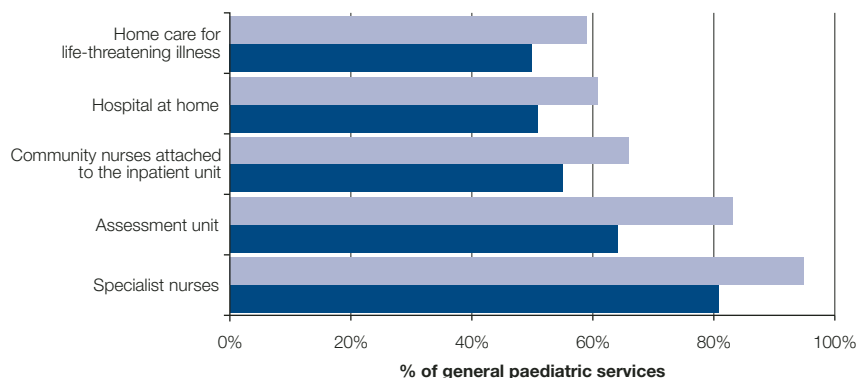
Diabetes services delivered through general paediatrics

9.12   The standards on the clinical care of children and young people with diabetes are found in the NSF for Diabetes[11]. The children's section focuses on early clinical assessment and management, continuity of care across all settings and transition to adulthood.

9.13   In total, 205 of the 246 general paediatric services mapped (83%) 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 204 diabetes services, 146 (72%) provided all three models of care. 186 services (91%) provided inpatient care, 191 (93%) provided outpatient care and 155 (76%) provided outreach. All services (except one non-response) managed Type 1 diabetes while 177 services (87% of general paediatric services providing diabetes care) managed children and young people with Type 2 diabetes.

9.14   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. Services were asked if their diabetic service had input from a range of specialists. It was found that input from specialists varied widely across the country. Dieticians were the most common specialists, contributing to 196 (96%) of services (Fig. 9.5). Children's nurses with a special interest in diabetes contributed to 192 (94%) services. 135 (67%) services had input from a diabetologist, up from 56% in 2005, and 118 (58%) from an endocrinologist, up from 49% in 2005. Child psychology input was available in 95 (46%) services and child psychiatry input remained rare, reported in only 53 services (26%) but this was up from 16% in 2005.

Fig. 9.5:   **Trends in access to particular expertise for diabetes in general paediatric services**
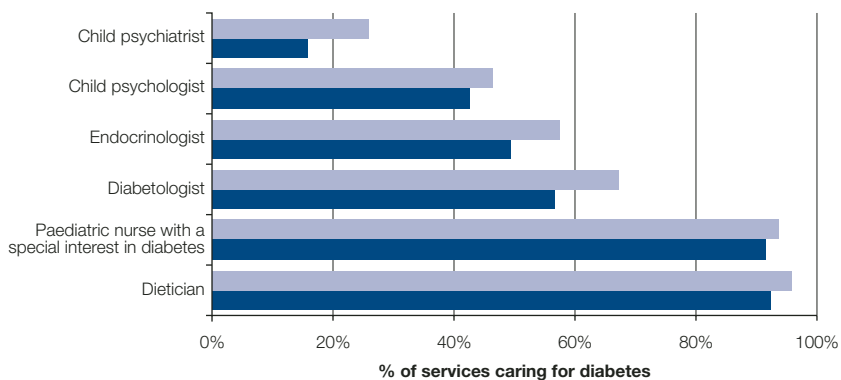
Paediatric surgery

"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*

9.15   Currently 189 of the 213 paediatric surgery services mapped (93%) offered day surgery and 69 services (32%) offered outpatient surgery in order to reduce inpatient stays to a minimum and to provide, as far as possible, a community/child centred approach.

9.16   The mapping investigated the use of dedicated operating lists for children and the availability of staff trained specifically in the care of children in paediatric surgery units (Fig. 9.6). Dedicated operating lists for children were found in 85 of the 213 paediatric surgery services mapped (40%), a decrease from 67% of services reporting this in 2005/6. Operating lists were supported by nurses with child-specific training in 170 (80%) services but trained staff were only available for all children's surgery in 99 (46%) services. In the other 71 (33%) services, only some surgery was supported by nursing staff who had undergone specialist children's training. This showed very little change from the previous year.

Fig. 9.6:   Trends in paediatric surgery (RN-C: Registered Children's Nurse)
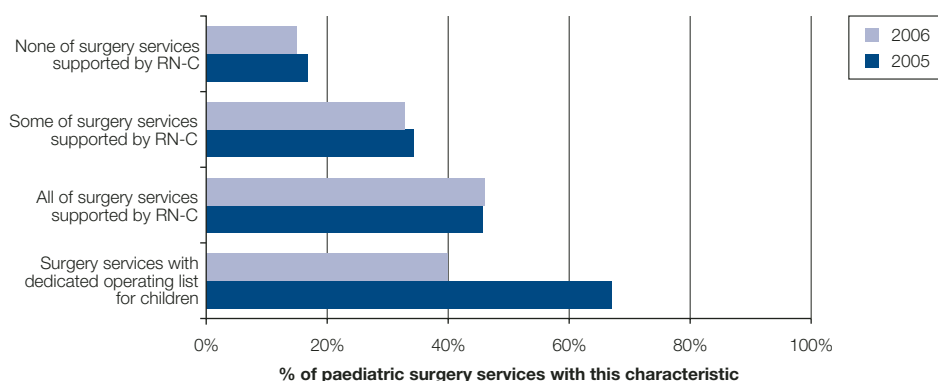
9.17   Despite a reduction in the number of dedicated operating lists for children, an increase of 79% was reported in the number of surgery cases in child specific operating lists and non-child specific lists undertaken in the 12 months January to December 2006. The number of surgery cases reported in 2006 was 293,413 as opposed to 163,624 in 2005. The average number per 100k population aged 0 to 17 years was 26 but this ranged from 12 to 37 in SHAs (Fig. 9.7).

Fig. 9.7: **Average number of children's surgery cases per 100k population aged 0 to 17 in 2006 by SHA**

Surgery cases per 100k population 0 to 17
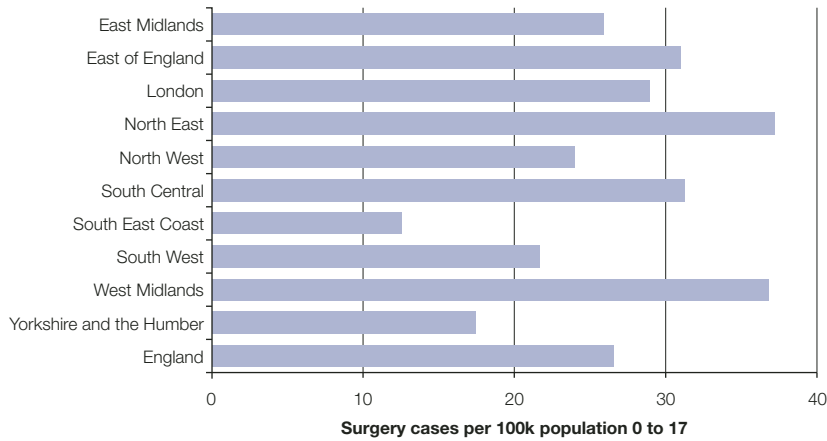
Network of care for critically ill children

9.18   Of the 33 PICU services mapped, all reported belonging to a managed clinical network for critically ill children. 15 (45%) of the services led the network, a slight reduction from 2005/6 (Fig. 9.8).

Fig. 9.8:   **Trends in participation in networks of care for critically ill children**

% of PICU
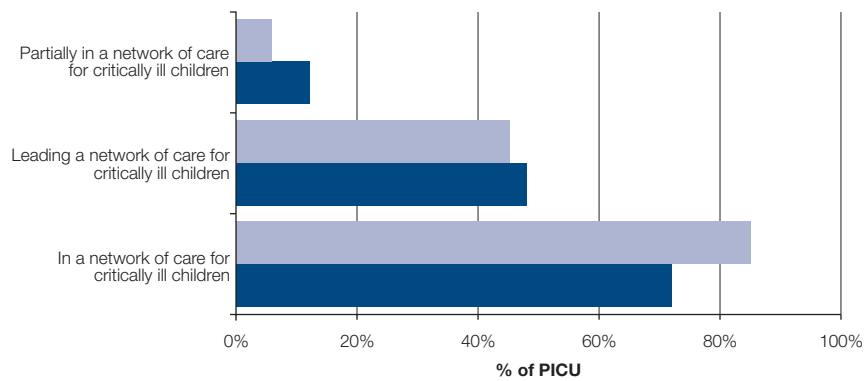
Chapter 10.

Delivering NSF Standard 8:

Disabled children and young people and those with complex health needs

Introduction

10.1 Standard 8 of the National Service Framework for Children, Young People and Maternity Services states: **"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."**

10.2 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 all universal, targeted and hospital services.

10.3 The scope of disabilities recorded 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 need[12].

10.4 This chapter reports the mapping findings most related to this theme, as follows;

- Focus on disability in universal and targeted services
- Keyworker system.

10.5 Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

Focus on disability in universal and targeted services

10.6 The mapping data showed that disability was the growing concern of many universal and targeted teams (Fig. 10.1). Almost all services specifically for children with disabilities and special needs had this focus (incomplete returns are suspected in 5% of cases). A high proportion of paediatric therapy (89%), early years and health visiting (74%) and school health services (74%) also identified a focus on working with disabled children and young people. 58% of community paediatric services indicated this focus.

Fig. 10.1: Focus on disability in universal and targeted services (N=1,763)

% of universal and targeted services with focus on disability
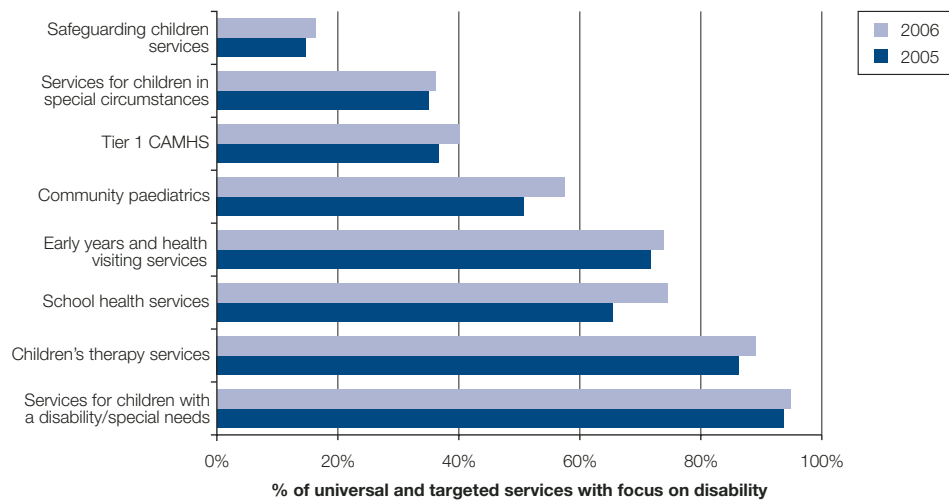
10.7   Looking at the focus of universal and targeted service, they tended to work across the range of physical and learning disabilities, autistic spectrum disorders and sensory impairment to an almost equal degree (Table 10.1). The only exception was children with complex health disorders, who were the focus of specialist services for children with disabilities.

Table 10.1: Proportion of universal and targeted services working with children and young people with particular disabilities (N=1,763)

| Type of service	Physical Disability	Learning Disability	Sensory Impairment	Autistic Spectrum Disorder	Complex Health Disorders	Other Disabilities
Children's therapy services	81%	73%	67%	59%	-	13%
Early years and health visiting services	64%	61%	58%	59%	-	2%
Community paediatrics	45%	37%	36%	29%	-	6%
Safeguarding children services	7%	7%	6%	7%	-	0%
School health services	58%	57%	51%	48%	-	1%
Services for children in special circumstances	21%	21%	16%	14%	-	1%
Services for children with a disability/special needs	88%	82%	75%	74%	82%	9%
Tier 1 CAMHS	24%	29%	26%	28%	-	-

Keyworker system

Definition:

Keyworker: A keyworker is both a source of support for the families of disabled children and a link by which other services are accessed and used effectively. Keyworkers 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 child[13].

10.8   Good practice recommends that a keyworker system is in place to support disabled children with high levels of need. Keyworkers 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 that they require[14]. Improvement was found in the proportion of specialist disability services for children that had adopted a keyworker system. 62% of services for children with disabilities and special needs had a keyworker system in 2006/7 compared to 47% in 2005/6. Only 3 SHAs had above average numbers of disability services providing a keyworker system (Fig. 10.2).

Fig. 10.2: Percentage of disability services operating a keyworker system by SHA

% of services for children with disabilities
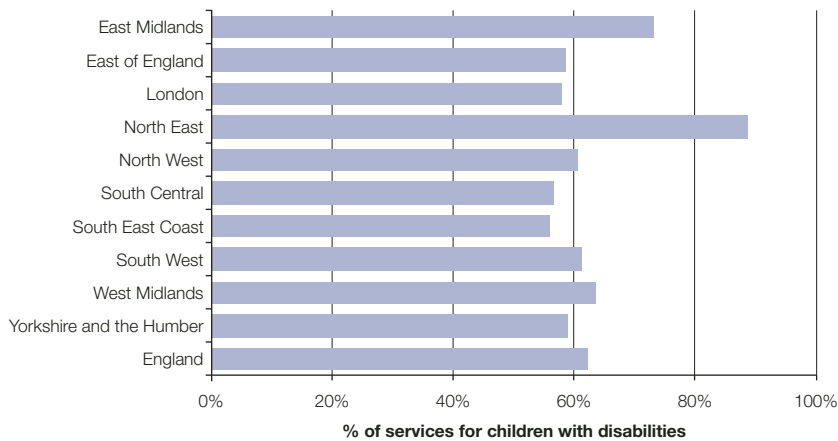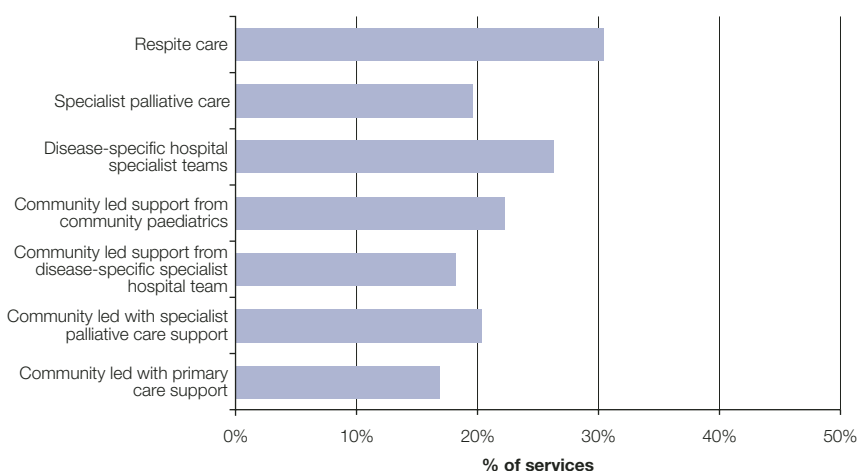
Palliative care

10.9   In total, 610 children's health services indicated that they provided palliative care. It was provided by a range of universal, targeted and hospital services including, 46% of general paediatric services, 33% of PICU, 29% community paediatric services, 27% of services for children with disabilities and special needs, 26% of specialist paediatrics and 26% of children's therapy services (Fig. 10.3).

Fig. 10.3: Percentage of services providing palliative care (N=610)
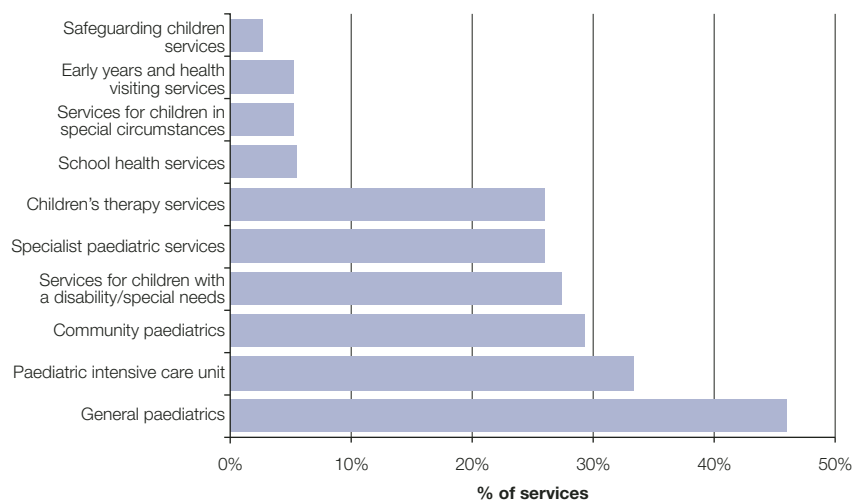
10.10 The most common type of palliative care was respite care which was provided by 31% of palliative care services overall (Fig. 10.3). Disease specific hospital specialist teams were provided by 26% of palliative care services. Community based care supported by primary care teams was the least common type of palliative care provided by just 17% of services.

Fig. 10.4: Percentage of services providing different models of palliative care (N=610)

10.11 Of the palliative care services, 23% were available 24/7 but 55% of services worked together with the local community nursing service to extend the support that could be provided. Only 11% of services had a lead doctor for palliative care.

Chapter 11.

Delivering NSF Standard 9:

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

Introduction

11.1 Standard 9 of the National Service Framework for Children, Young People and Maternity Services states: **"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."**

11.2 By way of clarification, specialist or tier 2 to 4 CAMHS (as defined in Annex 3) are mapped through the CAMHS mapping data collection. Tier 1 provision, provided by non-specialist CAMHS is mapped through the child health mapping exercise. This is the most comprehensive chapter since specialist CAMHS has been the focus of a single mapping exercise for the past five years.

11.3 This chapter reports the findings most related to this standard, as follows;

- Towards a comprehensive CAMHS: Teams, staff and settings
  - Trends in CAMHS tier 2 to 4 provision
  - The range of CAMHS team provision
  - Provision of a range of professionals
  - Availability of CAMHS in different settings
  - Tier 4 services
  - On-call and emergency response
  - Services for people aged sixteen and seventeen
  - Learning disability provision
  - Looked after children
  - Services for young offenders
  - ADHD and autistic spectrum disorder provision
- Towards a comprehensive CAMHS: Progress against national performance indicators
- Towards a comprehensive CAMHS: Services for target groups
  - Looked after children
  - Services for young offenders
  - ADHD provision
  - Autistic spectrum disorder provision
  - CAMHS tier 1 provision
- Towards a comprehensive CAMHS: Functions, interventions and training
  - Assessment
  - Consultation and liaison
  - Interventions
  - Training
- Towards a comprehensive CAMHS: Use of IT and outcomes measures
  - Use of outcome measures
  - Use of IT
- Towards a comprehensive CAMHS: Caseload and case characteristics
  - Changes to data collection in 2006
  - National summary and trends
  - New cases seen
  - Cases waiting and length of wait
  - Length of treatment
  - Age and gender profile
  - Ethnicity
  - Primary presentation
  - Referral source.

11.4   Detailed tables of the data can be found and downloaded from the mapping website at
        www.childhealthmapping.org.uk/reports

Towards a comprehensive CAMHS provision: Teams, staff and settings

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 singledisciplinary 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.

11.5   In total, 1,055 CAMHS teams were mapped in 2006/7, an increase of just 4 teams from the 1,051 mapped the previous year. This reflected a slowing of growth following a 9% increase in team numbers between 2003 and 2004 and a 6% increase between 2004 and 2005. The workforce of these teams showed a small decline, decreasing from 9,876 wte in 2005 to 9,705 wte in 2006, a decrease of 2%. Between 2003 and 2005 an overall increase in the CAMHS workforce of 26% had been reported and so this decrease in staff numbers marked a significant reversal in trends. Possible reasons for this are discussed in Chapter 3 on workforce.

11.6   A slight shift in the types of teams provided was observed (Fig. 11.1). The number of single agency generic teams rose by 12% and the number of targeted teams grew by 10%. All other team types saw a decline. Multi-agency generic teams reduced by 5%, dedicated worker teams were down by 3% and tier 4 teams fell by 1%.

11.7   The slight changes in the configuration of teams were also reflected in small changes in the workforce (Fig. 11.2). The staffing of multidisciplinary generic teams fell by 4% while single agency generic teams grew by the same amount. Targeted team staff increased by 1% and the workforce of dedicated worker teams increased by 18% despite reductions in the number of teams. Overall, the workforce of tier 4 units decreased by 2%.

Fig. 11.1: Trends in the development of CAMHS tier 2 to 4 provision
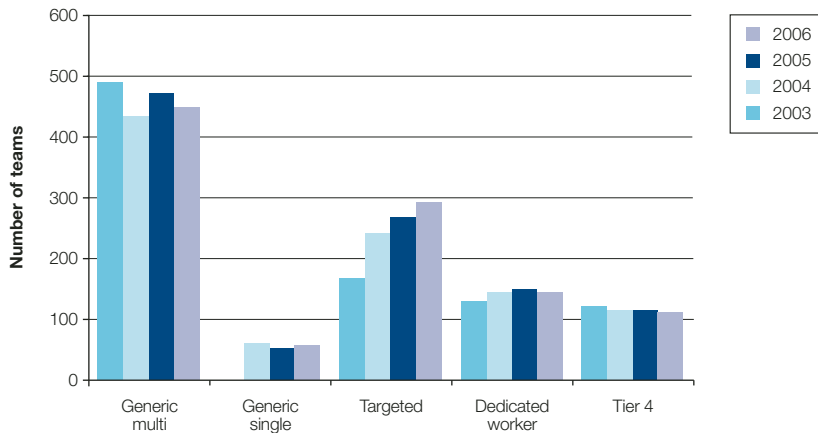
Fig. 11.2: Trends in the staffing of CAMHS tier 2 to 4 provision
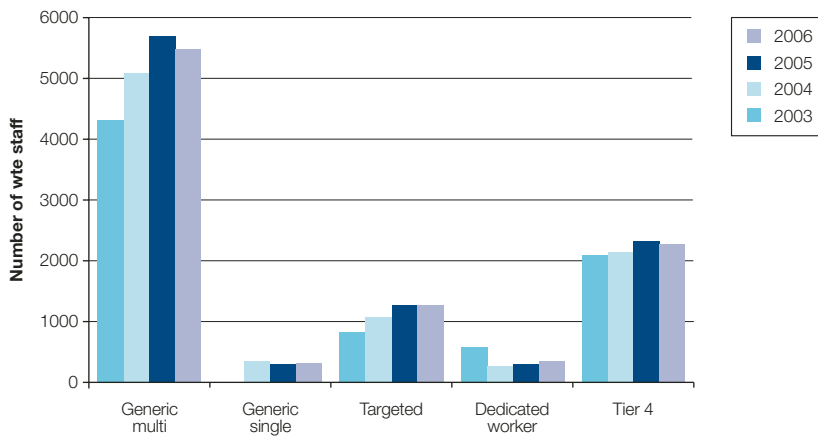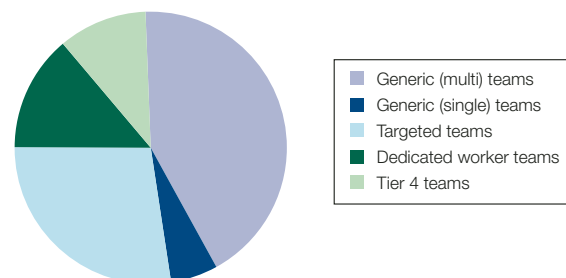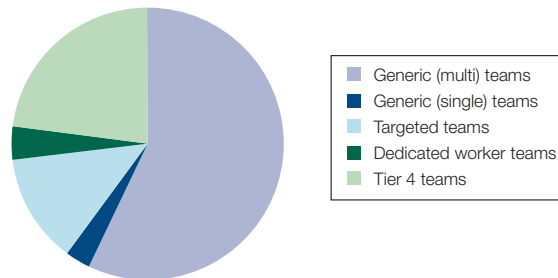

The range of CAMHS team provision

11.8   Nationally, the balance of CAMHS teams found in 2006 was as follows:

- There were 506 generic teams of which 449 were multi-disciplinary and 57 single disciplinary (Fig. 11.3). Generic multi professional teams made up 43% of all CAMHS teams and 57% of the workforce (Fig. 11.4). Generic teams provide the backbone of specialist CAMHS provision ensuring a range of therapeutic interventions were available to children, young people and families locally.

Fig. 11.3: Types of CAMHS teams 2006 (N=1055)

Generic (multi) teams
Generic (single) teams
Targeted teams
Dedicated worker teams
Tier 4 teams

Fig. 11.4: Staffing (wte) by team type 2006 (N=9705)

Legend:
- Generic (multi) teams
- Generic (single) teams
- Targeted teams
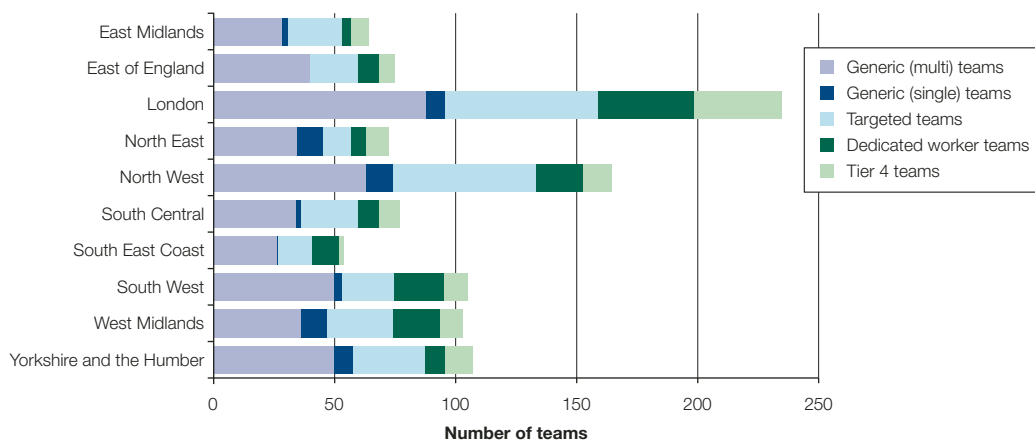- Dedicated worker teams
- Tier 4 teams

- Single disciplinary generic teams made up 5% of all teams and accounted for 3% of the workforce. The staff of these teams were almost exclusively clinical psychologists, educational psychologists and other therapists. The exceptions were teams of primary mental health workers.
- There were 293 targeted teams making up 28% of all teams but accounting for only 13% of the workforce, suggesting the teams tended to be small in size. These teams focused on meeting specific needs of children and young people.

- The 144 dedicated worker teams accounted for 14% of the number of teams but only 4% of the workforce. These were CAMHS professionals who provided a specialist mental health input in teams which have another related focus such as education or community paediatrics. Teams were often individual workers, or 'virtual' groups of workers who fulfil similar tasks in different teams.
- 11% of teams were tier 4 provision. These 112 teams provided intensive support through in-patient care, day care or home support of various kinds. Needing high staffing levels, tier 4 teams employed 23% of the CAMHS workforce (Fig. 11.4).

11.9 The distribution of CAMHS team types varied across the country (Fig. 11.5) with different service models used. Tier 4 provision was particularly uneven.
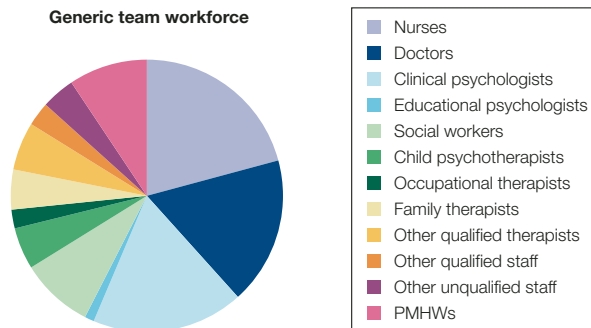
Fig. 11.5: Distribution of CAMHS team type by SHA

Legend:
- Generic (multi) teams
- Generic (single) teams
- Targeted teams
- Dedicated worker teams
- Tier 4 teams

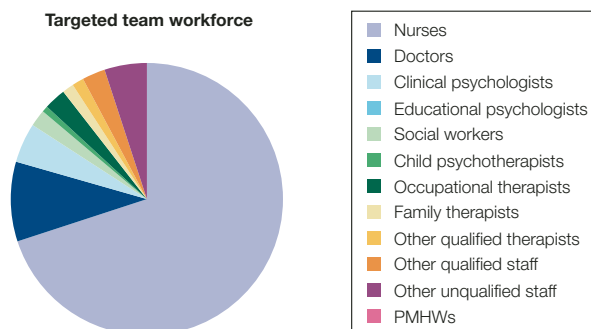## Provision of a range of professionals

11.10 Multi and single disciplinary generic teams, as the name implies, were largely staffed by a range of mental health professionals. The workforce of these teams was made up of nurses (16%), doctors (14%) and clinical psychologists (14%) (Fig. 11.6). These teams provided 74% of the input into CAMHS from doctors, 68% of clinical psychologists' time and 64% of social work input. Although numbers were low, generic teams also employed 80% of psychotherapists, 73% of family therapists and 68% of other qualified therapists input into specialist CAMHS. Importantly, 78% of primary mental health workers worked in generic teams.

Fig. 11.6: Professional make-up of the workforce of generic multi and single disciplinary teams (wte of staff) (N=5,801)

Generic team workforce

- Nurses
- Doctors
- Clinical psychologists
- Educational psychologists
- Social workers
- Child psychotherapists
- Occupational therapists
- Family therapists
- Other qualified therapists
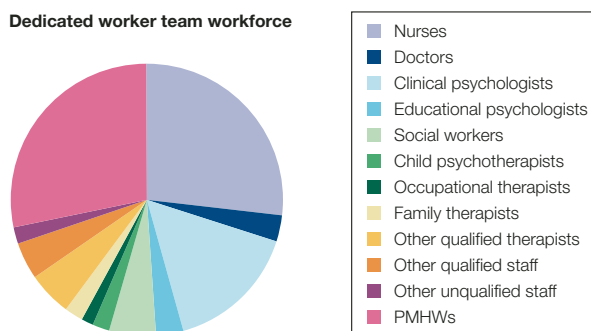- Other qualified staff
- Other unqualified staff
- PMHWs

11.11 The staff profile of targeted teams differed from that of generic teams in that there was a greater emphasis on the contribution of social workers (12% of target team staffing) and high input from clinical psychologists (18% of team staffing) (Fig. 11.7). The input of doctors to targeted teams was considerably less, as was the contribution of PMHWs and 9% of the workforce was made up of unqualified workers.

Fig. 11.7: Professional make-up of the workforce of targeted teams (wte of staff) (N=1,280)

Targeted team workforce

- Nurses
- Doctors
- Clinical psychologists
- Educational psychologists
- Social workers
- Child psychotherapists
- Occupational therapists
- Family therapists
- Other qualified therapists
- Other qualified staff
- Other unqualified staff
- PMHWs

11.12 The average size of dedicated worker teams was 2.6 wte, often made up of a single professional working with an administrator and/or manager. Nationally, 24% of the workforce were PMHWs, 23% were nurses, 13% were clinical psychologists and 5% were social workers (Fig. 11.8).

Fig. 11.8: Professional make-up of the workforce of dedicated worker teams (wte of staff) (N=355)

Dedicated worker team workforce

- Nurses
- Doctors
- Clinical psychologists
- Educational psychologists
- Social workers
- Child psychotherapists
- Occupational therapists
- Family therapists
- Other qualified therapists
- Other qualified staff
- Other unqualified staff
- PMHWs

11.13 Tier 4 teams/units employed 64% of the total nurse workforce and 9% of doctors (Fig. 11.9). Although there were a relatively small number of OTs working in tier 4 teams, 33% of all OTs working in specialist CAMHS were working in tier 4.

**Fig. 11.9: Professional make-up of the workforce of tier 4 teams (wte of staff) (N=2,269)**
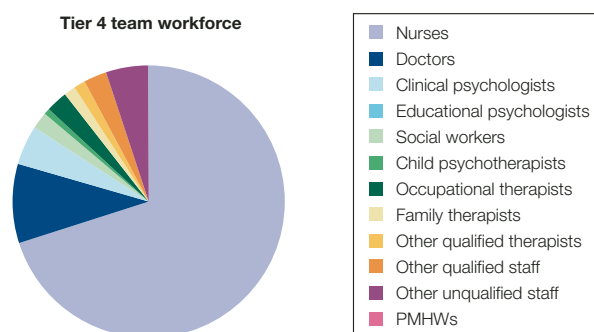
Availability of CAMHS teams in different settings

11.14 One of the aims of the development of comprehensive CAMHS provision is to improve the accessibility and availability of teams. An aspect of this is to ensure CAMHS operate in a range of hospital and community settings. Therefore, in the mapping exercise, all services were requested to identify their main location and the settings of their outreach work.

11.15 Multi and single disciplinary generic teams tended to be located in community based clinics (67%) and 22% were hospital based (Fig. 11.10). However, outreach work emphasised the range of settings that the teams worked in. Health settings were important with 28% of teams providing outreach in community based clinics, 20% in hospitals and 17% in GP surgeries. In addition, 31% of teams provided outreach in educational settings, 23% in social services and 12% in voluntary sector locations.

Fig. 11.10: Settings of main base and outreach work for multi and single disciplinary generic teams (N=506)
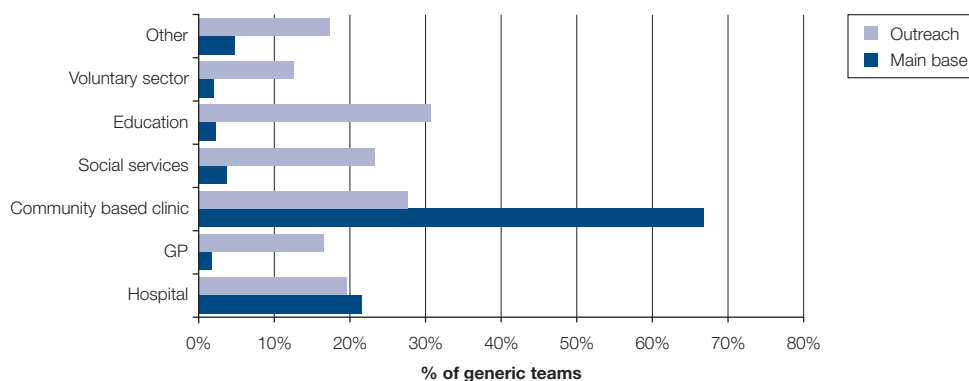
11.16 Targeted teams worked in very mixed locations (Fig. 11.11). 44% were based in community clinics, 25% in hospitals and 15% in social services settings. Their outreach work extended to education settings (31% of teams), community clinics (25%), social services locations (23%), hospitals (14%) and the voluntary sector (10%). Almost a quarter of teams also listed other settings.

Fig. 11.11: Settings of main base and outreach work for targeted teams (N=293)
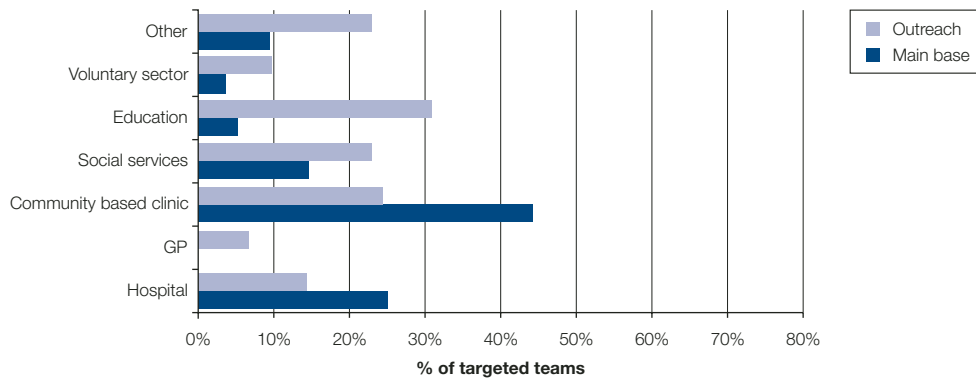
11.17 Dedicated worker teams contained a higher number of social services-led services and, as a result, 27% of teams were based in social service settings. 24% were based in community clinics and 16% in education settings (Fig. 11.12). Some of the dedicated worker teams only worked in one location and did not provide outreach. Of those that did, 18% of teams worked in community clinics, 18% in education settings and 19% in other undefined settings. Only 11% of teams provided outreach in social services and 10% in voluntary sector settings.

Fig. 11.12: Settings of main base and outreach work for dedicated worker teams (N=144)
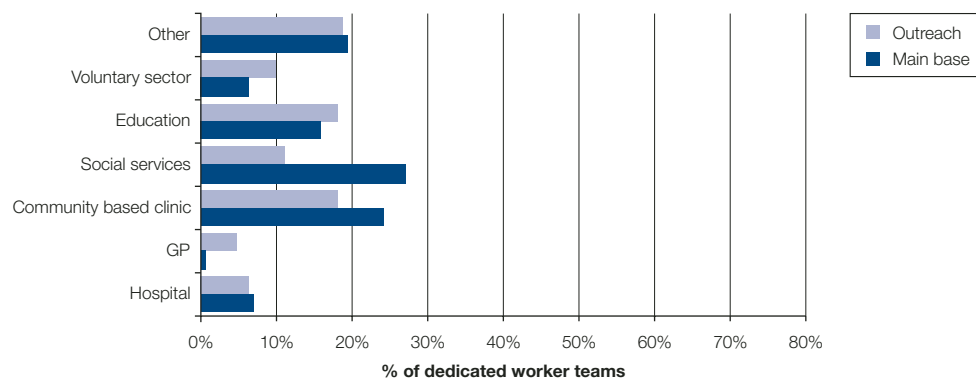
11.18 Tier 4 teams and units tended to be hospital based (77%). Only 12% were located in the community, 4% with social services and 3% with education (Fig. 11.13). Outreach was rarely provided with less than 10% of teams working in any particular outreach setting.

Fig. 11.13: Settings of main base and outreach work for tier 4 teams (N=112)
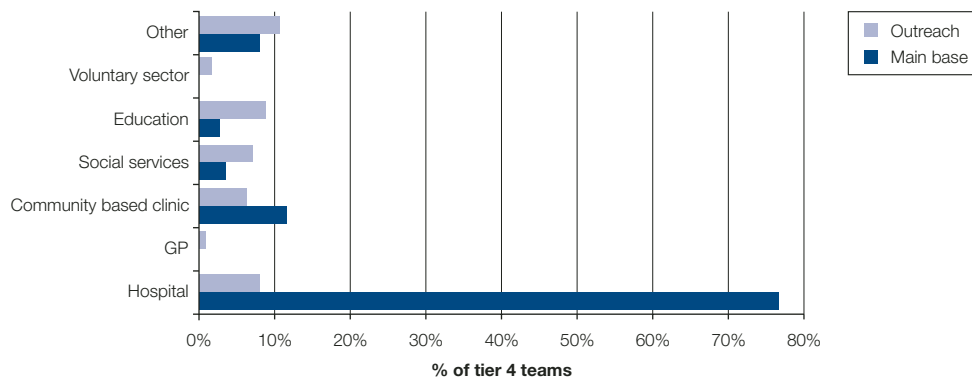
Tier 4 services

11.19 The 112 tier 4 units reported a changing picture of service provision. The number of commissioned inpatient beds decreased by 3%, from 680 in 2005 to 659 in 2006 (Fig. 11.14) but the number of available inpatient beds increased by 1%, from 621 in 2005 to 629 in 2006. The number of day places provided fell by 13% from 478 in 2005 to 415 in 2006. However, the number of intensive home support places increased during the same period by 18% from 747 places in 2005 to 879 places in 2006. The number of intensive foster care placements also increased, from 64 places in 2005 to 83 places in 2006, a rise of 30%.

**Fig. 11.14: Trends in capacity of tier 4 provision 2003 to 2006**
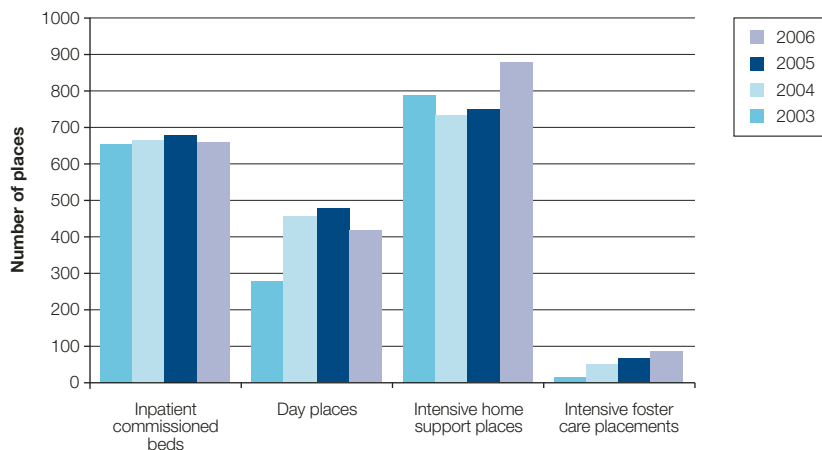
11.20 Table 11.1 indicates uneven tier 4 provision throughout the country especially in the provision of specialised care such as intensive foster care, home support and specialist beds. The capacity of these units is shown in Table 11.1 and Fig. 11.15.

Table 11.1: Provision of tier 4 units by SHA

2006	Number of tier 4 units	Inpatient units commissioned beds	Forensic units with commissioned beds	Commissioned beds in other units	Day care places	Intensive home support places	Intensive foster care places	Other intensive outreach placements
East Midlands	7	34	-	2	24	21	-	-
East of England	7	45	-	-	10	286	4	-
London	36	171	-	9	103	74	30	-
North East	9	61	18	-	22	-	-	-
North West	12	52	10	-	66	171	10	-
South Central	9	58	-	12	40	66	30	-
South East Coast	2	19	-	-	10	90	-	-
South West	10	44	-	-	40	106	-	22
West Midlands	9	54	20	-	5	25	7	-
Yorkshire and the Humber	11	50	-	-	95	40	2	-
Total	**112**	**588**	**48**	**23**	**415**	**879**	**83**	**22**

Fig. 11.15: Number of beds and day places provided in tier 4 units by SHA
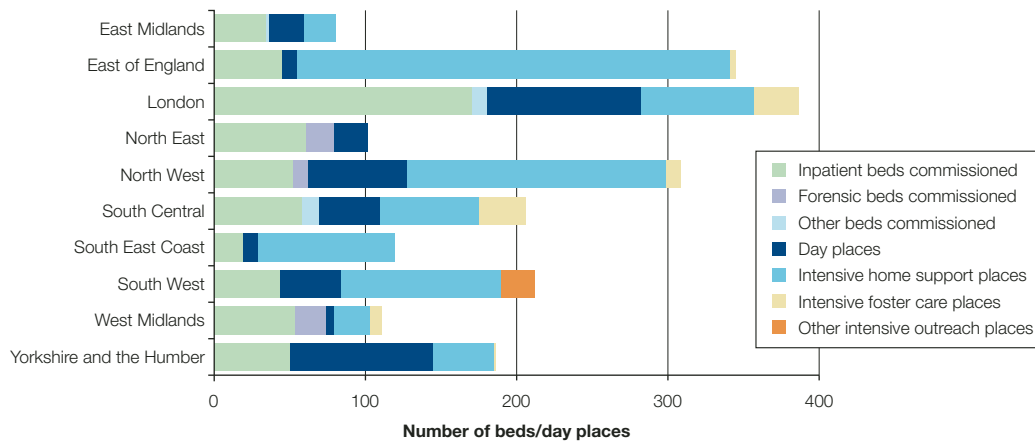
11.21 In addition to the intensive support provided by tier 4 units, some tier 2/3 teams provide alternatives to inpatient care. It was found that 187 teams (20% of tier 2/3 teams) provided early intervention services, 138 teams (15%) provided intensive home support and 68 teams (7%) provided intensive foster care. Intensive day support was provided by 41 teams (4%). A further 93 teams reported the provision of other intensive support which serves as alternatives to hospital admission. The distribution of this provision by SHA is shown in Fig. 11.16.

Fig. 11.16: Provision of alternatives to inpatient care in tier 2/3 teams
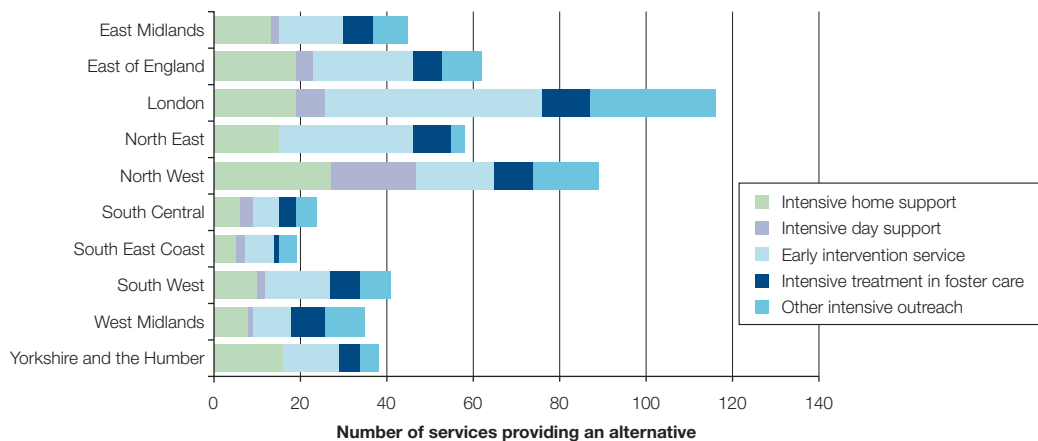
11.22 Tier 2/3 teams also provide support to tier 4 teams and cases. Of the 943 tier 2/3 teams, 458 (49%) reported providing support to tier 4, a considerable increase on the 28% of teams providing support in 2005 (Fig. 11.17). The increase in support could be seen in all SHAs.

Fig. 11.17: Tier 2/3 team support to tier 4
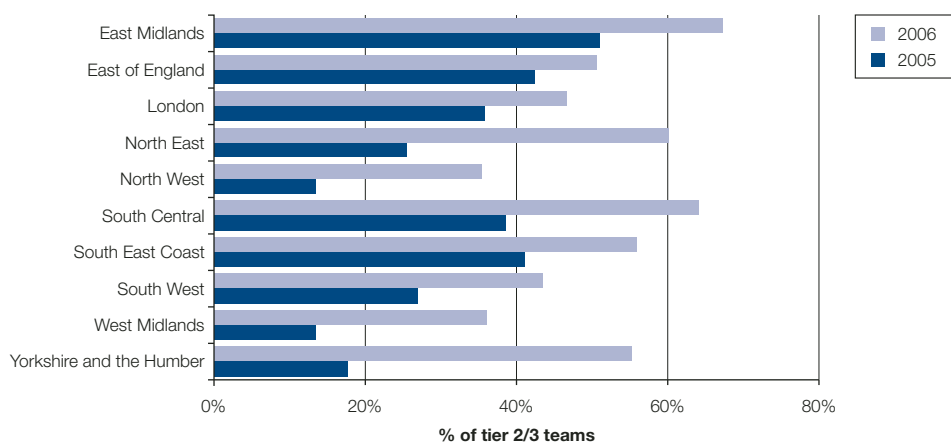
Towards a comprehensive CAMHS: Progress against national performance indicators

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 Services*[15]

11.23 From the outset, CAMHS mapping has tracked the development of on-call and emergency cover for children and young people who need urgent care or mental health assessment. The setting up of specialist CAMHS response services that are available 24 hours a day, 7 days a week was slow at first but good progress can be reported in 2006.

- Overall 82% (94) of the 114 NHS provider trusts that reported having CAMHS provision recorded an on-call service with a response by CAMHS professionals (Fig. 11.18), 54% (61) of these services were exclusively CAMHS. This was a marked improvement on the 64% of services that provided specialist on-call in 2005.
- Only one NHS trust provided an on-call service that did not have a specialist CAMHS response.
- Next working day appointments with CAMHS professionals were available in 91% (104) of services. The greatly increased availability of this since 2005 indicated in mapping was due in part to a change in data collection. In 2005, only those services that did not provide 24 hour on-call reported on the availability of next working day appointments. In 2006, all services were asked to indicate this availability.
- Only 8 CAMHS reported neither an on-call service or emergency next day response service. These tended to be small providers of CAMHS or specialist tier 4 services which would not be expected to provide the local emergency services in their area.

Fig. 11.18: Growth of CAMHS on-call and emergency response services 2003 to 2006
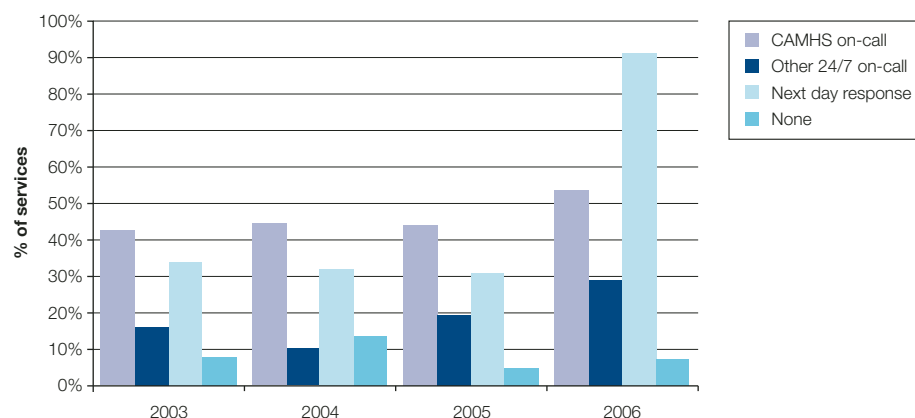
11.24 Enquiries about which teams provided the on-call response showed that a total of 448 (49%[i]) CAMHS teams contributed. Of the teams contributing to an on-call response, 290 (65%) were generic multi-disciplinary teams, 72 (16%) were tier 4 teams and 82 (18%) were targeted teams (Fig. 11.19). It was interesting to note that over 60% of all tier 4 and generic teams contributed to an on-call service.

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[i] *Not asked of dedicated workers in non-CAMHS teams (N=144)*

Fig. 11.19: Teams contributing to an on-call response (N=448)

Legend:
- Generic (multi) teams
- Generic (single) teams
- Targeted teams
- Tier 4 teams
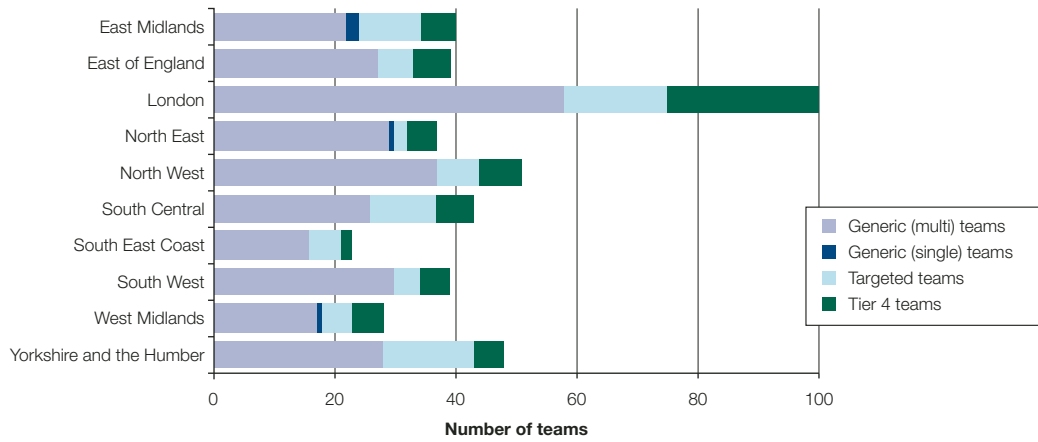
11.25 Local authorities were asked about the arrangements they had in place to ensure that 24 hour cover was available to meet urgent mental health needs of children and young people and for specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated. 85 (57%) local authorities were found to have fully implemented on-call services compared to 55 (37%) local authorities in 2005 (Fig. 11.20) (2% of local authorities gave no response). A further 59 (39%) local authorities had plans, protocols and partially implemented services. Just 1 local authority had plans and protocols, but no services in place. 2 local authorities (1%) were yet to address the need for 24/7 cover in their strategic plans.

Fig. 11.20: Development of 24/7 CAMHS response by local authority
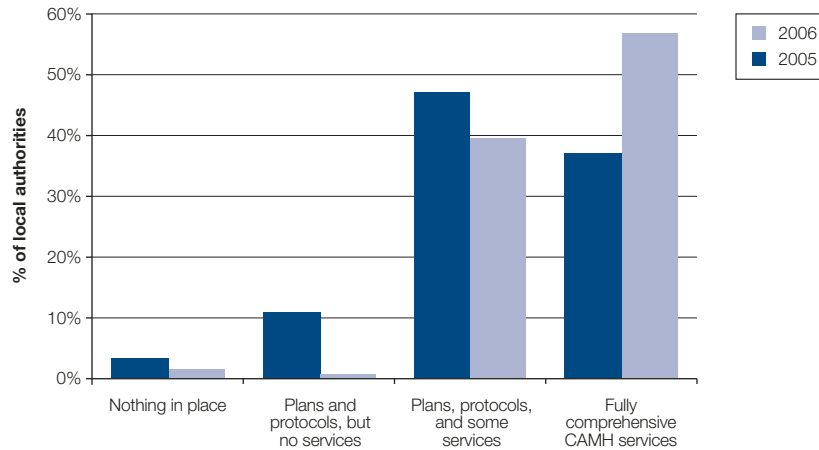
Services for people of sixteen and seventeen years of age

> **"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 2004*[16]

11.26 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.

11.27 Of the 114 CAMHS registered with the mapping exercise, 84 (74%) reported having specialist provision for 16 and 17 year olds, an increase from 2005 when only 66 (56%) services provided these services. The number of individual CAMHS teams that reported provision appropriate for the level of maturity of young people of this age also increased from 338 (32%) teams in 2005 to 553 (52%) teams in 2006 (Table 11.2). Similarly, the upper age of young people accepted by services is continuing to rise. The number of services that did not accept young people over 16 has fallen annually since 2004 and the number accepting young people of 18 and over has risen steadily (Table 11.2).

Table 11.2: Provision of age appropriate CAMHS teams for 16 and 17 year olds

|	2004	2005	2006
Number of CAMHS with provision for 16 and 17 year olds	Not asked	66	84
% of services with 16 and 17 year old provision	Not asked	56%	74%
Number of teams with 16 and 17 year old provision	Not asked	338	553
Team upper age limit 16 years	211	200	174
Team upper age limit 17 years	135	137	127
Team upper age limit 18 years +	542	618	665
Cases aged 16 to 25	12,913	17,577	17,578
Cases aged 16 to 25 as % of total caseload	14%	16%	16%

11.28 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. 61 (41%) local authorities had fully comprehensive CAMHS for 16 and 17 year olds across the whole council area, up from 25 (17%) in 2005. 81 (54%) local authorities, had plans, protocols and some services and 8 (5%) had plans and protocols but no services, a drop from 27 (18%) in 2005 (Fig. 11.21). There were no local authorities with nothing in place.

Fig. 11.21: Local authority development of CAMHS appropriate for 16 and 17 year olds
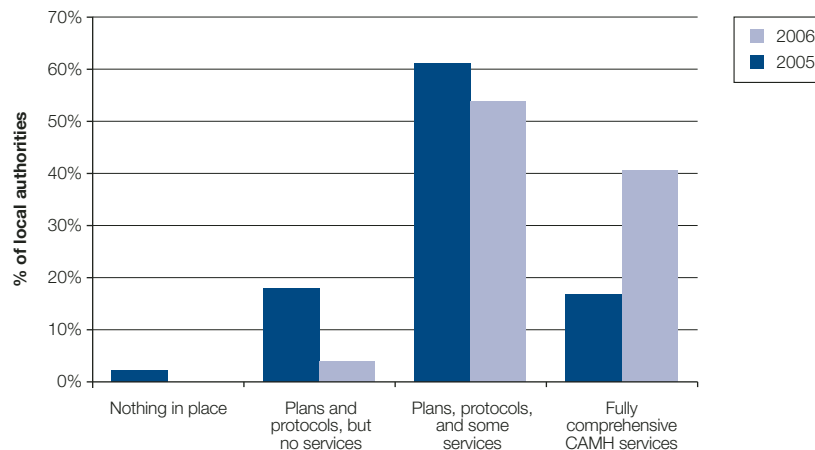

11.29 Of the 553 teams providing specialist services for 16/17 year olds, 260 (47%) were multi-disciplinary generic teams, 26 (5%) were single discipline generic teams, 140 (25%) were targeted teams, 67 (12%) were dedicated worker teams, and 60 (11%) were tier 4 teams (Fig. 11.22).

Fig. 11.22: Teams appropriate for 16 and 17 year olds (N=553)
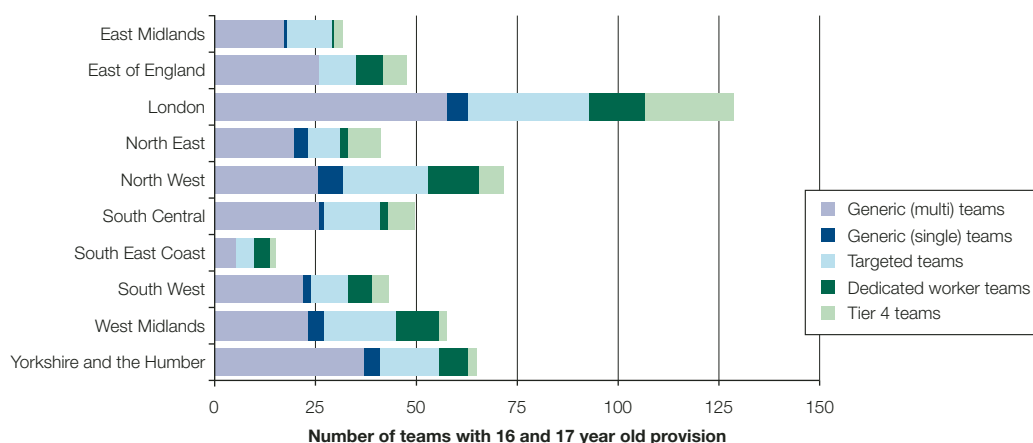
11.30 CAMHS caseload information was collected in the age band 16 to 18 year. In 2006, there were 16,587 young people aged between 16 and 18 using CAMHS services in the survey period, 15% of the total caseload. This was an increase of 7% on the previous year when 15,537 had been in this age band (Fig. 11.23). In 2006, 14,648 (14%) of the tier 2/3 team caseload was aged 16 to 18 and 1,939 (40%) of the tier 4 unit caseloads.

Fig. 11.23: Trends in caseload of 16 to 18 year olds
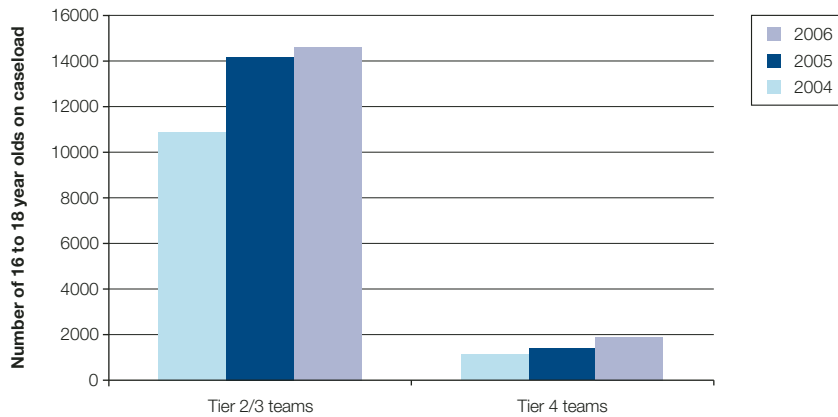
Learning disability provision

> **"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 2004*[17]

11.32   The NSF stresses the importance of equity of access to CAMHS for children and young people with both mental health needs and learning disabilities. Adequate 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 inpatient, day-patient and outreach units.

11.33   Growth in specialist mental health services for children and young people with learning disabilities has continued since 2003 (Fig. 11.24). The number of services increased from 48 in 2003, to 62 in 2004 and 68 in 2005 and 85 in 2006, an overall increase of 77% in 3 years. However, care should be taken in interpreting this data as small service providers may have no specific learning disability provision because a service is being provided by a neighbouring trust through partnership arrangements.

Fig. 11.24: Trends in the development of CAMHS for children and young people with learning disabilities
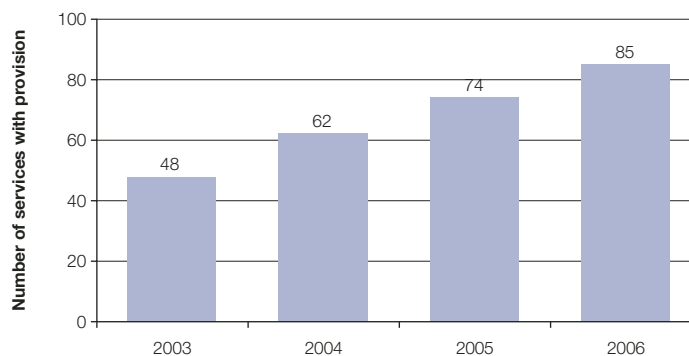
11.34 Considerable progress was reported by local authorities in the development of provision for children with learning disabilities and mental health needs (Fig. 11.25). 38 local authorities (25%) were able to report provision of a fully comprehensive CAMHS for children with learning disabilities that was available in the whole council area, compared to just 4 local authorities in 2005. A further 101 local authorities (67%) had plans and protocols and some services in place, but services still needed to be developed to cover the whole council area. 9 local authorities (6%) had plans and protocols in place, but were yet to develop services and no local authorities had to report that nothing was yet in place.

Fig. 11.25: Local authority arrangements for and provision of CAMHS learning disability services
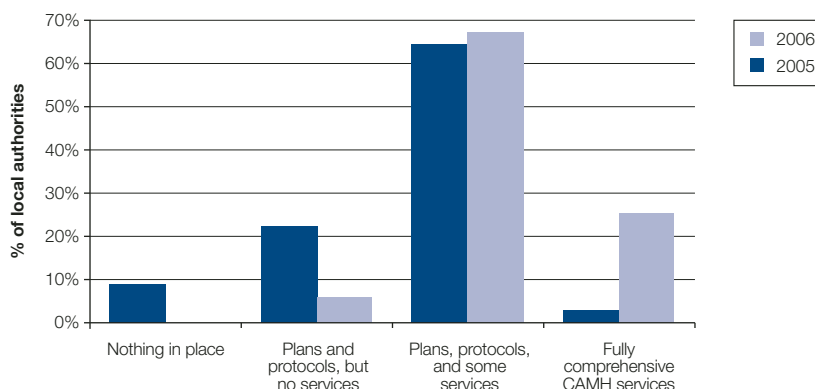

11.35 To find out where this specialist support was provided, every team was asked to indicate if they offered a specialist service for children and adolescents with mental health problems who also have a learning disability. Overall, 590 (55%) teams reported provision, up from 346 (33%) teams in 2005.

11.36 An examination of team caseload revealed that the majority of children with learning disabilities were supported by generic teams and a very small number of tier 4 team caseloads reported having a learning disability (Fig. 11.26):
- 5,266 cases in generic multi-disciplinary teams (57% of learning disability cases)
- 699 cases in single professional generic teams (8% of learning disability cases)
- 2471 cases in targeted teams (27% of learning disability cases)
- 406 cases in dedicated worker teams (4% of learning disability cases)
- 417 cases in tier 4 teams (5% of learning disability cases).

Fig. 11.26: Learning disability cases by team type and SHA (N=9,259)
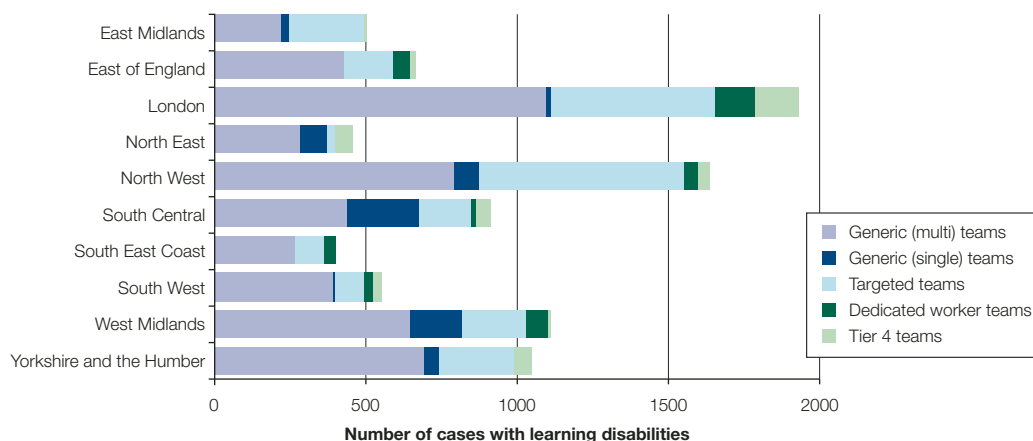
# Towards a comprehensive CAMHS: Services for target groups

Looked after children

"Looked after children are five times more likely than their peers to have a mental health disorder."

NSF for Children, Young People and Maternity Services 2004[18]

11.37 There were 9,454 cases (9% of the total 2006 CAMHS caseload) identified as looked after children (LAC) in the mapping, a drop of 3% from the 9,745 in 2005. The number of targeted and dedicated worker teams that had a LAC or social services focus has risen steadily (Fig. 11.27).

Fig. 11.27: Trends in the development of targeted and dedicated worker teams focusing on looked after children
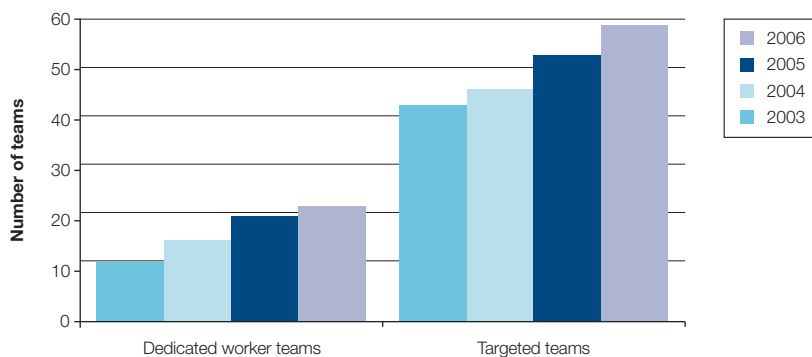
11.38 53% of looked after children (4,968) received care from multi-professional generic teams, 31% (2,954) from targeted teams, 8% (716) from dedicated worker teams, 6% (579) from tier 4 teams and 3% (237) from generic single discipline teams. However, this varied across SHA area (Fig. 11.28).

Fig. 11.28: Looked after children on the caseload by team type and SHA (N=9,454)
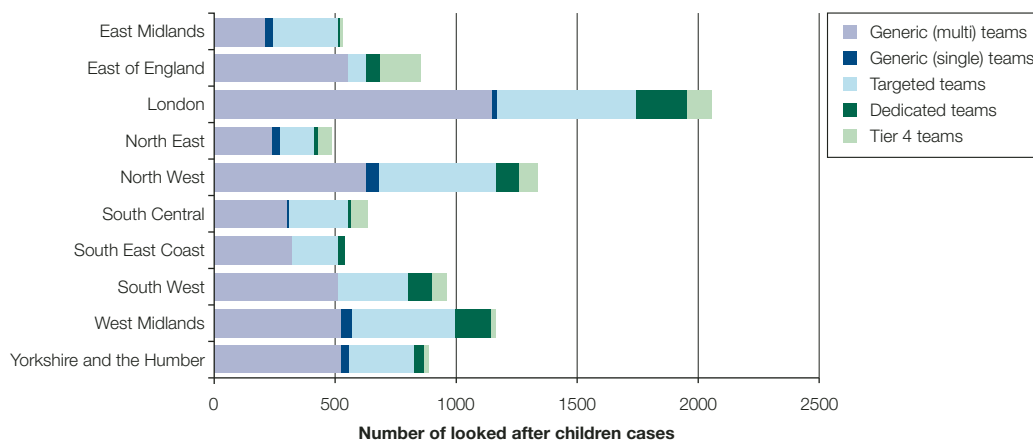
Services for young offenders

11.39 Overall there were 59 teams specifically targeting support for youth offenders (Fig. 11.29), a decrease of one on the previous year. These included 24 targeted teams and 35 dedicated CAMHS workers working in non-CAMHS teams. This reversed the trend observed the previous year. There were a total of 6,223 youth offenders receiving care from CAMHS in 2006, 6% of the total caseload. This is an increase of 578 cases on the 5,645 youth offenders in 2005 (5% of the 2005 caseload). Fig. 11.30 highlights variations across the country in the types of team that have young offenders on their caseload. The proportion of young offenders within the total CAMHS caseload varied between 4% to 8% across the SHAs.

Fig. 11.29: Trends in the development of targeted and dedicated worker teams focusing on young offenders
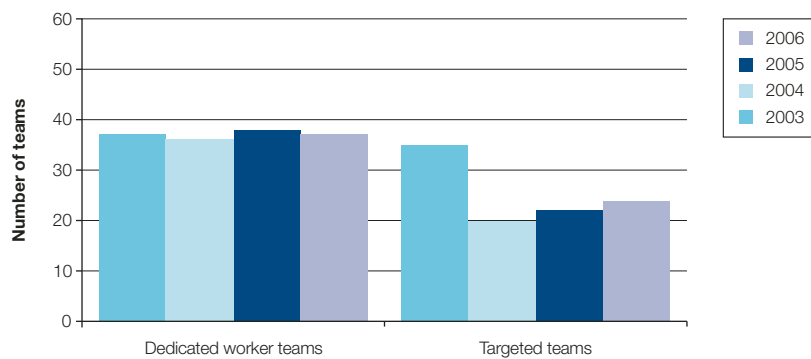
Fig. 11.30: Young offenders by team type and SHA (N=6,223)
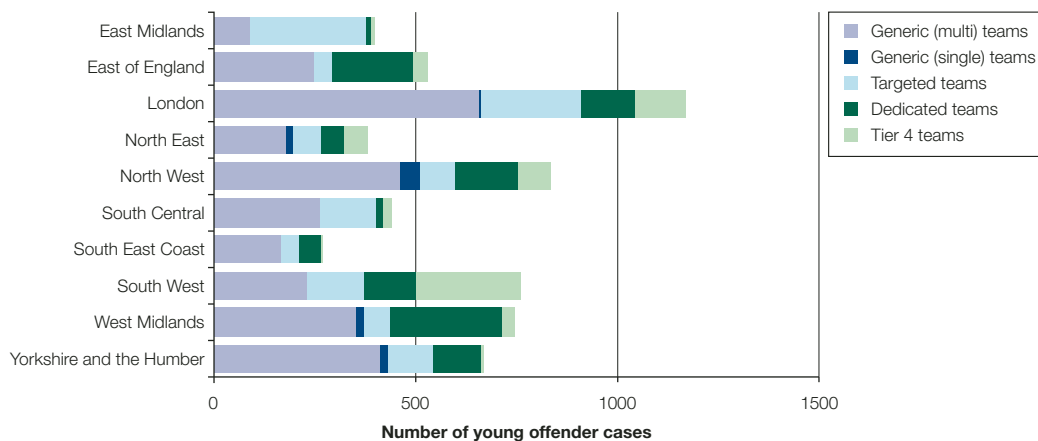
ADHD provision

11.40 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 76 (14%) of the 466 community paediatric services and the time spent on ADHD tended to be small. In community paediatric services where ADHD clinics were provided, no staff were spending more than 75% of their time delivering these services, in 3% of services the time spent was between 50% and 75%, in 22% of services the time spent was between 25% and 50% and in 74% of services less than 25% staff time was dedicated to ADHD. A total of 14,311 tier 2 to 4 CAMHS cases in the sample period were reported with hyperkinetic disorders, including ADHD (13% of the caseload).

Autistic spectrum disorder provision

11.41 Community paediatric services were also asked about time spent running autistic spectrum disorder (ASD) clinics. Overall, 67 (14%) community paediatric services ran ASD clinics. Only 2% of services providing an ASD service had more than 50% of staff time dedicated to it. In 18% of services between 25% and 50% of time was given to this specialty and in 79% of services running clinics the time dedicated to them was less than 25% of total staff time.

CAMHS tier 1 provision

11.42 In child health mapping, 58 tier 1 CAMHS were mapped with a workforce of 196 wte, giving an average team size of 3.4 wte. The number of services mapped in 2006 was slightly down on the number mapped in 2005, but it was clear from the number of services that identified mental health and emotional wellbeing as a focus of their work that tier 1 CAMHS is delivered through numerous universal and targeted services. Overall, mental health was identified as a focus of work by 80% of school health services, 72% of early years and health visiting services, 66% of services for children in special circumstances and 46% of disability services (Fig. 11.31).

Fig. 11.31: Focus on mental health in universal and targeted teams

% of services indicating mental health focus
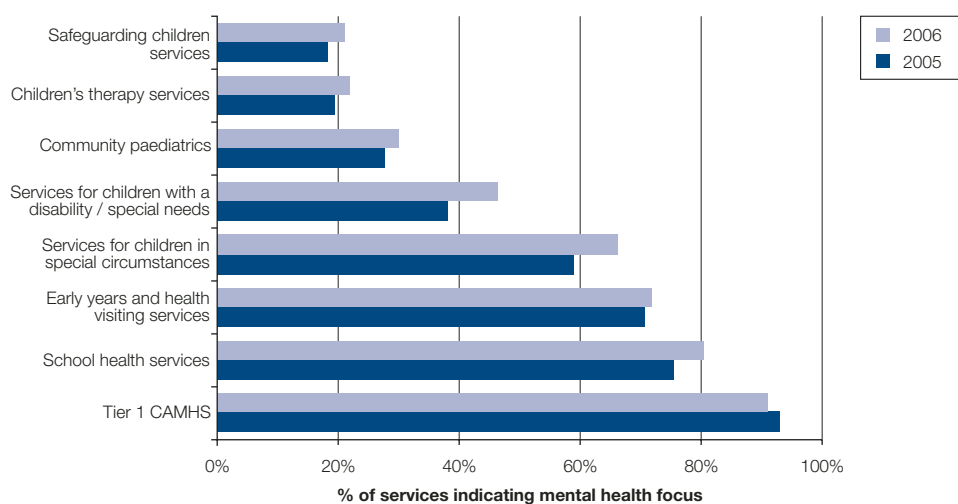
Towards a comprehensive CAMHS: Functions, interventions and training

Introduction

11.43 The team classification used in CAMHS mapping was designed to give a broad description of the types of teams provided and, over the 5 years of the mapping data collection, changes in team configurations have been reported and tracked. However, the classification does not describe the work that teams undertake. Therefore, in 2006/7 a new level of detail was added to give an indication of some of the functions, such as, assessments and interventions that teams provide. These questions were added at the request of local service planners and commissioners who were seeking to identify where particular features of services were provided and where there were gaps. Although designed for local use, the information also provides an interesting national picture of comprehensive service provision that is given below.

Assessment

11.44 It was found that 87% of CAMHS teams (920 teams) undertook assessments at least once a week. This included 94% of generic multidisciplinary teams, 89% of tier 4 and single discipline generic teams, 80% of targeted teams and 78% of dedicated worker teams.

11.45 Eight types of assessment were investigated. Overall, 89% of CAMHS teams provided general initial assessments but 11% of teams only provided initial assessments occasionally while 78% of teams provided them on a regular basis (Fig. 11.32). These assessments were provided by 91% of multidisciplinary generic teams, 82% of single discipline generic teams and 71% of tier 4 teams (Fig. 11.33). 75% of teams undertook psychological assessments, 15% occasionally and 60% at least weekly. Psychiatric assessments were provided in 61% of teams overall with 49% of teams providing them at least weekly and 11% of teams carrying them out less frequently. These were provided by over 70% of multidisciplinary generic and tier 4 teams. Similarly, high risk assessments were mainly provided by multidisciplinary generic and tier 4 teams (65%) reflecting the multi-disciplinary nature of these teams.

Fig. 11.32: Percentage of CAMHS teams providing assessment functions
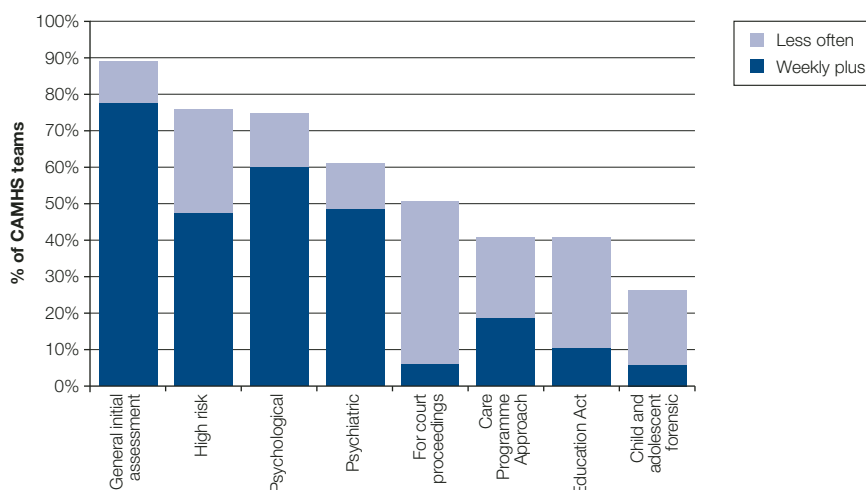
11.46 CPA assessments were provided by 41% of teams overall but regularly by only 19% of teams. CPA assessments were carried out at least weekly in 42% of tier 4 teams but over half of the teams carrying out CPA assessments on a regular basis were generic multidisciplinary teams. Education Act assessments were also provided by 41% of teams overall but only 11% of teams provided them at least weekly. Forensic assessments and assessments for courts were provided by all types of CAMHS teams and were linked to youth offending roles.

**Fig. 11.33: Provision of assessment at least once a week by team type**
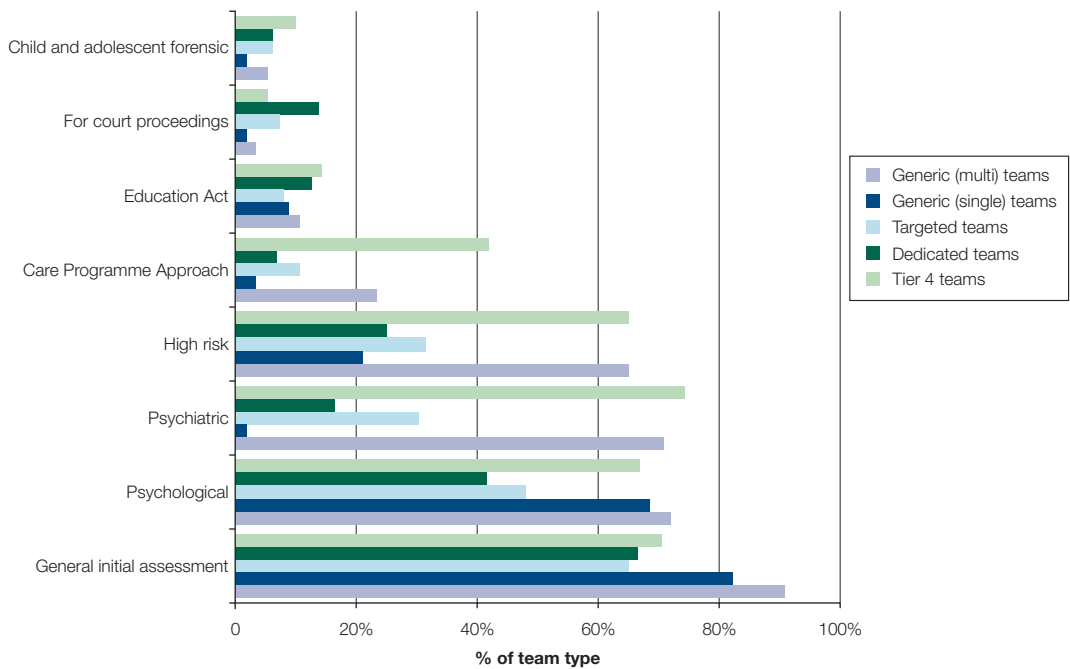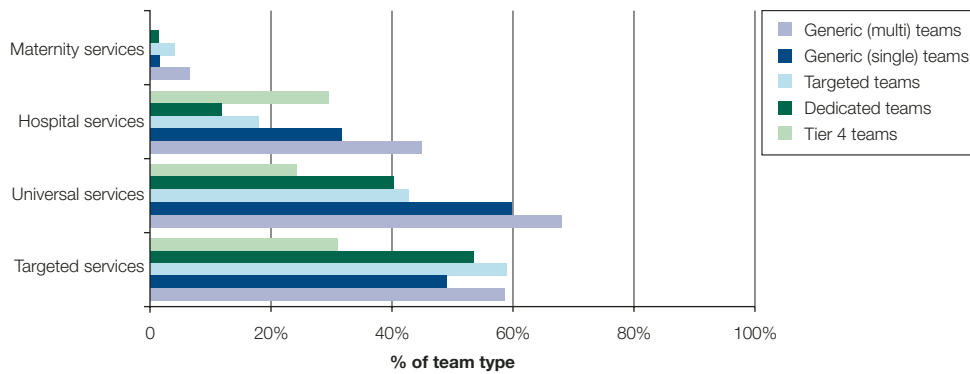

Consultation and liaison

11.47 CAMHS teams were asked whether they provided consultation and liaison with a range of children's health, education and other children's services. Over 70% of CAMHS teams reported consulting and liaising with children's health services at least occasionally and over 50% of teams liaised with universal and targeted child health services at least once a week (Fig. 11.34). These targeted services included community paediatric services, children's therapy services, tier 1 CAMHS teams and specialist services for children with disabilities, special needs, or in special circumstances (such as looked after children). Universal services included school health services and early years and health visiting services. Targeted CAMHS teams were most likely to liaise with targeted child health teams. Generic teams were most likely to liaise with universal services (Fig. 11.35).

11.48 There were fewer regular links reported between CAMHS teams and children's hospital services with only 31% of CAMHS teams recording weekly or more frequent consultation and liaison with them. Just 4% of CAMHS teams liaised weekly or more with maternity services, reflecting the limited role of CAMHS in working with the under five year olds. In total 6% of the CAMHS caseload was aged under 5.

Fig. 11.34: Percentage of CAMHS teams providing consultation and liaison with child health and maternity services
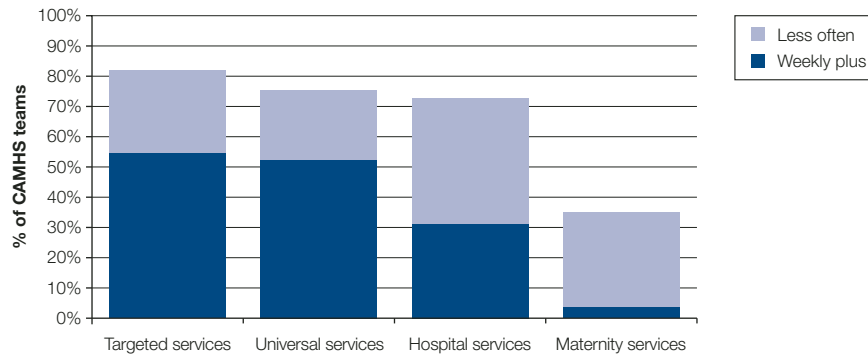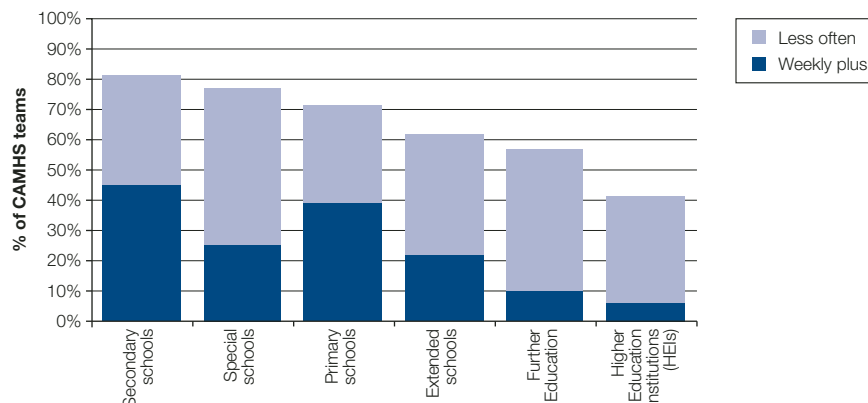

Fig. 11.35: Provision of consultation and liaison with child health and maternity services at least once a week by team type


11.49 Regular consultation and liaison with schools was reported by fewer CAMHS teams although occasional consultation and liaison with all types of educational establishments was common (Fig. 11.36). 45% of teams liaised with secondary schools at least once a week, 39% with primary schools, 25% with special schools and 22% with extended schools. Over 50% of multidisciplinary generic teams liaised with primary and secondary schools (Fig. 11.37) but only 26% liaised with special schools and 31% with extended schools. A much smaller proportion of CAMHS teams liaised with further and higher education reflecting the upper age limit of 18 for many CAMHS teams.

Fig. 11.36: Percentage of CAMHS teams providing consultation and liaison with education estabishments

Fig. 11.37: Provision of consultation and liaison with education at least once a week by team type
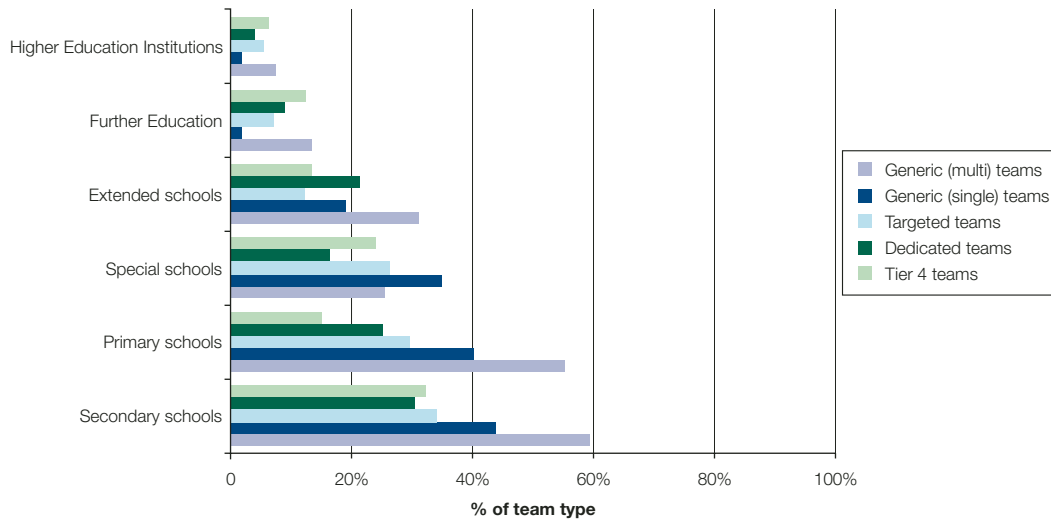
11.50 The pattern of liaison and consultation with other children's services showed high levels of contact on an occasional basis but only 20-30% of CAMHS teams reported contact as frequent as once a week or more (Fig. 11.38).

Fig. 11.38: Percentage of CAMHS teams providing consultation and liaison with other children's services
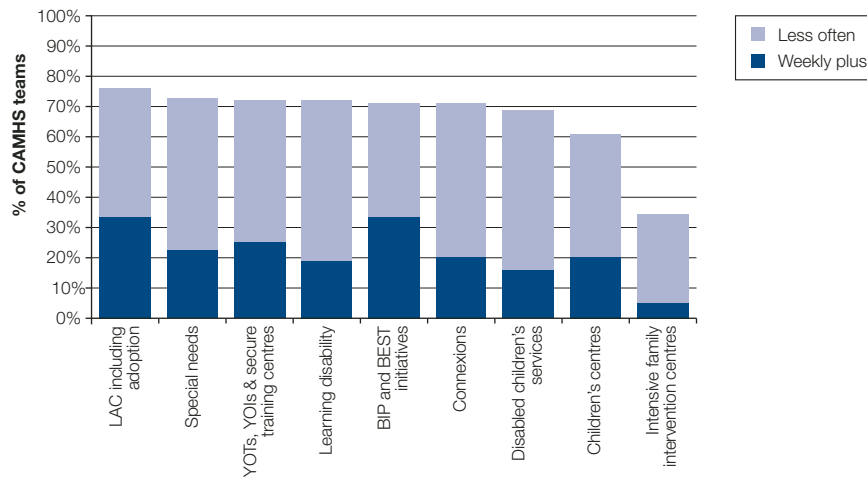

Interventions

11.51 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 on a regular basis behaviour management, individual psychological therapy, systemic approaches, CBT and counselling (Fig. 11.39). 94% of teams provided advice and information, 90% of them providing this weekly or more often. Just over half of teams (52%) provided management of mental health crisis regularly and 16% occasionally. Play, art, drama and music therapy were the least likely to be provided.

Fig. 11.39: Percentage of CAMHS teams providing a range of specific interventions
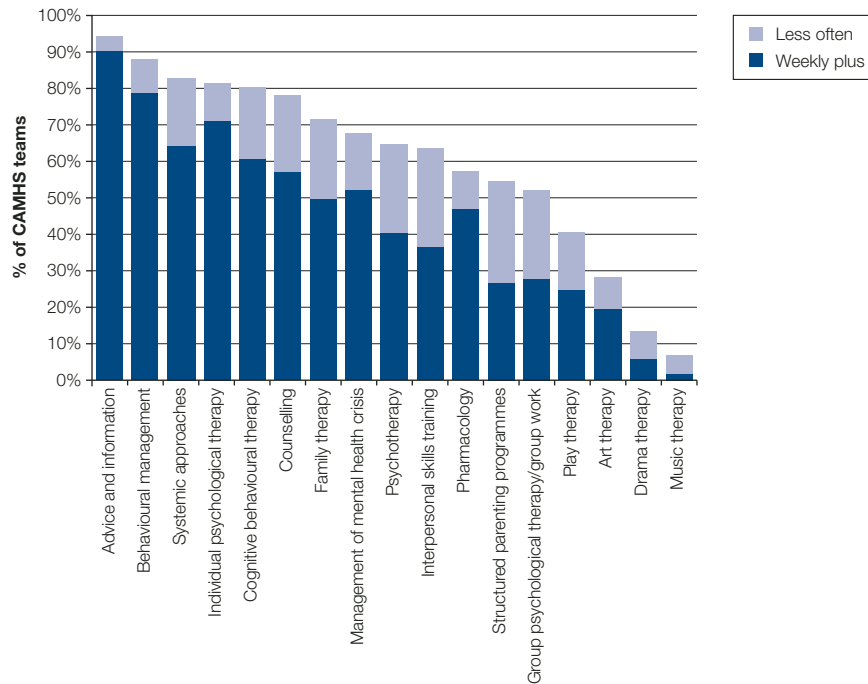
Training

11.52 CAMHS teams are encouraged to contribute to training to increase understanding of CAMHS provision and to promote the emotional wellbeing of children and young people. It was found that over 60% of CAMHS teams provide training but this tended to be training in response to ad hoc requests (Fig. 11.40). 35% of teams had sessional input into child health service staff training, 23% to education service staff training and 24% to the training of staff in other children's services. 28% of teams had regular input into the training of child health service staff and 10% undertook certificated training. For the training of education service staff and the staff of other children's services, contributions to regular or certificated training programmes was much less common.

Fig. 11.40: Percentage of CAMHS teams providing training for child health, education and other services
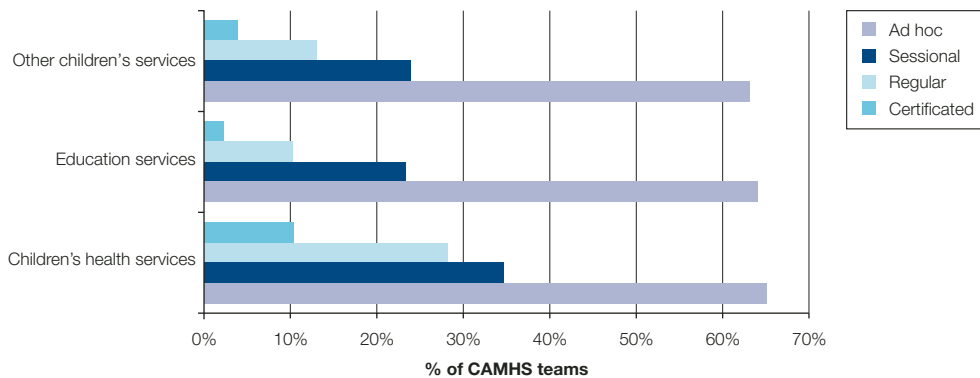
Towards a comprehensive CAMHS: Use of IT and outcomes measures

11.53 Steady growth in the use of IT by CAMHS staff has been recorded over the last 4 years (Fig. 11.41). In 2006, email and the internet were being used by 66% and 65% of staff respectively, up from 59% and 54% in 2003. A more significant increase was seen in the use of on-line activity statistics about CAMHS with 43% of staff having access to and using this data in 2006 and 17% using it in 2003. Usage of on-line clinical information, such as Cochran Reviews increased from 25% of staff using this source of information in 2003 to 35% using it in 2005. The principle users of it were single disciplinary generic teams whose staffing was dominated by psychologists (Fig. 11.42). The use of electronic clinical patient records had also increased sharply. These were used by only 4% of staff in 2003 and were being used by 27% of staff in 2006. Access and use of these records was best developed in tier 4 teams.

Fig. 11.41: Trends in the use of IT in CAMHS teams
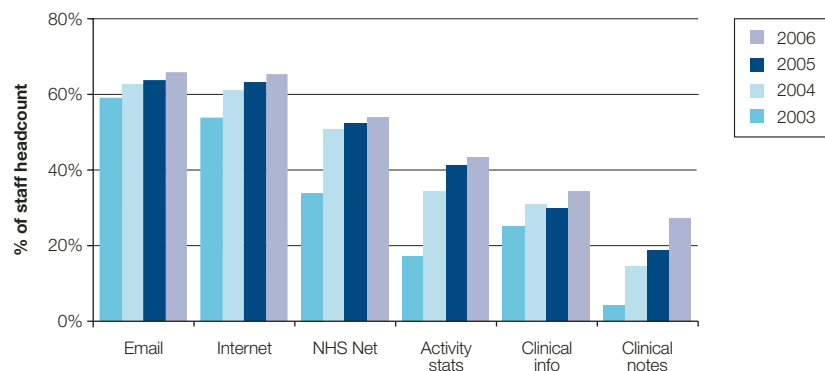
**Fig. 11.42: Use of IT by team type in 2006**
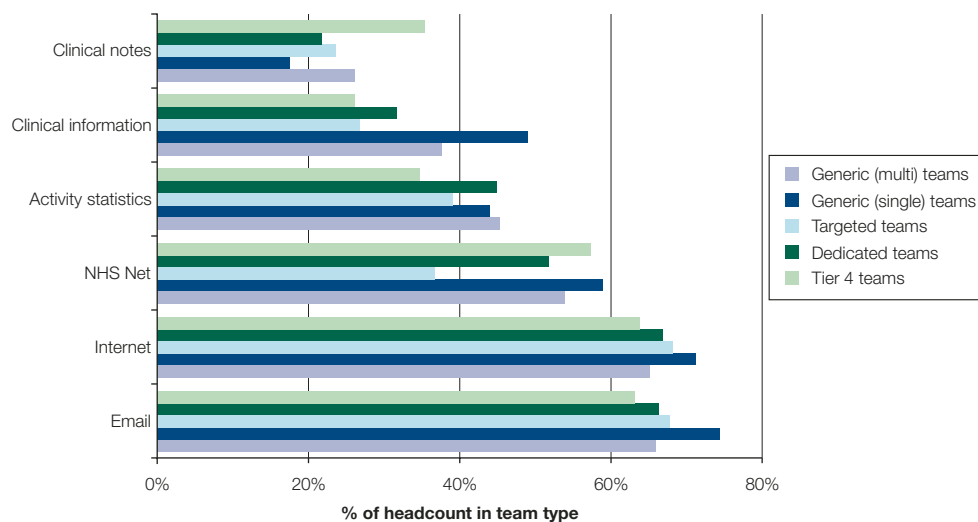
Use of outcome measures

11.54 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. For the first time in CAMHS mapping, in 2005, CAMHS teams were asked about their use of these outcome measures.

11.55 Overall 59% of teams reported the use of at least one standard outcome measure but rates of collection varied by team type. 73% of multi-disciplinary generic teams and 72% of tier 4 teams used measures. The least likely teams to do so were dedicated CAMHS workers working in non-CAMHS (Fig. 11.43).

Fig. 11.43: Use of at least one outcome measure by team type
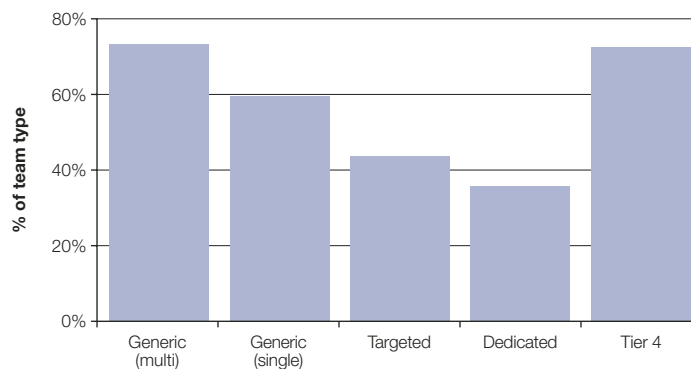
11.56 As different measures are used to collect different perspectives, teams tended to use a range of measures. Of the 623 services that reported collecting outcome data, 21% used one measure, 33% used 2, 16% used 3 and 10% used 4 (Fig. 11.44). 20% of services used 5 or 6 different measures on a routine basis; 15% using 5 and 5% using 6.

Fig. 11.44: Number of outcome measures used by CAMHS teams (N=623)
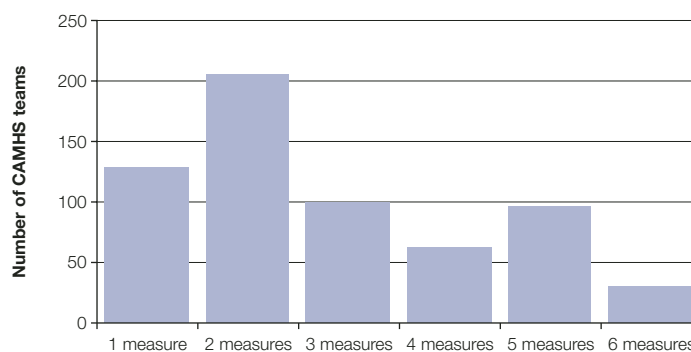
11.57 The most commonly used measures were SDQ for Parents and Children (Strengths and Difficulties Questionnaire) which are used to assess change in the strengths and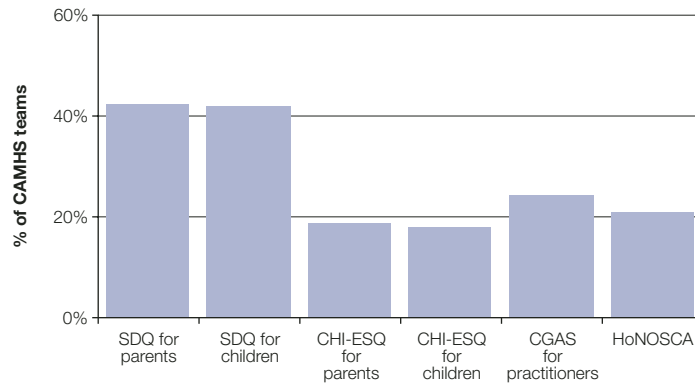 difficulties encountered by children. It is used with children aged 11 to 18 and with parents of children aged 3 to 16. Use of these measures were reported by 42% of teams overall and 57% of generic multidisciplinary teams (Fig. 11.45).

Fig. 11.45: Percentage of CAMHS teams using a range of outcome measures

11.58 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. Use with parents was reported by 19% of teams and use with children by 18% of teams. Again these measures were most commonly used by generic multidisciplinary teams (Fig. 11.46).

Fig. 11.46: Percentage of CAMHS teams using a range of outcome measures by team type
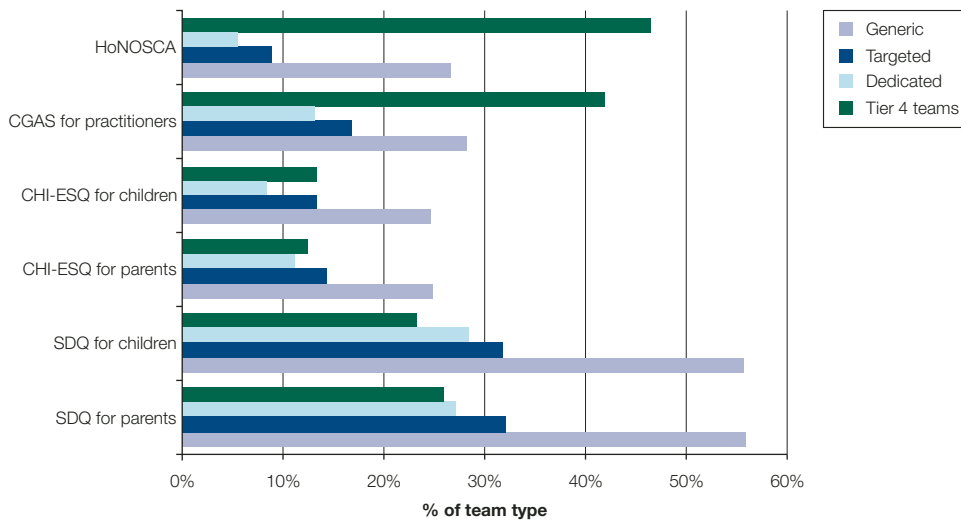
11.59 CGAS, the Children's Global Assessment Scale, is a measure completed by practitioners to capture change in difficulties. It can be used on children and young people of all ages and is a way of rating the extent of child and family difficulties at the start of contact and six months later in order to evaluate change. CGAS was used by 24% of CAMHS teams, including 42% of tier 4 teams. Use of the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was reported by 21% of CAMHS teams overall and 46% of tier 4 teams. Variable rates of use of outcome measures was found across the country (Table 11.3).

Table 11.3: Percentage of CAMHS teams using a range of outcome measures by SHA

Strategic Health Authority 2006	SDQ for Parents	SDQ for Children	CHI-ESQ for Parents	CHI-ESQ for Children	CGAS for practitioners	HoNOSCA	Total no. of teams
East Midlands	35%	31%	14%	13%	12%	35%	65
East of England	39%	53%	26%	26%	34%	13%	76
London	49%	45%	19%	18%	39%	19%	235
North East	35%	35%	25%	24%	22%	42%	72
North West	33%	33%	18%	15%	17%	27%	165
South Central	41%	39%	17%	17%	25%	22%	76
South East Coast	52%	50%	7%	7%	17%	7%	54
South West	44%	43%	13%	14%	18%	10%	105
West Midlands	42%	44%	13%	13%	7%	18%	103
Yorkshire and the Humber	46%	47%	31%	33%	33%	16%	107
Total	**42%**	**42%**	**19%**	**18%**	**24%**	**21%**	**1058**

Towards a comprehensive CAMHS: Caseload and case characteristics

Introduction

11.60 This section summarises information collected on caseload in CAMHS mapping. This includes data on caseload size, the length of time cases have waited to be seen and the length of treatment. Attention is also given to key characteristics of the children and young people making up the caseload. The caseload recorded was that of a sample period only. This was the calendar month of November 2006 for tier 2/3 teams and the 6-month period 1st June to 30th November 2006 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 2006.
Tier 4 teams: caseload data were collected for the six-month period June 1st to November 30th 2006.

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.

Changes to the data collection in 2006

11.61 Caseload is measured using the 'active' caseload for a sample period. An active case was a child or young person (and/or their family) who was seen by a member of staff of a CAMHS team for the purposes of assessment, treatment, monitoring, support or advice/health promotion.

11.62 CAMHS professionals may also be consulted about children and young people outside of their service. An important role for tier 2 to 4 CAMHS teams is to provide specialist advice for staff working within other CAMHS or in less specialised services. **In 2006, consultations were recorded separately from the active team caseload for the first time.**

11.63 This change had a number of important consequences:
- 2006 caseload data is not comparable to data on 2005 caseloads
- Many more consultations have been reported in 2006, but there appear to be significant differences in the ways that organisations have interpreted a consultation
- 2005 data should have included consultations – this was clarified in guidance and had been the advice of the Helpdesk. However, analysis of the 2006 data revealed:
  - Not all organisations reported consultation in 2005
  - Of those that did, the number of consultations within combined 2005 caseload data tended to be lower than the separately reported caseload figures in 2006.

11.64 It should also be noted that team caseload and consultations are simply a headcount of children and young people who received support, treatment and care from specialist CAMHS professionals or were the subject of specialist advice. They do not reflect either the number of staff who had been involved in the case/intervention, or the intensity of the care provided.

National summary and trends

11.65 In tiers 2 to 4 CAMHS, a total of 108,618 active cases and 60,411 consultations were reported in 2006, giving an inclusive caseload figure of 169,029 children and young people. The total number of cases in tier 2/3 teams was 102,966, whereas the total tier 4 caseload was 5,652.

11.66 Although comparisons with previous years' findings should be treated with care it is interesting to note that the total caseload (including consultations) in 2005 was 112,984. Looking further back, the magnitude in the improvement in the accessibility and capacity of CAMHS becomes apparent. There were 86,521 cases reported in 2003 and 104,744 on 2004, giving a cumulative total increase of 31% between 2003 and 2005.

11.67 The rate of tier 2/3 cases per 100k population age 0-17 receiving care nationally was 932. This varied substantially between SHAs ranging from under 712 to 1,303 (Fig. 11.47).

11.68 The tier 4 caseload is not included in this calculation as only a small number of cases were reported, the sample period for tier 4 is a six month period and the caseload is often drawn from across SHA boundaries.

Fig. 11.47: CAMHS tier 2/3 caseload by 100k population aged 0 - 17 by SHA
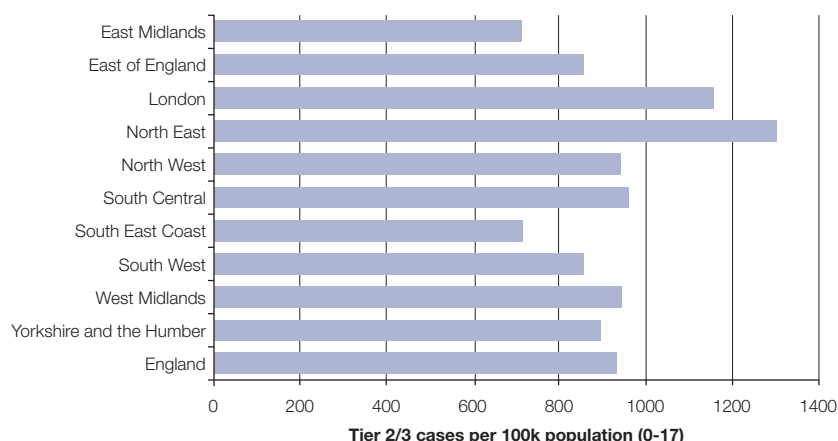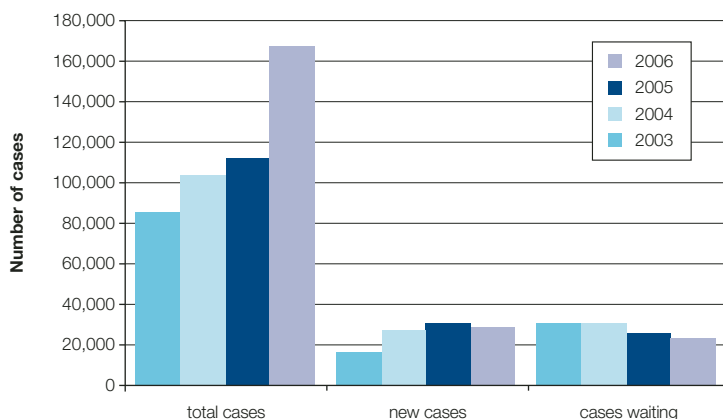
New cases seen

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 or cancellations, the wait is recorded from the most recent DNA or cancellation.

11.69 In total there were 29,078 new cases in tiers 2 to 4 CAMHS reported in the 2006 exercise, a decline of 7% on the 31,279 new cases reported in 2005. The overall change between 2003 and 2006 was 78% growth. The decline in 2006 could be explained by the changes made to data capture with the consultations being excluded from the new case count.

11.70 Figures 11.48 and 11.49 illustrate the trends in cases seen, new cases and cases waiting and highlight the difference when consultations are and are not included in the 2006 cases seen total. The number of cases waiting to be seen by CAMHS at the end of the sample period has fallen since 2004 and a decrease of 10% was observed in 2006 giving 23,680 cases waiting to be seen by a CAMHS team at the end of November that year.
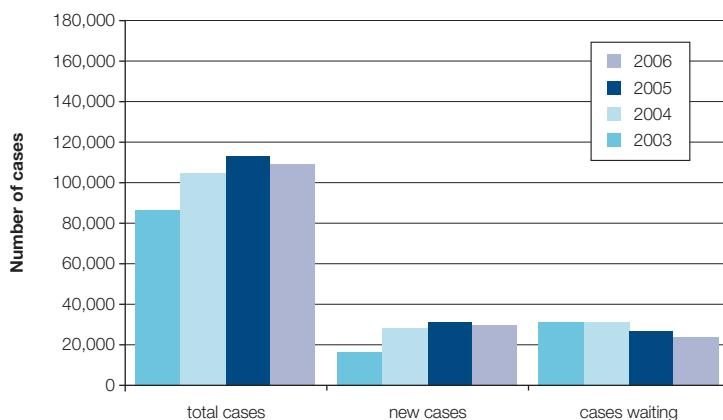
Fig. 11.48: Trends in cases seen, new cases and cases waiting

Note:
This shows total cases seen in the survey period inclusive of consultations in 2006 when 108,618 active cases and 60,411 consultations were reported.

Fig. 11.49: Trends in cases seen, new cases and cases waiting


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

11.71 Taken as a proportion of total recorded caseload, cases identified as being 'new' increased from 19% in 2003, to 27% in 2004, 28% in 2005 and fell slightly to 27% in 2006. There were 25,857 (89%) new cases in tier 2/3 teams, and 3,221 (11%) new cases in tier 4 over the sample periods.

11.72 The majority of new cases were reported as having waited less than 4 weeks to be seen by a CAMHS team. 51% of new cases waited for less than 4 weeks in 2006 compared to 52% in 2005. 36% of new cases waited for 5 to 13 weeks in 2006 compared to 32% in 2005. A total of 9% of new cases had a 14 to 26 week wait in 2006 compared to 15% in 2005. Waits over 6 months remained at 5% in both years (Fig. 11.50).

Fig. 11.50: Trends in percentage of new cases seen and the length of wait
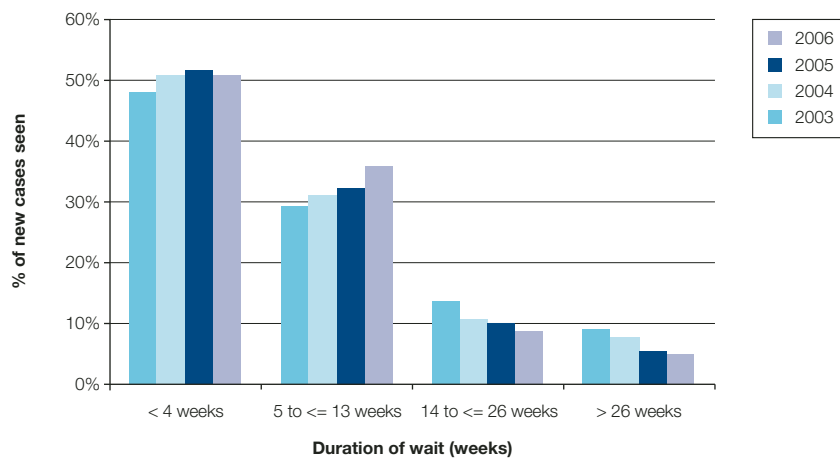

11.73 The length of wait for new cases was remarkably uniform across SHAs for tier 2/3 cases (Fig. 11.51).

Fig. 11.51: Length of wait for new cases accessing tier 2/3 tiers
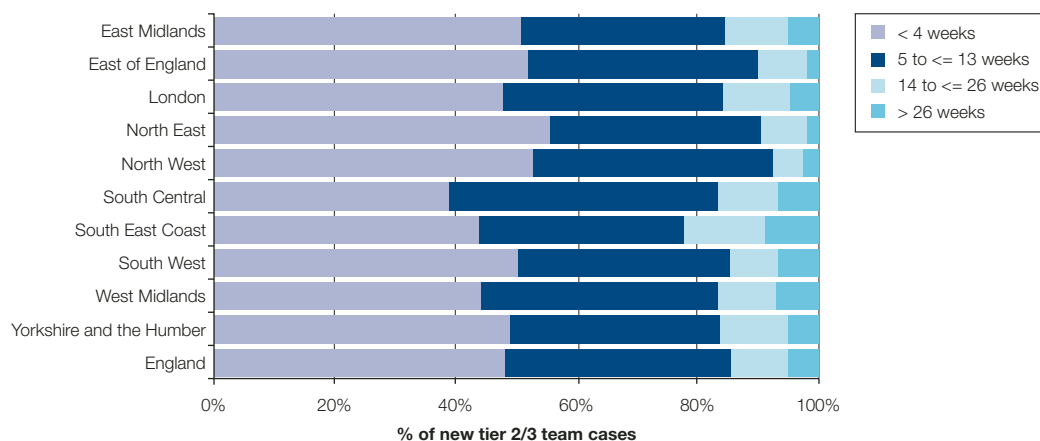
11.74 There was greater fluctuation across SHAs for the smaller number of tier 4 cases (Fig. 11.52). The percentage of cases waiting 4 weeks or less ranged from 52% of cases to 93% and the proportion waiting over 26 weeks ranged from no cases to 6%. Services in some SHAs were able to respond to demand for tier 4 care quickly and lengthy waits of over 6 months were very rare, continuing a trend observed in both the 2004 and 2005 CAMHS reports.

**Fig. 11.52: Length of wait for new cases to tier 4 teams**

% of new tier 4 unit cases
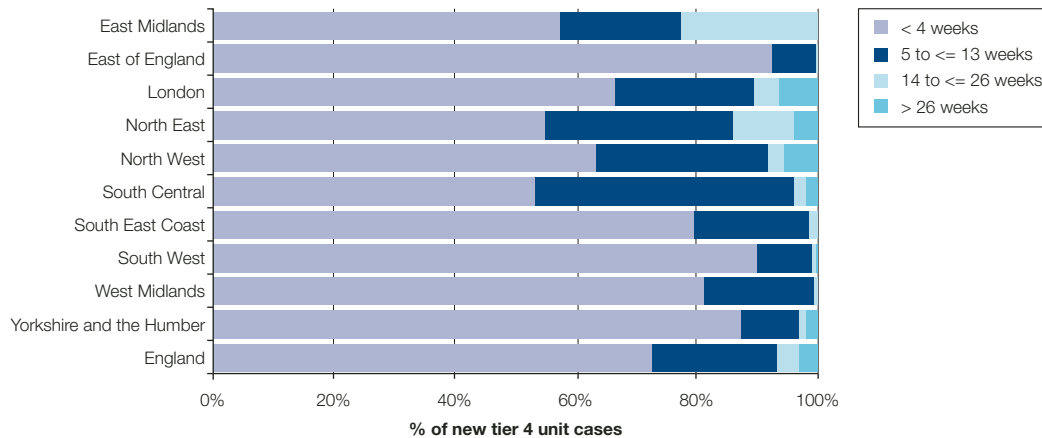
Cases waiting and length of wait

11.75 Tiers 2 to 4 CAMHS teams reported 23,680 cases waiting to be seen at the end of the data collection period in 2006. This marked a continued fall in the number of cases waiting from 26,199 in 2005, 30,716 in 2004 and 28,880 in 2003. As a proportion of active caseloads this was 22% in 2006, 23% in 2005, 29% in 2004, and 33% in 2003.

11.76 The number of children and young people who had waited to be seen for up to 4 weeks was 9,465 in 2006, an increase from 9,050 in 2005. Those waiting 5 to 13 weeks rose from 8,478 in 2005 to 8,569 in 2006. The number of children waiting between 14 and 26 weeks went down from 4,641 in 2005 to 3,232 in 2006. The numbers waiting over 6 months was 4,030 in 2005 and 2,429 in 2006. This shows that the long waits to be seen have reduced significantly (Fig. 11.53).

Fig. 11.53: Trend in cases waiting for tier 2 to 4 teams: proportion of total caseload
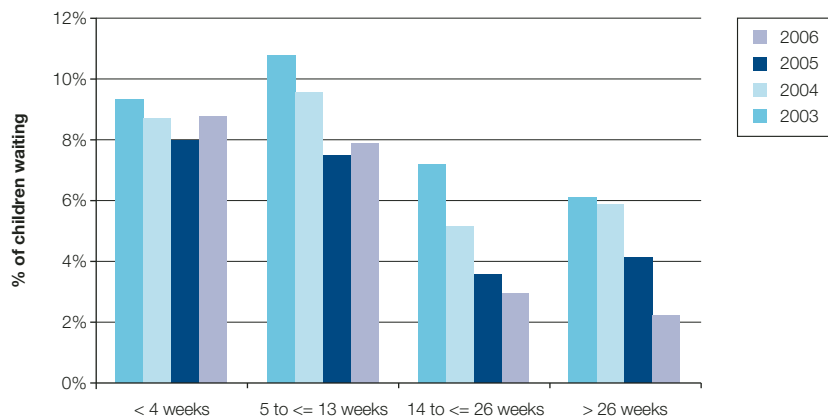
11.77 The pattern of waits for tier 2/3 and tier 4 teams was found to be very different (Fig. 11.54 and 55).

Fig. 11.54: Trend in cases waiting for tier 2/3 teams
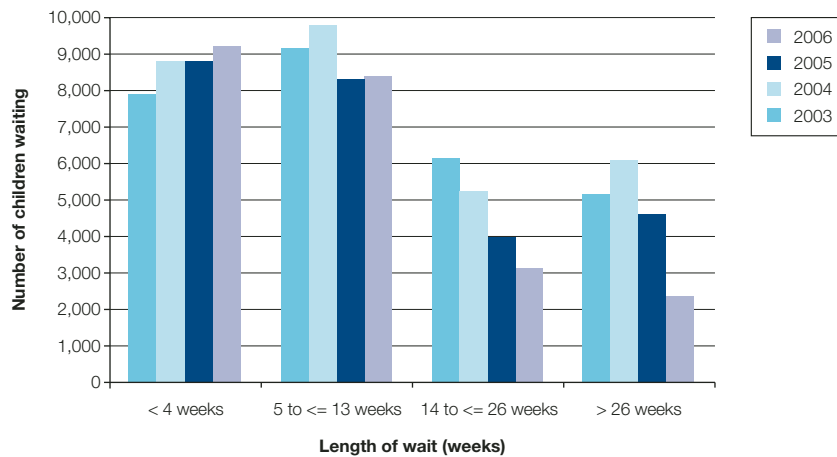
Fig. 11.55: Trend in cases waiting for tier 4 teams
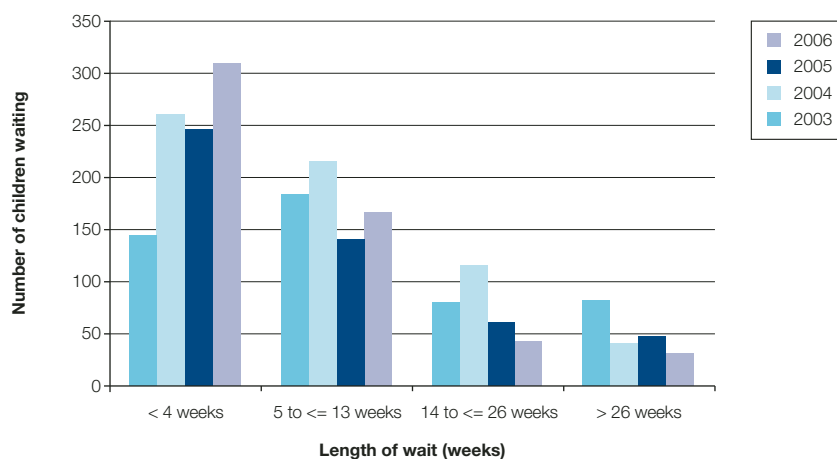

11.78 The total number of cases waiting for tier 2/3 teams was 23,130 in 2006 (22% of the active caseload). Of the caseload waiting, 9,156 (40%) had waited up to 4 weeks, 8,388 (36%) had waited from 5 to 13 weeks, 3,189 (15%) between 14 and 26 weeks and 2,399 (10%) over 26 weeks. All SHAs had cases that had waited for 26 weeks or more (Fig. 11.56).

11.79 Only 550 cases were waiting for tier 4 teams at the end of the study period emphasising the very specialist nature of these teams and the small number of referrals made to them. Predominantly waits were under 3 months with 309 (56%) under 4 weeks and 166 (30%) 5-13 weeks. Only 32 (6%) of cases had waited over 26 weeks (Fig. 11.57).

Fig. 11.56: Length of wait for cases waiting for tier 2/3 teams
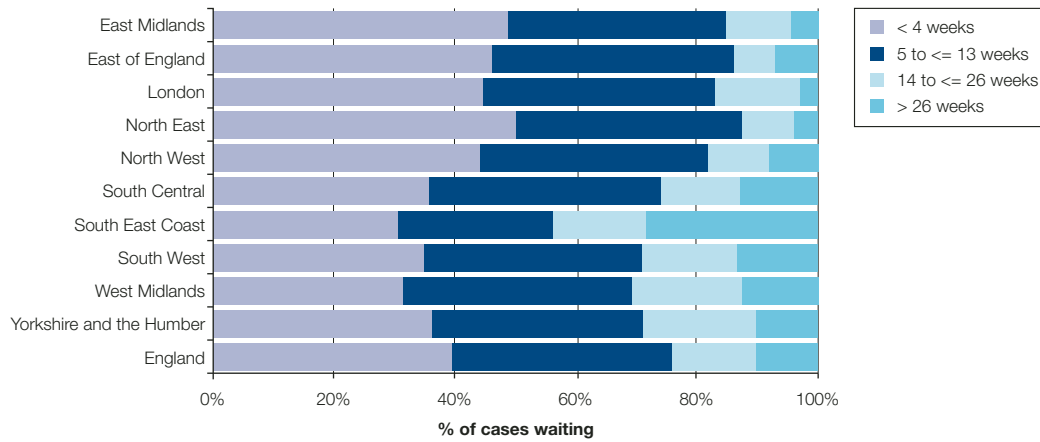
Fig. 11.57: Length of wait for cases waiting for tier 4 teams
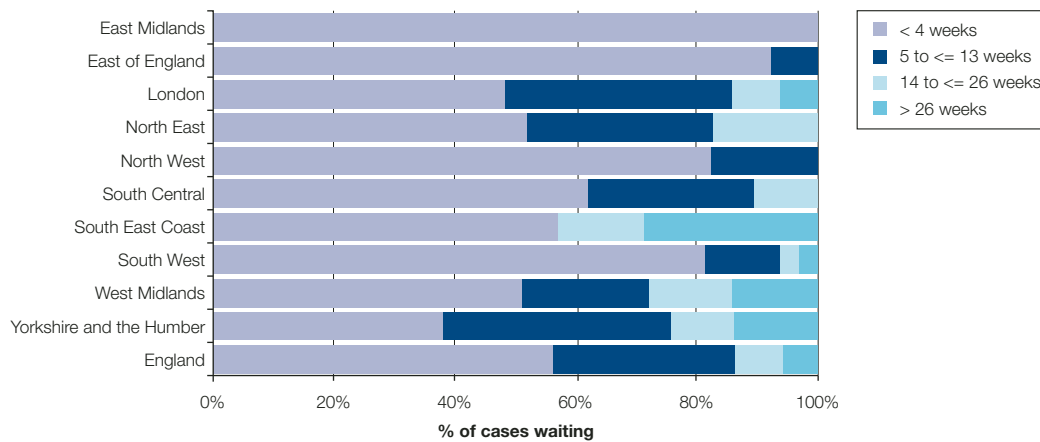
Length of treatment

11.80 Duration of treatment measures how long a case had been seen for, or, if the case was closed in the sample period, how long that case had been active, therefore examining a mix of open and closed cases. This was reported from the date the case was first worked with up until 30th November 2006, or until the case was closed. Information on the length of treatment was reported for 107,233 cases overall, 98.7% of the reported active total caseload.

11.81 Between 2005 and 2006 there were no major changes in the length of treatment received from tier 2/3 teams. The proportion of cases seen for 4 weeks or less and for 5 to 13 weeks has fluctuated between 20 and 23% since 2004. The proportion of cases receiving treatment for 3 to 6 months had fluctuated around 18%. Treatment over 6 months has increased. This was being received by 39% of 2006 cases compared to 33% in 2003 but was at the same level as reported in 2004 (Fig. 11.58).

Fig. 11.58: Length of treatment in tier 2/3 teams
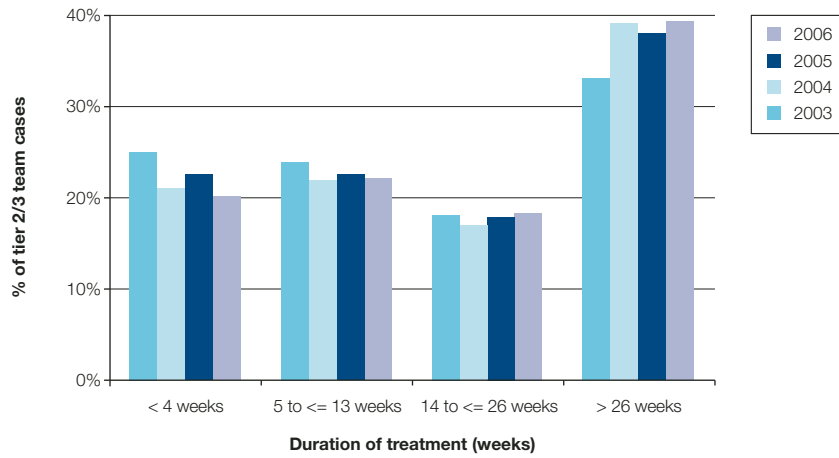
11.82 Tier 4 teams showed different trends in treatment length with evidence that tier 4 involvement with cases was becoming shorter (Fig. 11.59). 23% of cases were seen for 4 weeks or less and 30% were seen for 1 to 3 months – the highest this had been. Conversely the proportion of cases receiving treatment for 3 to 6 months has continued to drop from 20% in 2005 to 14% in 2006. There was also a drop in the proportion of cases treated for over 6 months from the levels reached over the last two years. As would be expected given the distribution of tier 4 units, greater variation between SHA were seen in the length of treatment provided by tier 4 teams than teams in tiers 2/3 (Figs. 11.60 and 61).

Fig. 11.59: Length of treatment in tier 4 teams
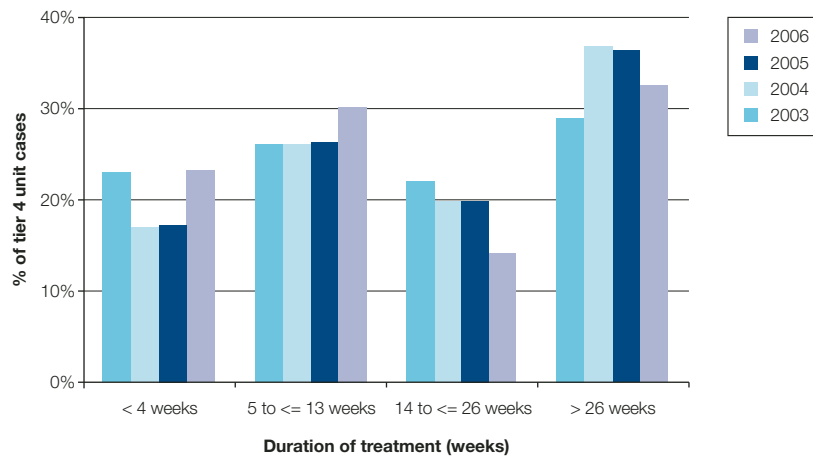
Fig. 11.60: Length of treatment in tier 2/3 teams

Legend:
- < 4 weeks
- 5 to <= 13 weeks
- 14 to <= 26 weeks
- 27 to <= 52 weeks
- > 52 weeks
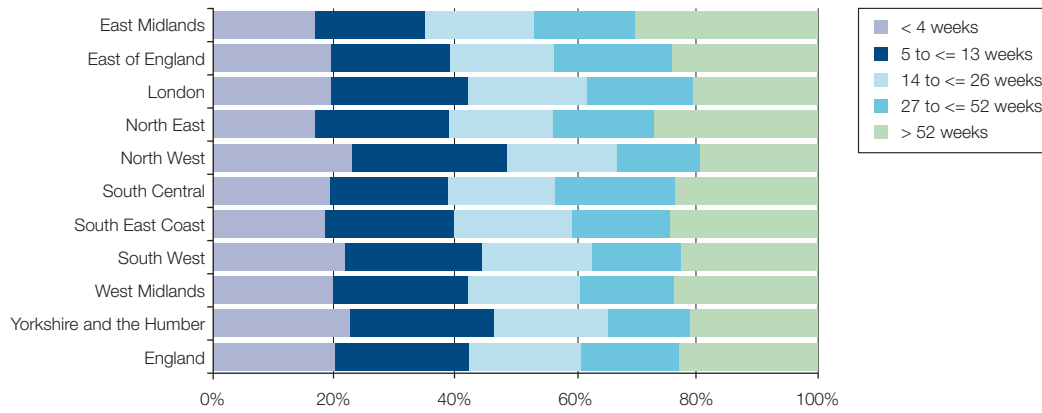
Fig. 11.61: Length of treatment in tier 4 teams

Legend:
- < 4 weeks
- 5 to <= 13 weeks
- 14 to <= 26 weeks
- 27 to <= 52 weeks
- > 52 weeks
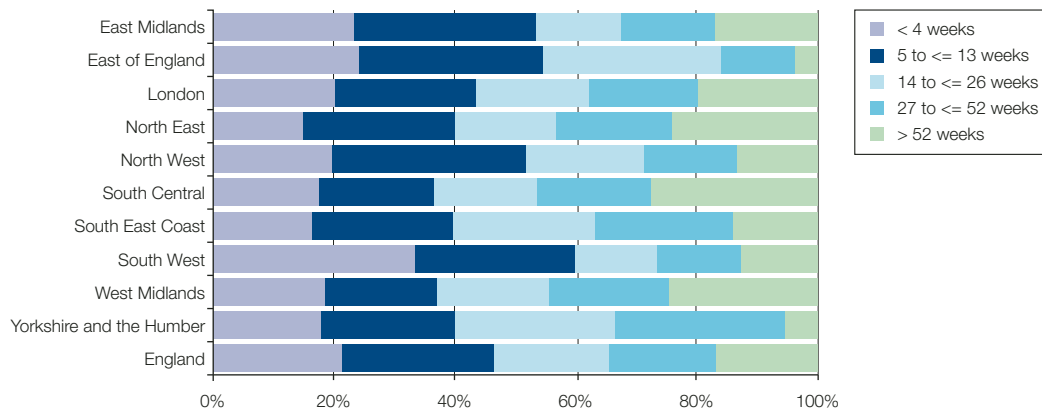
Age and gender profile

11.83 The age profile of children and young people using tier 2/3 CAMHS teams has remained very static on the whole. Children aged 5 to 9 years old have reduced from 29% of the caseload in 2003 to 26% in 2006 (Fig. 11.62). 10 to 14 year olds have continued to account for 40% to 41% of the caseload. At the same time the proportion of young people aged 16 to 18 has increased from 11% to 14% and the proportion aged 19 to 25 dropped from 2% to 1%.

Fig. 11.62: Trends in the age profile of tier 2/3 team caseloads
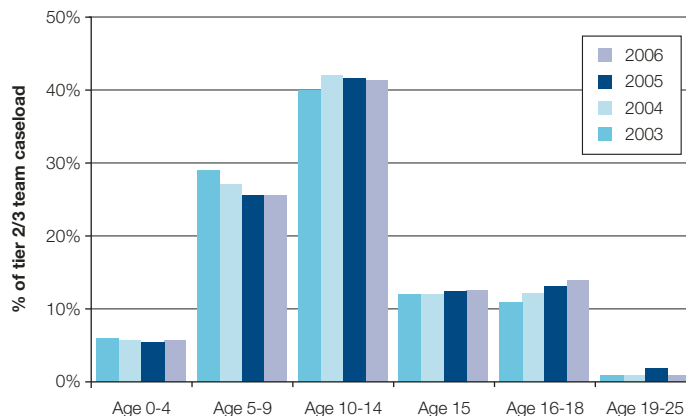
11.84 Greater variation was seen in age profile of the children and young people using tier 4 teams (Fig. 11.63) although it should be remembered that this makes up only 5% of the total 2006 CAMHS caseload. The proportion of 5 to 9 year olds being treated by tier 4 teams was down from 19% in 2003 to 13% in 2006 and the percentage of 10 to 14 year olds fell from 37% in 2003 to 32% in 2006 with some fluctuation. The proportion of 15 year olds has remained between 16 and 18% while the greatest change has been in the proportion of young people aged 16 and 17 which has risen from 23% in 2003 to 34% in 2006.

Fig. 11.63: Trends in the age profile of tier 4 team caseload
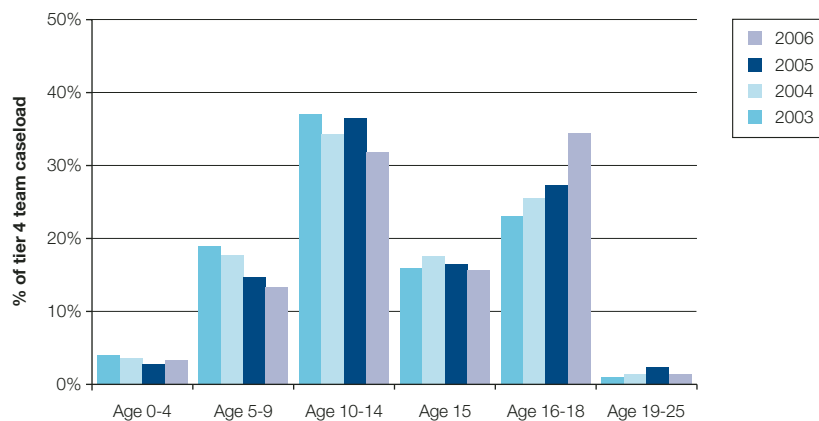
11.85 When compared to the age profile of the child population of England, the profile of the CAMHS caseload shows most variance around the very young and 10 to 15 year olds (Fig. 11.64).

Fig. 11.64: Age profile of the England population compared to the CAMHS caseload 2006
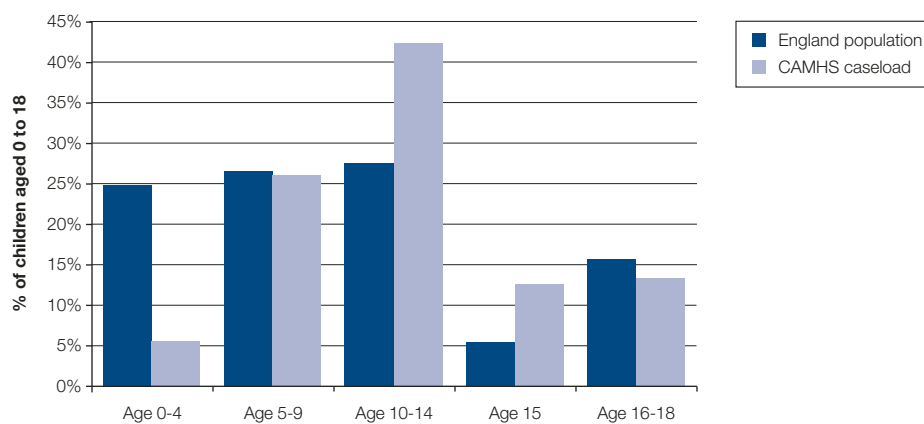
11.86 The variation between SHAs in the ages of children and young people using tier 2/3 teams remained small (Fig. 11.65). Much greater variance was seen in the users of tier 4 teams (Fig. 11.66). Owing to the nature of the services provided, tier 4 teams were more likely to be providing for adolescents and young people and the emphasis on this provision could be seen in some localities.

Fig. 11.65: Age profile of users of tier 2/3 teams (N=104,519)
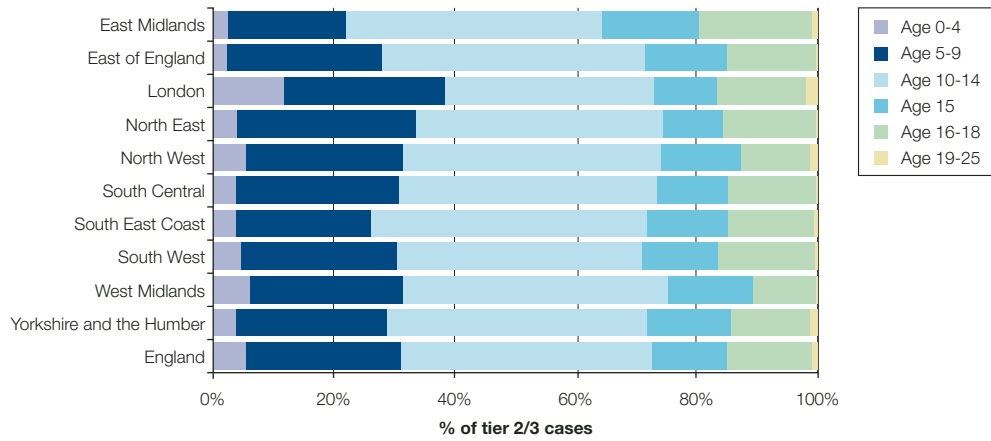
Fig. 11.66: Age profile of users of tier 4 teams (N=5,642)
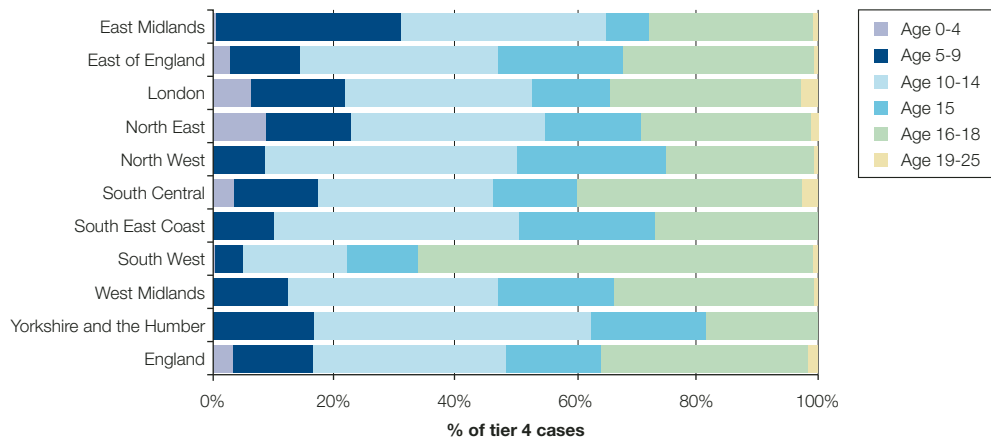
11.87 A total of 65,512 cases (59%) were identified as male, and 44,742 cases (41%) were identified as female, the same proportions as the previous year. Overall 59% of the children and young people using tier 2/3 teams were male and the gender profile by SHA was remarkably consistent nationally (Fig. 11.67).

Fig. 11.67: Gender of service users of tier 2/3 teams (N=104,519)

% of tier 2/3 team caseload
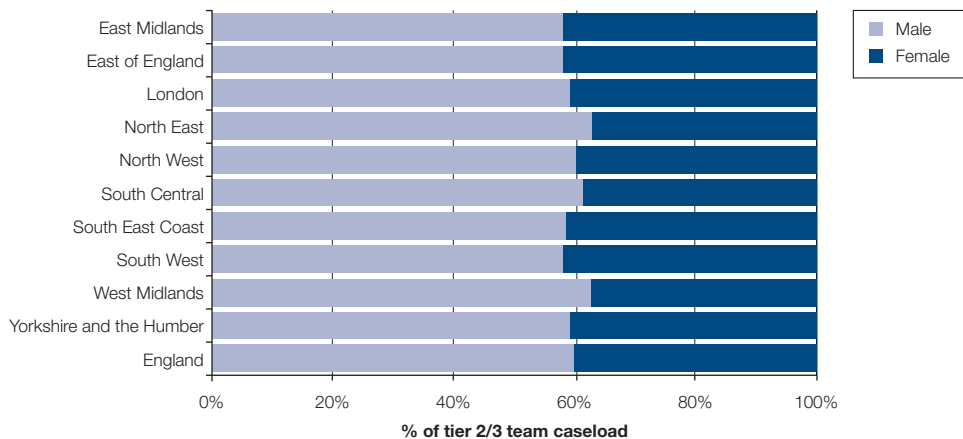
11.88 The gender profile of tier 4 team service users was more variable. This reflected the provision in SHAs of services, such as those for eating disorders, which tend to have a more gender specific client group. Overall, 52% of tier 4 users were male (Fig. 11.68).

Fig. 11.68: Gender of service users of tier 4 teams (N=5,642)

% of tier 4 caseload
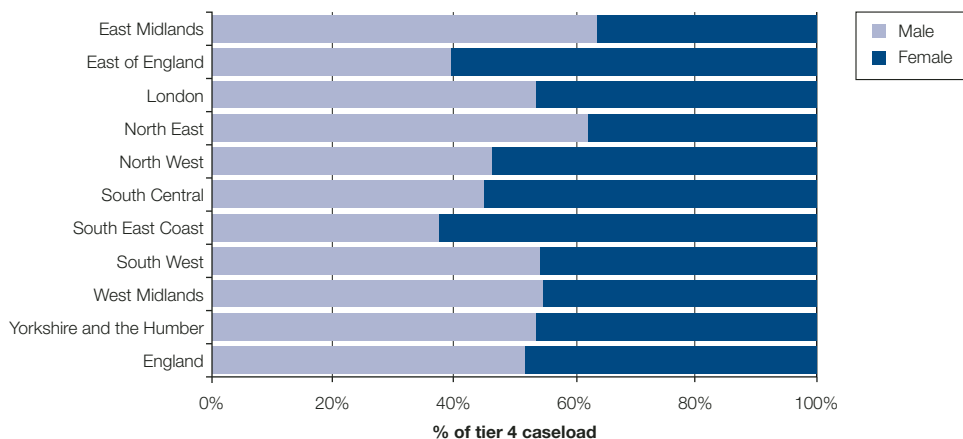
Ethnicity

11.89 The ethnic profile of the children and young people using CAMH services has changed very little in the last 3 years. However, this has to be qualified by the fact that there has been an increase in the number of cases with no ethnicity indicated from 2% in 2003 to 8% in 2004 and 10% in 2005. The main cause of this change was the inclusion of consultation cases for which full details of case characteristics were not always recorded by the professional being consulted as files on the case might not be held by that team. In 2006, when it was made clear that no case characteristics were expected to be recorded on consultation cases, the proportion of non-responses fell to 8% (Figs. 11.69 and 70).

11.90 Excluding cases where ethnicity was not stated, 87% of cases were white. Tier 2/3 teams saw a slight increase of cases from the black and minority ethnic communities (Fig. 11.69) while the number seen by tier 4 services continued to fall (Fig. 11.70). However, it is difficult to see clear trends emerging.

Fig. 11.69: Ethnicity of tier 2/3 team cases
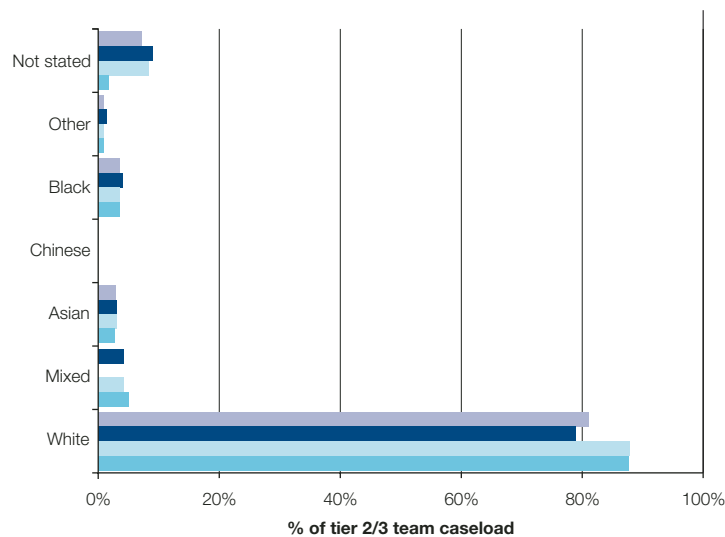
Fig. 11.70: Ethnicity of tier 4 team cases
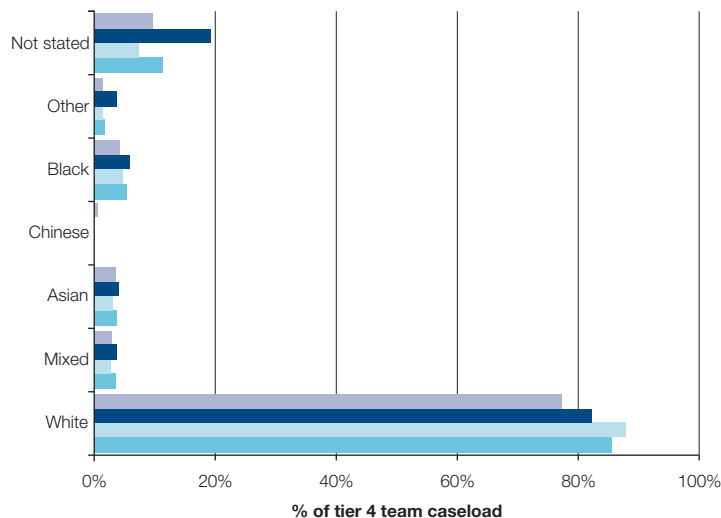
11.91 Not only were there important differences in the ethnicity of the CAMHS caseload between SHAs, but there were also significant differences in the number of cases whose ethnicity was 'not stated' across the SHA areas (Fig. 11.71 and 72).

Fig. 11.71: Ethnicity of service users in tier 2/3 teams by SHA (N=103,790)
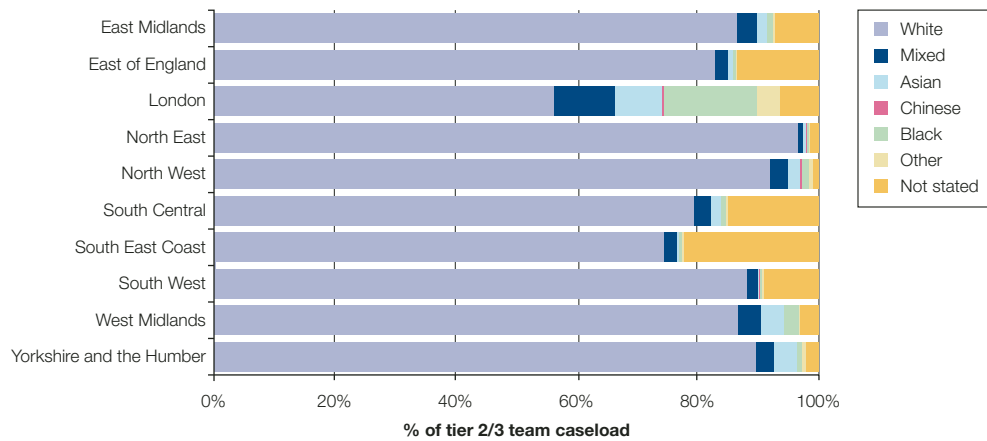
Fig. 11.72: Ethnicity of service users in tier 4 teams by SHA (N=5,650)
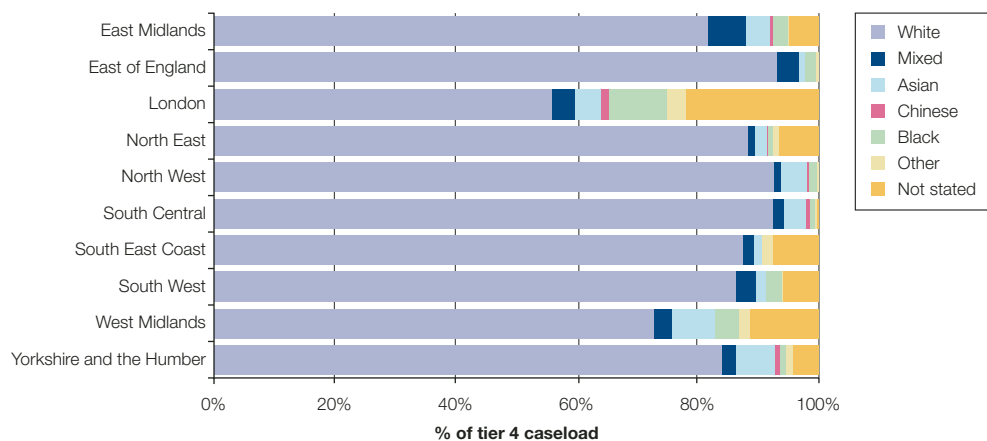
Primary Presentation

11.92 The primary presentation of children and young people using CAMHS has changed very little over the last 3 years. Emotional disorders accounted for 32% of tier 2/3 cases, and 21% of tier 4 cases. Conduct disorder (13%) and hyperkinetic disorder (13%) remained the next most common reasons for referral within tiers 2/3, whilst eating disorder (16%) was the next most common reason for referral in tier 4 (Figs. 11.73 and 74).

Fig. 11.73: Primary presentation of service users of tier 2/3 teams (N=106,212)

% of tier 2/3 team caseload
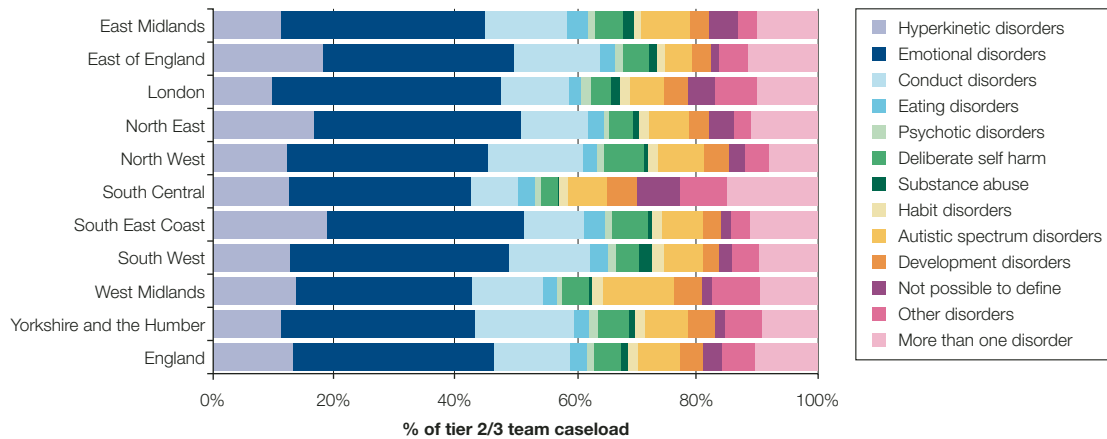
Fig. 11.74: Primary presentation of service users of tier 4 teams (N=5,612)

% of tier 4 caseload
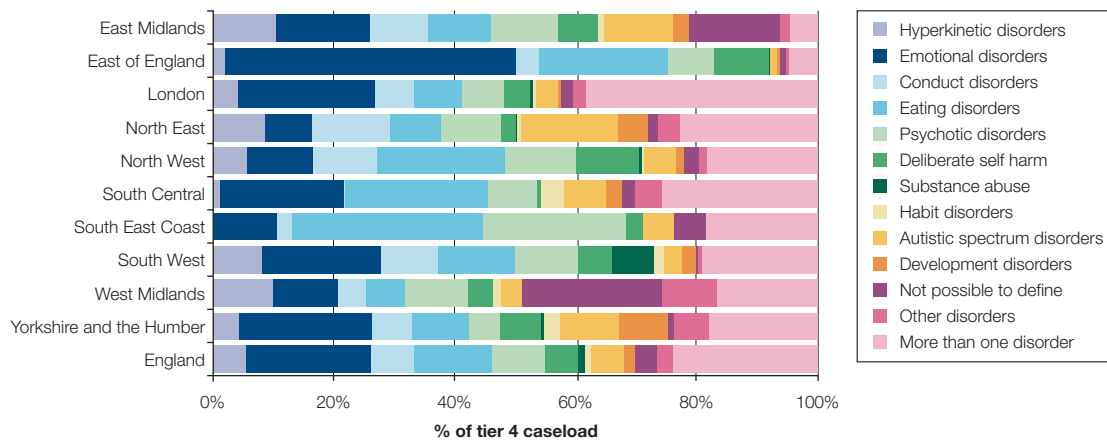
Referral source

11.93 Approaching half of all tier 2/3 referrals came from primary health care (44%), a further 16% came from child health services, whilst 11% of cases came from both education and from social services (Fig. 11.75). 10% came from within the CAMHS itself. These internal referrals were the main source of tier 4 referrals and accounted for 38% of those received. Other NHS trusts accounted for a further 29% of referrals emphasising the tertiary nature of much tier 4 provision (Fig. 11.76). Again the variation in tier 4 teams reported by SHA is reflection of the broad differences in tier 4 provision in each region.

Fig. 11.75: Referral source of service users of tier 2/3 teams (N=103,330)
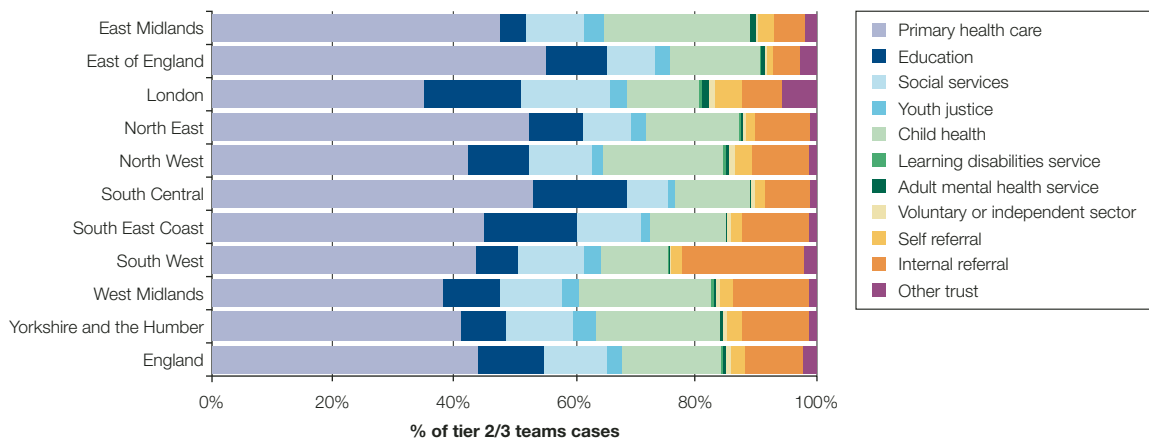
Fig. 11.76: Referral source of service users of tier 4 teams (N=5,599)
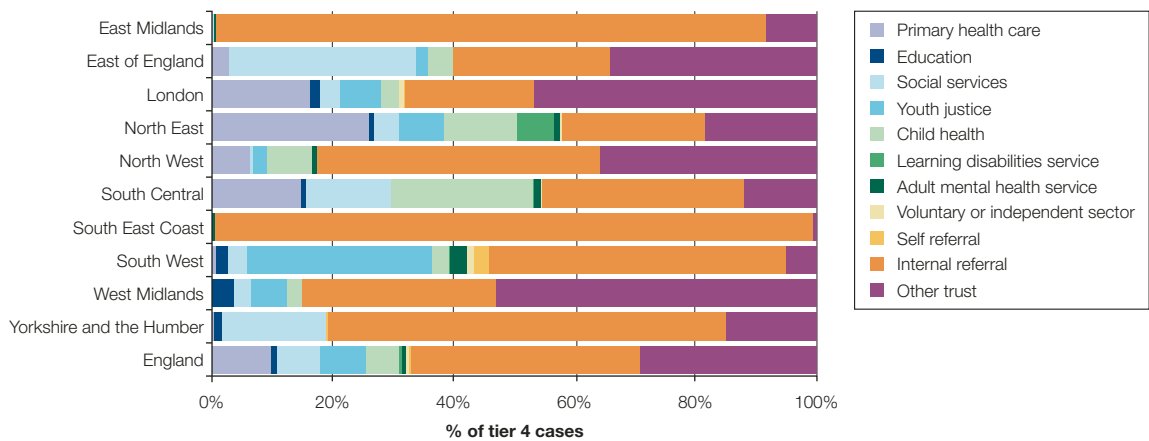
Chapter 12.

Delivering NSF Standard 10:
Medicines for children and young people

Introduction

12.1 Standard 10 of the National Service Framework for Children, Young People and Maternity Services states: **"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."**

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

12.3 This chapter reports the mapping findings most related to this theme, as follows;

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

12.4 Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.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'.[19]

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.[20]

12.5 Nurse prescribing was found to be well developed in all child health services. Prescribing under patient group direction was undertaken by 99% of school health services, reflecting their responsibilities in carrying out immunisation programmes. However, patient group prescribing was also carried out in over 90% of paediatric emergency services, children's surgery, maternity services and specialist and general paediatrics (Fig. 12.1). Supplementary prescribing was less well used except it was carried out in 67% of children's therapy services. Independent prescribing was used by 54% of early years and health visiting services, 50% of tier 1 CAMHS and 49% of community paediatrics.

Fig. 12.1: Nurse prescribing (N=3,645)
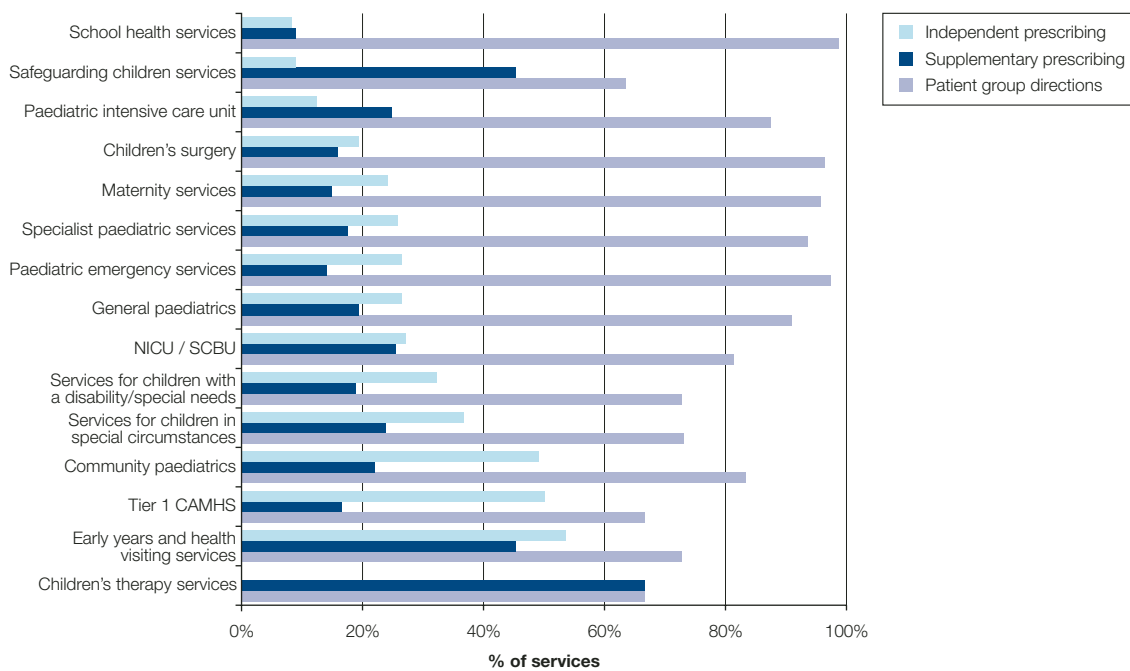
Parent and carer management of medication in hospital

> **"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 Services*[21]

12.6 Parents and carers often stay with their children in hospital and, in order to increase parent/carer 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, 149 general paediatric services reported that they had developed these services. This was 60% of all general paediatric services and 81% of those with inpatient provision, up from 67% in 2005/6.

Chapter 13.

Delivering NSF Standard 11:
Maternity services

Introduction

13.1 Standard 11 of the National Service Framework for Children, Young People and Maternity Services states: **"Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies."**

13.2 High quality maternity care aims to promote women's experience in having choice and control in giving birth and to improve access to maternity services that support women during pregnancy, childbirth and the postnatal period[22].

13.3 This chapter reports the mapping findings most related to this theme, as follows;

- Maternity service provision
- Neonatal services.

13.4 Detailed tables of the data can be found and downloaded from the mapping website at www.childhealthmapping.org.uk/reports

Maternity service provision

Maternity services
13.5 194 maternity services were reported in 2006/7, an increase of 21% on the 160 services reported the previous year. Again this was due to improved response rates and data capture and did not reflect growth in services. Maternity services had a workforce of 28,010 wte of which 17,608 wte (63%) were midwives and 2,791 wte (10%) were maternity support workers.

Maternity bed numbers
13.6 Maternity services provided a total of 8,886 maternity beds of which 2,174 beds (24%) were in birth rooms and 6,712 (76%) were maternity inpatient beds. This was an increase of 21% from 7,374 reported in 2005/6. The national average number of births per bed was 65 and the SHAs only varied 10 births per bed on either side of this average (Fig. 13.1)

Fig. 13.1: Average number of maternity beds per birth by SHA 2006/7
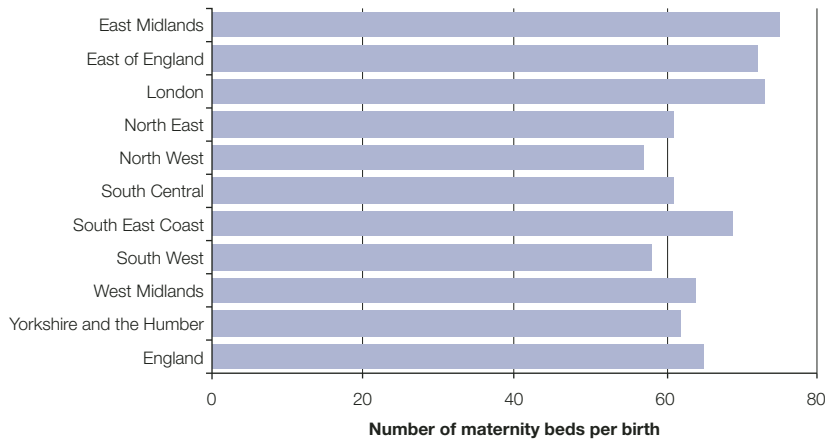
Models of maternity care

13.7   All of the maternity services provided postnatal care and all but 3 services provided antenatal and intrapartum care (Fig. 13.2). 14 services offered no consultant-led care and 9 services did not provide midwifery-led care.

Fig. 13.2: Model of care in maternity services (N=194)
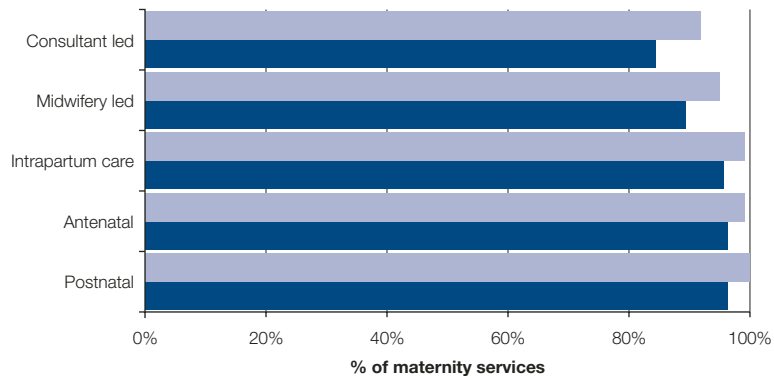
Provision of antenatal care

13.8   A range of antenatal care was widely available. Community based midwifery and antenatal clinics were available in almost all maternity services. 88% of services also had antenatal inpatient beds and 88% had an early pregnancy unit (Fig. 13.3). Preconception services were less well developed and were available on only 36% of services.

Fig. 13.3: Antenatal function in maternity services (N=180)

Horizontal bar chart showing % of maternity services for:
- Preconception service: ~36%
- Antenatal ward: ~88%
- Early pregnancy unit: ~88%
- Antenatal clinic: ~98%
- Community based antenatal clinic: ~99%
- Community based midwifery: ~99%

X-axis: % of maternity services (0% to 100%)
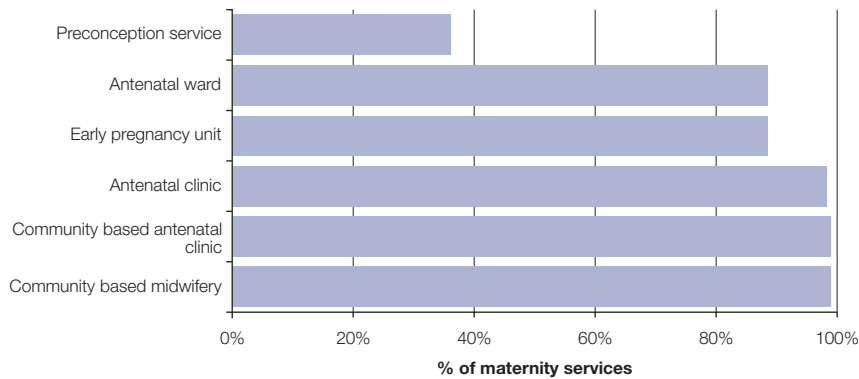
Facilities in maternity services

13.9   A range of facilities were available in maternity services but provision remained patchy (Fig. 13.4). For example, bereavement suites were available in 74% of services, overnight facilities for partners in 33% of services and single labour, delivery, recovery and post partum (LDRP) rooms or suites were only available in 30% of services.

13.10 A range of options for pain relief were available in the majority of maternity services. Active birthing equipment was available in 165 (90%) services, en-suite bath facilities in 158 (86%) services and women could opt to have an epidural 24/7 in 150 (82%) of services (Fig. 13.5).

Fig. 13.4: Availability of facilities in maternity services (N=177)

Horizontal bar chart showing % of maternity services for:
- LDRP suites: ~30%
- Overnight facilities for partners: ~33%
- Bereavement suite: ~74%
- Birthing pools: ~94%

X-axis: % of maternity services (0% to 100%)
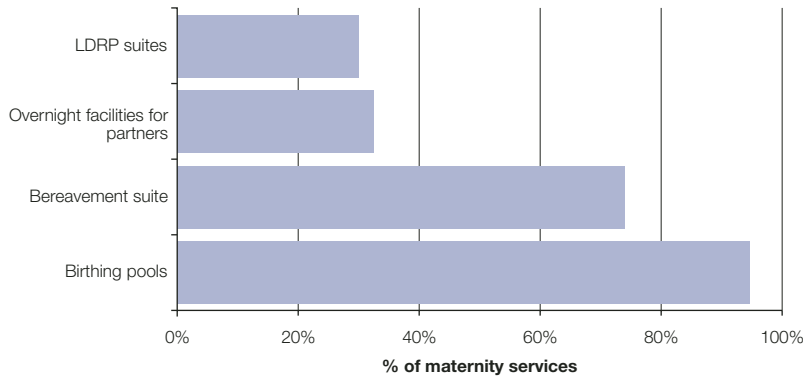
Fig. 13.5: Availability of pain options

Horizontal bar chart showing % maternity services for:
- Epidural not 24/7: ~5%
- Epidural 24/7: ~82%
- Bath en-suite facilities: ~86%
- Active birthing equipment: ~90%

X-axis: % maternity services (0% to 100%)
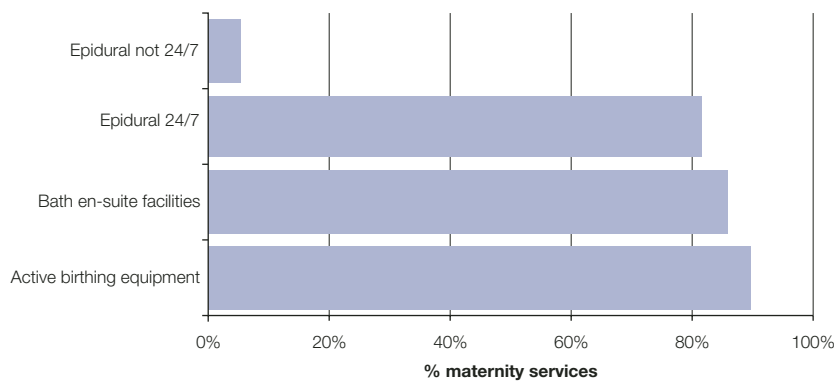
Involvement of mother's partner in antenatal education

13.11 The overwhelming majority of maternity services routinely involved fathers and other partners of mothers in antenatal education (92%). Only two services did not offer this involvement and in 12 services involvement was partial.

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 Review[23]

13.12 The Neonatal Intensive Care Review recommended that the types of care that babies might require should be clearly defined in 3 levels, special care, high dependency and intensive care[24]. 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

13.13 The number of neonatal intensive care units (NICU) increased from 109 in 2005/6 to 163 in 2006/7; an increase of 50% but it should be noted that the definition of NICU was extended to include special care baby units (SCBU). The neonatal service workforce showed a reported increase of 37% to 8,164 wte.

13.14 SCBU and NICU services were asked to identify the number of cots they have available using the three levels of intensity of care. The capacity of the 163 services was a total of 2,854 cots in total divided as follows:
- 1,755 cots in SCBUs at level 1
- 454 cots in High Dependency Units (HDU) at level 2
- 645 cots in NICU at level 3.

Fig. 13.6: Distribution of neonatal intensive care
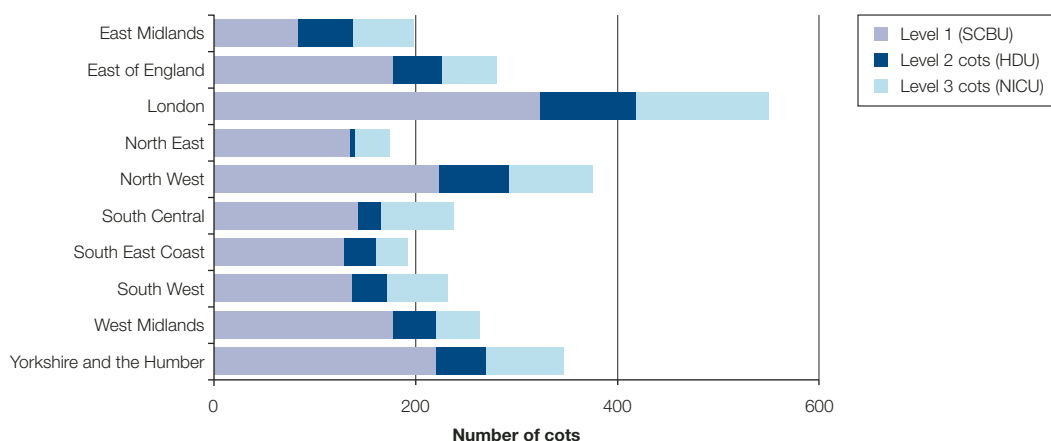
Neonatal transfer

13.15 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 homes[25].

13.16 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 2005/6 to 31% (51 services) in 2006/7. Of the 163 NICU services in 2006/7, 58% (94 services) rated their transfer as adequate and 6% (9 services) felt their transport was poor (Fig. 13.7).

Fig. 13.7: Adequacy of NICU access to neonatal transfer
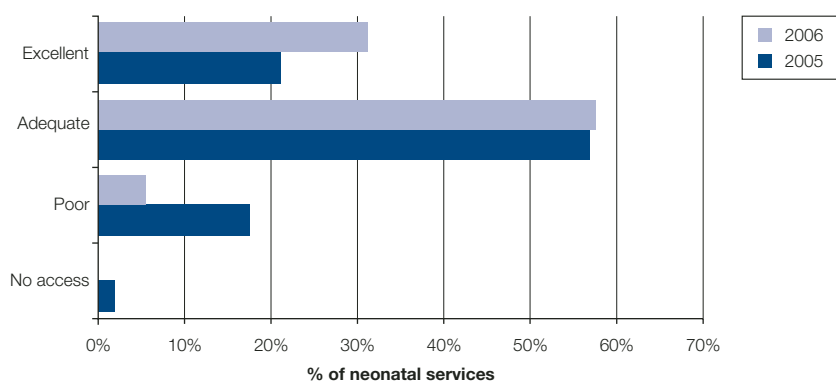
Participation in Managed Maternity Care Networks

13.17 The purpose of Managed Maternity Care Networks is to ensure health professionals and all agencies contributing to the provision of maternity services and support work together in a co-ordinated way, thereby ensuring equitable provision of high quality, clinically effective care[26]. Only PCTs were asked about their involvement in Managed Maternity Care Networks and nationally 39% were found to participate but the proportion of PCTs in SHAs that participated varied from 25% to 64% (Fig. 13.8).

Fig. 13.8: PCTs participation in Managed Maternity Care Networks
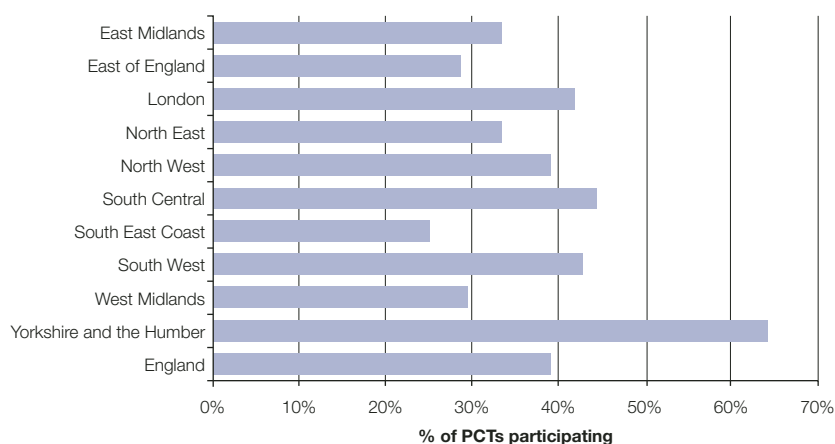
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12   Department of Health and Department for Education and Skills (2004) *Disabled children and young people and those with complex needs. National service framework for children, young people and maternity services.* London: Department of Health/Department for Education and Skills. Standard 8 s2.

13   Department for Education and Skills and Department of Health (2003) *Together from the Start: Practical guidance for professionals working with disabled children and their families.* LASSL (2003)4.

14   Department of Health and Department for Education and Skills (2004) *Disabled children and young people and those with complex needs. National service framework for children, young people and maternity services.* London: Department of Health/Department for Education and Skills. Standard 8 s5.8.

15   Department of Health and Department for Education and Skills (2004) *Mental health and psychological well-being of children and young people. National service framework for children, young people and maternity services.* London: Department of Health/Department for Education and Skills. Standard 9 p18.

[16] As above Standard 9 p21.

[17] As above Standard 9 p23.

[18] As above Standard 9 p7

[19] Department of Heath (2005) *Supplementary Prescribing by Nurses, Pharmacists, Chiropodists, Podiatrists, Physiotherapists and Radiographers within the NHS in England.* London: Department of Health.

[20] Department of Health (2000) *Health Services Circular 2000/026: Patient Group Directions.* London: Department of Health.

[21] Department of Health (2003) *Getting the right start: National Service Framework for Children: Standards for Hospital Care.* London: Department of Health. Standard 7, s3.14.

[22] Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services: Maternity services.* London: Department of Health/Department for Education and Skills. Standard 11.

[23] Department of Health (2003) *Neonatal Intensive Care Review - Strategy for Improvement.* London: Department of Health. Section 8.

[24] As above Section 8.

[25] As above Section 38.

[26] As above Standard 11 s4.3.

Annex 1:

General technical notes - Child Health, CAMHS and Maternity

A1.1: Basic mapping concepts

Key characteristics of child health 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
- 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.childhealthmapping.org.uk/reports

A1.2: Brief description of data collection process

- Introductory roadshow
- Telephone/email helpdesk is provided throughout collection period and reporting period
- Child health and maternity services and commissioner mapping leads are identified through previous mapping exercises and with the help of the CSIP Children's Change Agents and National CAMHS Support Team
- Mapping Leads register on the website and obtain a unique password giving access to that trust's data set
- The Mapping Lead registers colleagues to support the mapping process as appropriate (as 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 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 executives
- Data are frozen on 31st March 2007 but corrections to the data were accepted beyond this date.

A1.3: Changes to the child health and maternity exercise in 2006

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. The changes that were introduced 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 an organisation level
- The provision of help and guidance on the use of the website was substantially Improved
- 'Do-it-yourself' manual 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.

A1.4: 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 local chief executives
- Data scrutinised by Durham team during preparation of atlas and performance indicator tables; problems checked with local informants.

Annex 2:

CAMHS specific technical notes

A2.1: 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 gradings 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 deliver assessments, consultation and liaison, training and particular interventions
- Teams were asked if they use 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.

A2.2: Changes introduced in 2005

- Workforce gradings 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.

A2.3: 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.

A2.4: 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
- Data scrutinised by Durham team during preparation of atlas and performance indicator tables; problems checked with local informants.

Annex 3:

Working definition of CAMHS tiered system of provision

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
- 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.

Sources:
Health Advisory Service (1995) Together we stand. London: HMSO
Audit Commission (1999) Children in Mind. London: Audit Commission.

Annex 4:

National Children's Services Mapping and Information Steering Group

Remit:

To oversee the development of all children, young people and families related mapping projects, including CAMHS mapping (fifth year), Child Health and Maternity Services (second year) and Children's services mapping (pilot phase) by:

- Providing confirmation and approval for each stage of the development acknowledging all three mapping projects are at differing stages. This would include signing off project plans, advising on external working group membership, approving questionnaires and contributing to and approving the final atlas;
- Supporting the overall communication plan through group members utilising existing networks and keeping colleagues informed of progress at every stage;
- Supporting the project team to address and remove possible obstacles during the mapping cycles;
- Supporting the working groups, responsible for the design of each exercise;
- Agreeing the final design of all mapping exercises recommended by the working groups for approval by Department of Health Gateway processes; to ensure approval by the Review of Central Returns;
- Ensuring support for the exercise within government departments, professional bodies and across services.

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
Melanie Williamson	East of England Strategic Health Authority
Sue Eardley	Healthcare Commission

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

Annex 5:

Child Health, CAMHS and Maternity Service Mapping Expert Reference Group

Remit:

To support the development of the child health, CAMHS and maternity service mapping by:

- Providing general support to the Mapping Team through the provision of expert advice;
- Contributing to the quality assurance of the mapping data collected by helping the Mapping Team to recognise possible errors and interpret the results;
- Ensuring 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;
- Advising the Mapping Team on areas of the mapping that need improvement, identifying developments that will help in data collection or reporting;
- Acting 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 Eardley	Healthcare Commission
Sue Welsh	Northumberland, Tyne and Wear SHA
Sue Younghusband	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 to 2006/7 mapping.

Notes

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We would like to thank everybody who helped to complete the service mapping exercise and who have consistently supported its development and seen the impact of understanding service provision issues to improve outcomes for children and young people. This relates both to the senior sponsors of the exercise who have funded and personally supported the exercises since 2002 and especially the large number of practitioners and managers who have collected the data.

We would also make a special mention and thanks to Simon, Lee, Ruth, Charlotte, Kirsty, Rebecca, Dale, Coleen and Jonathan for the artwork that has become the trademark for CAMHS mapping. They originally developed the work in 2002 with the support of 'Investing in Children' when they were aged 8 to 11 years old. The children were from Easington, Derwentside, Durham and Chester-le-Street in County Durham. They made the figures while working in a group facilitated by Tees, Esk and Wear Valleys NHS Trust. The aim of the group was to promote self-esteem through art and story telling. The figures were made of collage and were life-sized.

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