## Durham
University

School of Applied Social Sciences

A profile of **children's health services, child and adolescent mental health services** and **maternity services** in England 2008/9

Di Barnes, Carol Devanney, Anja Uglebjerg and Richard Wistow with Claire Hartley

## Data warning

This 'atlas' reports the data submitted in the annual children's services mapping exercise but time series data in this report should be treated with particular caution.

Children's services mapping is a voluntary exercise and response rates, although consistently high, vary each year. In this report no attempt is made to compensate for this. Therefore trends reported may be due to changes in response and not actual change.

# Contents

# Abbreviations

| | |
|---|---|
| A&E | Accident and emergency |
| ADHD | Attention deficit hyperactive disorder |
| AFC | Agenda for change |
| ASD | Autistic spectrum disorder |
| BACP | British Association for Counselling and Psychotherapy |
| CAF | Common Assessment Framework |
| CAMHS | Child and adolescent mental health services |
| CBT | Cognitive behavioural therapy |
| CEO | Chief Executive Officer |
| CGAS | Children's Global Assessment Scale |
| CHaMP | Child Health and Maternity Partnership |
| CHI-ESQ | Commission for Health Improvement – Experience of Services questionnaire |
| ChiMat | Child and maternal health observatory |
| CPA | Care Programme Approach |
| CSM | Children's services mapping |
| CSSR | Councils with Social Service responsibilities |
| CYPP | Children and young people's plan |
| DCSF | Department for Children, Schools and Families |
| DNA | Do not attend |
| ECM | Every Child Matters |
| ERG | Expert Reference Group |
| GP | General practitioner |
| HDU | High dependency unit |
| HoNOSCA | Nation Outcome Scales for Children and Adolescents |
| JSNA | Joint strategic needs assessment |
| LA | Local authority |
| LAC | Looked after children |
| LGA | Local Government Association |
| LSCB | Local Safeguarding Children Board |
| MSLC | Maternity Services Liaison Committee |
| NCCG | Non consultant career grade (doctor) |
| NEET | Not in education, employment or training |

| | |
|---|---|
| NICU | Neonatal intensive care unit |
| NSF | National Service Framework |
| PALS | Patient advice and liaison service |
| PCT | Primary Care Trust |
| PICU | Paediatric intensive care unit |
| PMHW | Primary mental health worker |
| RCOG | Royal College of Obstetricians and Gynaecologists |
| ROCR | Review of Central Returns |
| SARC | Sexual assault referral centre |
| SCBU | Special care baby unit |
| SDQ | Strengths and difficulties questionnaire |
| SEN | Special educational needs |
| SHA | Strategic Health Authority |
| SLA | Service led agreement |
| wte | whole time equivalent |

# Chapter 1.

# Introduction

## Overview

1.1  Since 2005, a profile of child health, child and adolescent mental health services (CAMHS) and maternity services in England has been published to report the findings of the annual mapping exercise.  This report summarises the 2008/09 exercise that was carried out between 1st November 2008 and 27th February 2009.  It marked the fourth child health and maternity service mapping data collection and the seventh CAMHS mapping exercise.  This report focuses on findings at a national level with some references to regions but all data can be interrogated at the level of Strategic Health Authority (SHA), NHS organisation, and individual service at www.childrensmapping.org.uk/results.

1.2  In 2008, the annual mapping of child health, CAMHS and maternity services became part of an integrated children's services mapping (CSM) exercise that covers all services that come under the responsibility of Children's Trusts.  Local authorities were invited to participate and the mapping system was developed to support the recording of Children's Trust structures, interagency service provision and joint working.  This makes CSM an unusual and powerful tool that collects information across service areas irrespective of the sector in which services are provided.

1.3  This report reflects the different stages of mapping development. National trend data is available for CAMHS, child health and maternity services but not yet available for local authority commissioned and/or provided children's services due to their more recent involvement. However, we are able to report on the development of Children's Trust arrangements at an organisational level and this is included in section 2.

## Background and policy context

1.4  The mapping of children's services was originally developed in 2002 to provide a description of specialist CAMHS in England and since then the annual exercise has successfully tracked change in service provision to support the measurement of performance and to help drive forward improvements in CAMHS investment, staffing and activity.  In 2005, the mapping system was extended to cover dedicated child health and maternity services and in 2007 the first joint report of the mapping exercise was published which was structured around the 11 standards of the children's National Service Framework[1] (NSF).

1.5  Children's services mapping is an online data collection and reporting system that creates an annual snapshot of national service provision and investment.  As annual data accumulates, trends are generated that indicate where, and in what direction, change is taking place.  This underlines the principle aim of the mapping exercise to contribute to the monitoring of the change for children agenda set out in Every Child Matters (ECM)[2], the National Service Framework for Children, Young People and Maternity Services (NSF), the Children's Plan[3] and most recently in Healthy lives, brighter futures: The strategy for children and young people's health[4].

1.6  In addition to reflecting these overarching policies in the design of questionnaires, CSM has referrenced policy and guidance specific to individual areas of service delivery to ensure the data collection is informed by the most up-to-date thinking and requirements of front-line services. For example, data requested from maternity services has been informed by 'Maternity Matters'[5], the mapping of safeguarding services has been developed with reference to both national inquiries (Victoria Climbié[6], and Baby Peter[7]) and disabled children's service questions have been linked to 'Aiming High for Disabled Children'[8].  See Appendix 8 for a full list of the policy documents used to inform mapping content.

1.7    Most recently, the role of children's services mapping within the Child and Maternal Health Observatory (known as ChiMat) is set out in the Child Health Strategy, 'Healthy lives, brighter futures'. CSM and ChiMat are part of the infrastructure for delivery, providing data to inform needs assessment and performance improvement with the overall aim of developing well commissioned services which provide the best outcomes for children, young people and their families. Specifically, CSM in partnership with ChiMat aim to provide data on the link between investment, workforce, activity and outcomes across the public sector to inform the drive for value for money.

1.8    To reflect this much broader agenda, the structure of the annual atlas has moved away from linking results to NSF standards and seeks to report against key service areas. The atlas is a contractual requirement of the Department of Health as sponsor, and as such reports on predominantly health service areas. However, new this year, and made possible by the inclusion of local authorities to mapping in 2008, is a multi agency report on the development of children's trusts nationally (para. 2.7).

## Purpose of mapping

1.9    The purpose of children's services mapping is to:
   • Support Children's Trust partners in developing joint commissioning strategies
   • Support joint service planning, development and provision
   • Assist in the bid for resources
   • Act as a source of data for national, regional and local performance monitoring
   • Provide annual updates for the development and maintenance of local service directories.

1.10   The mapping system is also beginning to support local and national benchmarking and can be used alongside other information such as national indicators and vital signs.

## Project management

1.11   The mapping exercise is funded by the Department of Health, the Department for Children, Schools and Families (DCSF) and the NHS Child health and Maternity Programme (CHaMP). It is managed and developed by the National Children's Mapping Team led by Claire Hartley. The Durham Mapping Team in the School of Applied Social Sciences at Durham University run the exercise, developing and maintaining the online systems and reporting the results.

1.12   The work programme of the project has been overseen in the past by a national steering group, led by the Department of Health, with representation from the Department for Children, Schools and Families, Regional Government Offices, the Care Quality Commission, the Association of Directors of Children's Services, the NHS, the third sector and key professional associations (Appendix 6). However, as children's services mapping will formally integrate with ChiMat, new joint governance arrangements have recently been put in place, replacing the former steering group and expert reference group with the ChiMat Board and National Stakeholders Advisory Group. These new arrangements will continue to involve the key partners.

1.13   The exercise was advised at the time of data collection by an expert reference group made up of policy and workforce leads, commissioners, service managers and practitioners across children's services (Appendix 7).

1.14 The approval of the Review of Central Returns (ROCR) at the Department of Health for the mapping process was granted in December 2008, licence number ROCR/OR/0246.

## Mapping process

1.15 The mapping exercise follows an annual cycle with distinct phases:

- **Review and development:** A review of the mapping questionnaires is carried out each year to ensure the questions are relevant and the outputs are useful. Changes are kept to a minimum in the interest of supporting year-on-year comparisons but questions are improved in response to feedback from the field and new questions are added to reflect changes in policy or emerging areas of interest in service delivery.

- **Data collection:** All data is input online by primary care trusts (PCTs), NHS Foundation Trusts and other NHS trusts that provide child health, CAMHS or maternity services. Local authorities are also involved in inputting CAMHS data and mapping the children's services that they provide and commission. Each relevant organisation is asked to nominate a senior member of staff to act as the Mapping Lead, taking responsibility for overseeing and coordinating the exercise for their organisation. The Mapping Lead is responsible for setting up the exercise, structuring it to suit local circumstances and nominating colleagues to assist in the completion of the exercise. As the details of all services reported in the previous year are imported into the current data set, the annual exercise is essentially one of data revision once all services have been recorded. The data collection period runs from the beginning of November to the end of February, describing the services in operation on 30th November. Finance data is collected for the previous and current financial year. To end the data collection phase, all data is signed off by the Chief Executive Officer of each participating organisation and the Directors of Children's Services for local authority CAMHS performance information.

- **Evaluation:** At the end of each annual exercise, an evaluation survey is run to gather feedback. Analysis of this contributes to the review and redesign of the mapping system and content. The findings of the 2008/09 evaluation survey can be viewed at: http://www.childrensmapping.org.uk/results/publications.php.

- **Data checks:** The Durham Mapping Team carries out a series of checks on the data before releasing reports on an open access website.

- **Reporting:** Interactive online tables, preset reports and publications are prepared throughout the summer months. These include a series of publications, reports on specific topics and one-off reports on request.

## Data accuracy, change and completion

1.16 Children's services mapping is a voluntary exercise. Although completion rates remain high, the number of participating organisations varies each year and returns are not always complete. Therefore, mapping data should be read with caution.

1.17    In 2008, 362 PCTs and NHS provider trusts took part in the CSM exercise.  They all registered on the
        mapping website and completion rates were as follows (details in Appendix 1):
        • Finance data was 'signed off' as complete by 90% of the 152 PCTs
        • Child health and maternity service data was sign off by 86% of the 320 providers
        • CAMHS data was signed off by 100% of the 112 providers.

1.18    However, a number of additional factors affected the accuracy of the CSM data in 2008.  These included:

        • With the extension of the mapping exercise to cover all children's services that come under the
          responsibility of Children's Trusts, two new classifications were developed that are fundamental to the
          structure of CSM data.  First the classification of service types was extended to encompass not only
          child health, CAMHS and maternity services but also all children's services including: children's social
          care; education and learning services; youth and leisure services.  Secondly, a new classification of staff
          categories/professional groups was developed to describe the integrated children's workforce.  The
          complete classifications are presented in Appendix 3 and 4.

        • An impact of the new classifications was that services provided by NHS organisations were sometimes
          categorised as social care (e.g. safeguarding services) or youth services (e.g. drug and alcohol and
          teenage pregnancy services).  Similarly, staff working for the NHS sometimes found that their job roles
          were classified in a non-health staff categories, such as, nursery nurses or play workers.  As 2008 was
          the first year that these comprehensive children's service categories had been used there was some
          confusion over how information should be recorded, and a reluctance to classify health-related services
          as anything other than health. Staff often preferred to use the 'other' category than cross a cultural
          boundary and use social care or education classifications.

        • Organisational change in the NHS has continued to disrupt year-on-year trend data.  No PCT  data is
          reported before 2006 when there was widespread reorganisation of the trusts but more recently the
          separation of PCT commissioning and service provision functions has had an impact.  90 of 150 PCTs
          chose to register their commissioning and service provision roles separately in 2008 and a number
          chose to register as a completely new provider organisation with an independent Chief Executive Officer
          who signed off the mapping return.

        • The mapping exercise has clear boundaries – the inclusion of dedicated child health/children's services,
          specialist CAMHS tiers 2 to 4 (see Appendix 5) and maternity services.  However, it can be difficult to
          define dedicated children's services.  All-age health services should not be included in the mapping
          exercise and yet it may be appropriate to include services such as emergency departments that do not
          have a separate children's unit/team but do have a child and family friendly area and operate a children's
          pathway of care.  A common-sense approach is called for in order to apply a single service mapping
          template across the country taking into account regional and historic differences, but this is not always
          easy to achieve.

1.19    Though every effort is made to maintain the CSM questions year-on-year to support annual the generation
        of trend data, questions are added and removed to maintain the currency of the data collection.  Therefore
        the trends reported vary in length, depending on when questions were introduced.

1.20    At a national level the mapping data gives a good indication of levels of service provision, investment and
        the direction of change.  At regional and local levels, gaps and inconsistencies tend to be easier to identify
        by those with local knowledge.  Consequently, the mapping data may raise as many questions as it
        answers.  Paradoxically, this is one of its major strengths as it can stimulate informed debate and help to

develop understanding both of the nature of services provided, and who they are being provided for. Where data stands out as different, this may indicate errors in inputting or missing information that can be corrected next year. Equally there may be reasons for the difference that are helpful to articulate and explore.

1.21    Where data needs further investigation, it can be 'drilled into' using the online tables on the mapping website www.childrensmapping.org.uk/reports. By clicking on the hyperlinked names on the left-hand side of all tables, access is given to the original questionnaire completed about each service and the totality of information submitted about that service can be scrutinised.

## Using this atlas

1.22    This report is set out as follows:

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

**Section 2: Commissioning and finance** showing the development of Children's Trusts and joint commissioning arrangements and trends in expenditure on child health, CAMHS and maternity services.

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

**Section 4: Overview of services mapped** explaining the classification of integrated children's services developed for the exercise and identifying key characteristics.

**Sections 5 to 11:** Findings are reported for a range of specific service areas to include;
•   **Maternity services, including neonatal care**
•   **Early intervention services**
•   **Paediatric services for the ill child**
•   **Services for disabled children**
•   **Child and adolescent mental health services**
•   **Safeguarding services**

**Appendices: Technical notes** providing explanations of completion rates, services types, the CAMHS 4-tier system, governance arrangements describing accountability for the 2008/9 exercise and policy references used throughout the mapping exercise.

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

## Feedback

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

# Chapter 2.

# Commissioning and finance

# Introduction

2.1 Robust commissioning is central to the provision of high quality services and securing improved outcomes for children, young people and their families. 'Healthy lives, brighter futures', the children's health strategy[9], was accompanied by guidance for commissioners[10], outlining how the strategy can be achieved using world class commissioning. An essential component is having the appropriate leadership in place and a clear framework for joint planning and commissioning that brings together children's service commissioners from health, local authorities, schools and youth justice. The mechanisms to be used are Children's Trusts and this section reports findings from a CSM questionnaire on the development of Children's Trusts that was included in the mapping exercise for the first time in 2008.

2.2 Since 2005, finance mapping has collected finance data from PCT commissioners. Trends in PCT investment in child health and maternity services and CAMHS are reported here.

2.3 The section reports commissioning and finance results as follows:

- Development of Children's Trusts
    - Representation
    - Children and Young People's Plan
    - Joint strategic needs assessment
    - Joint commissioning

- PCT children's lead

- Finance: An overview of spend on child health, CAMHS and maternity services
    - Total expenditure
    - Spend by service categories
    - Spend per child on child health services
    - Spend per birth on maternity services
    - CAMHS expenditure
    - Individual care expenditure

2.4 Completion rates for finance mapping are shown in Appendix 1. The rate of sign off by Chief Executive Officers of PCTs in the 2008 exercise was 90% compared to 95% in 2007 and 87% in 2006. Sign off indicated their agreement with the data submitted. Further confidence in the data resulted from 91% of the 2116 finance spreadsheets submitted being confirmed as complete. This was down on the 95% of spreadsheets being confirmed complete in 2007. Therefore it is acknowledged that inconsistencies in the data remain as the information is complex and errors are difficult to identify without detailed local knowledge.

2.5 Local authorities have also been asked to submit data on expenditure on CAMHS since 2004 and in previous years this has been included in this annual report. However, due to the more holistic way local authorities were involved in the mapping exercise in 2008, the focus on CAMHS was not maintained and the number of local authorities providing information on CAMHS spend dropped below 50%. As a result, local authority CAMHS spend is not reported for 2007/8 or previous financial years.

2.6 In this chapter, the data is reported at a national level only. Detailed tables of the data used can be found and downloaded from www.childrensmapping.org.uk/reports.

# Development of Children's Trusts

## Representation

2.7 Children's Trusts are core to the reform of children's services as set out in Every Child Matters: Change for Children agenda and underpinned by the Children Act (2004). This agenda aims for services to be built around the needs of children and young people to improve well-being based on the 5 Every Child Matters outcomes: be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic well-being. Children's Trusts are made up of the local authority, statutory 'relevant partners'; and other partners considered appropriate by the local authority. PCTs are statutory partners and have duties under section 10 of the Children Act (spelt out in the revised guidance published in 2008[11]) to cooperate in implementing the vision of The Children's Plan and put arrangements in place to ensure improvements in all areas of service delivery and in associated outcomes for children and young people.

2.8 As local authorities have lead responsibility for Children's Trusts, they were asked to provide information on the development of their trust in the 2008 CSM exercise, consulting with PCT partners in doing so. Overall, 119 of the 150 local authorities returned data, a response rate of 79%.

2.9 An integrated governing board is the cornerstone of a Children's Trust. These should include representation of key partners at a senior level, be determined to drive whole-system change through clear leadership and effective action, and have appropriate arrangements in place to ensure the voices of children, young people, parents and front line workers are heard. In 2008, half of the Children's Trust Boards were chaired by elected members of the council who held the local authority lead for children. 36% of Children's Trusts were chaired by Directors of Children's Services and 14% by others, including one PCT Chief Executive Officer and one PCT Director of Commissioning.

2.10 Representation of PCT commissioners was reported by 97% of Children's Trusts and PCT provider agencies were involved in 84% (Fig. 2.1). However, Strategic Health Authorities were only represented in 31%. The level of representation of PCT commissioners was at Director/CEO level in 76% of Children's Trusts, and at senior officer level in 21%. 55% of PCT providers reported representation at Director/CEO level and 45% at senior officer level (Fig. 2.2).

**Fig. 2.1: Representation of 'relevant' statutory partners on Children's Trusts 2008 (N=119)**



% of Children's Trusts
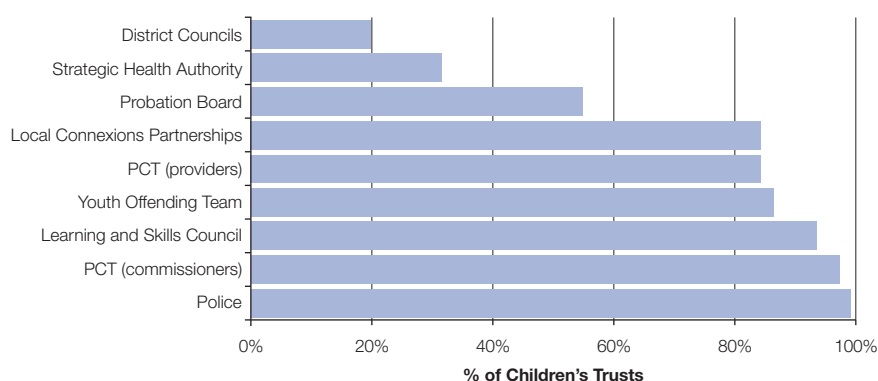
**Fig. 2.2:** **Level of representation of 'relevant' or statutory partners on Children's Trusts 2008 (N=119)**
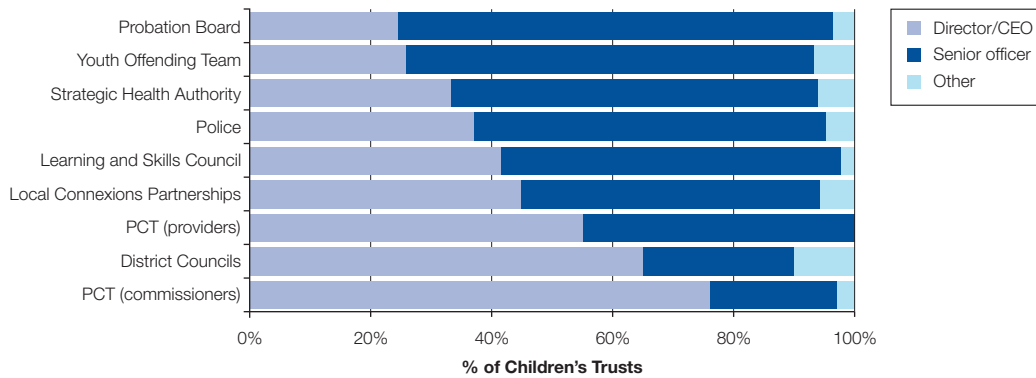


## Children and Young People's Plan

2.11 The Children and Young People's Plan (CYPP) covers all services for children, young people and families within a single strategic and overarching vision for the local area. Children's Trust partners should be closely involved in its development and ensure their own plans are fully aligned with it. Children's Trusts should sign off the CYPP, then ensure that it is published, refreshed, evaluated and reviewed. In 2008, all Children's Trusts had a completed and up-to-date CYPP for the local authority area that had been agreed and signed off by the Trust and its partners. 98% reported that the CYPP covered the whole of the Every Child Matters agenda while 2% focused on particular areas - prevention and 'narrowing the gap'.

2.12 All Children's Trusts reported that the CYPP included the views of children and young people but their views tended to be included more than those of parents, families and carers. The most common way to obtain the views of both groups was through consultation exercises but the use of feedback from children's services, young people's forum and school level surveys were also frequently used (Fig. 2.3)

**Fig. 2.3:** **Ways of including the views of children, young people and families in the development of the Children and Young People's Plan 2008 (N=119)**
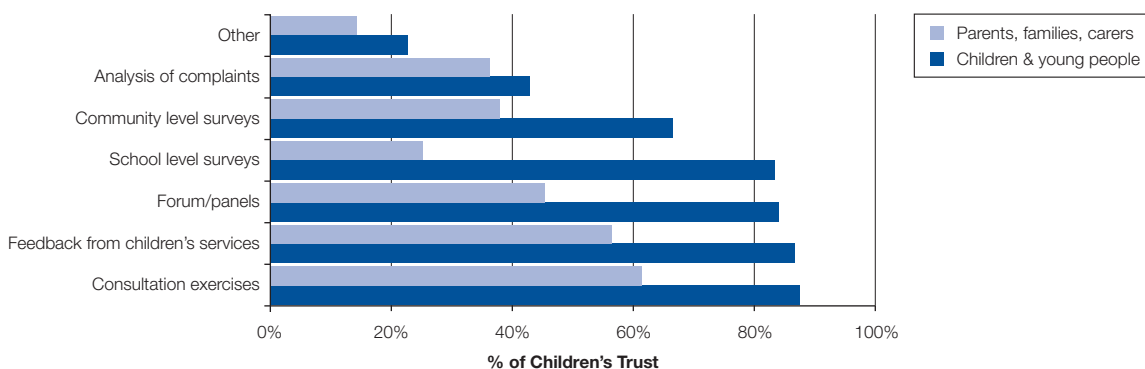
## Joint strategic needs assessment

2.13 94% of Children's Trusts had carried out a Joint Strategic Needs Assessment (JSNA) to identify the needs of children, young people and their families in the Children's Trust area. Of these, 95% covered the whole Children's Trust area and 5% only part of the area. Specific aspects of the JSNA fall into six broader domains and considerable variation was found in whether these elements had been considered. The most commonly included elements were analysis of population and its age profile (86%), healthy weight (85%), teenage pregnancy (83%), and children living in poverty (81%) (Table 2.1). Least often analysed were the prevalence of disease and disability in children and service provision by the 3rd sector.

**Table 2.1: Completed aspects of JSNA 2008 (N=119 Children's Trusts)**

| Domain | Aspects of JSNA | % completed |
|---|---|---|
| Domain 1: **Demography** | Total child population | 86% |
| | Age profile | 85% |
| | Ethnic profile | 79% |
| | Disability profile | 67% |
| | Migration | 53% |
| Domain 2: **Social and environmental context** | Children living in poverty | 81% |
| | Employment of young people | 66% |
| | Housing for families and young people | 65% |
| | Environment | 59% |
| Domain 3: **Lifestyle and risk** | Healthy weight/obesity | 85% |
| | Sexual behaviour/ teenage pregnancy | 83% |
| | Smoking | 81% |
| | Breastfeeding | 81% |
| | Substance misusing children | 77% |
| | Eating habits | 75% |
| | Physical activity | 74% |
| Domain 4: **Ill health and disability** | Vulnerable children | 67% |
| | Dental decay | 67% |
| | Children with disability | 66% |
| | Children in road accidents | 62% |
| | Hospital admissions | 61% |
| | Hospital admissions due to accidental and non-accidental injury | 57% |
| | Children with long-term limiting illness | 48% |
| | Prevalence of illness and disability in children/young people: infectious diseases | 35% |
| | Prevalence of illness and disability in children/young people: cancer | 31% |
| | Prevalence of illness and disability in children/young people: diabetes | 30% |
| Domain 5: **Service for children, young people and families** | Social care provision and use | 59% |
| | Health provision and use | 56% |
| | Education provision and use | 55% |
| | Voluntary sector provision and use | 29% |
| | Private sector provision and use | 17% |
| Domain 6: **Voice** | Community views | 59% |
| | Views of parents and carers | 53% |
| | Views of children and young people | 43% |

## Joint commissioning

2.14    79% of Children's Trusts reported there was an agreed Joint Commissioning Strategy for children's services and 96% reported joint commissioning arrangements were in place in at least one service area. CAMHS had the highest proportion of joint commissioning or pooled budget arrangements in place (in 93% of Children's Trusts), followed by disability (92%) and substance misuse (78%) (Table 2.2). The joint commissioning or pooling of budgets for hospital services was reported by the lowest proportion of local authorities (13%), followed by maternity services (19%) and child health surveillance (20%).

**Table 2.2:  Joint commissioning arrangements reported by Children's Trusts 2008 (N=119 Children's Trusts)**

|  | Pooled budget S31 | Pooled budget voluntary | Joint service delivery under S31 | Joint service delivery voluntary | Lead commissioner under S31 | Lead commissioner voluntary | Aligned budget S31 | Aligned voluntary | % Children's Trusts reporting |
|---|---|---|---|---|---|---|---|---|---|
| **CAMHS** | 4% | 20% | 7% | 57% | 7% | 44% | 5% | 37% | 93% |
| **Disability** | 11% | 15% | 8% | 54% | 5% | 31% | 2% | 42% | 92% |
| **Substance misuse** | 5% | 24% | 8% | 47% | 8% | 49% | 1% | 38% | 78% |
| **Youth offending** | 3% | 28% | 3% | 67% | 6% | 30% | 1% | 36% | 68% |
| **Looked after children** | 6% | 12% | 6% | 59% | 6% | 28% | 1% | 34% | 67% |
| **Complex & continuing care** | 11% | 11% | 7% | 42% | 7% | 28% | 4% | 47% | 56% |
| **Family support** | 2% | 13% | 5% | 55% | 4% | 41% | 2% | 45% | 55% |
| **Targeted youth support** |  | 17% | 2% | 60% | 2% | 33% | 2% | 33% | 51% |
| **Public health / Inequalities** | 3% | 18% | 5% | 45% | 3% | 37% |  | 39% | 38% |
| **Palliative Care** |  | 13% | 4% | 35% | 4% | 48% | 4% | 39% | 23% |
| **Child Health Surveillance** | 5% | 10% | 10% | 35% | 10% | 40% | 5% | 20% | 20% |
| **Maternity** |  | 11% |  | 37% | 5% | 42% | 5% | 37% | 19% |
| **Hospital** |  | 8% |  | 15% | 8% | 46% |  | 46% | 13% |

## PCT children's lead

2.15    Within PCTs themselves, there were indications that the children's lead has become a less important role. All PCTs reported having a children's lead in place but in 2008 this role was shared with other responsibilities in 47% of PCTs compared to 40% in 2007 and the lead was held at director level in only 25% of PCTs compared to 42% in 2007. The proportion of children's lead directors who were members of the PCT board had also declined (Fig. 2.4).

**Fig. 2.4:  Seniority of PCT children's leads 2007 and 2008**
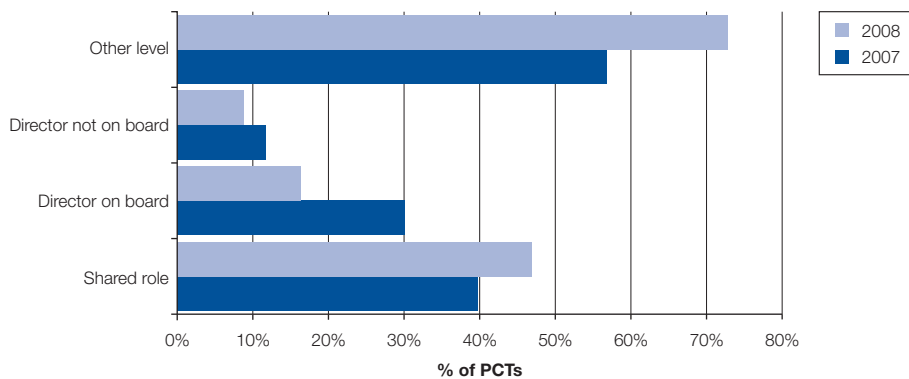


# Finance: An overview of expenditure on child health, CAMHS and maternity services

2.16    The finance mapping exercise aims to identify annual national expenditure on child health, CAMHS and maternity services, distinguishing investment in particular service categories and tracking changes in expenditure.  However, the identification of funding for children's health services remains difficult because:

- Contracts for children's health services can be wrapped up in a single service level agreement for all-age services and may not be specific about children's services
- The commissioning of health services remains in transition with the development of payment by results, practice-based commissioning and world class commissioning
- The development of joint commissioning with local authorities through Children's Trust arrangements adds complexity.

2.17    PCT spend and budget data covered staff, non-staff and a proportion of overhead costs but excluded capital costs.  Where PCTs were unable to disaggregate child health spend within the timeframe, they were asked to provide estimates and to indicate where estimates had been used.

## Total expenditure

2.18    In 2007/8, the total reported PCT expenditure on child health, CAMHS and maternity services was £5,123M, an increase of 4% on the £4,913M reported in 2006/7.  As in previous years, the 2007/8 spend should be regarded as an indicative figure only.

## Spend by service categories

2.19    Out of a total reported expenditure of £5,123M in 2007/8, £1,733M (35%) was spent on maternity services, £1,679M (33%) on children's hospital services, £1,078M (22%) on child health services in the community (including universal and targeted services)and £415M on CAMHS (8%) (Fig. 2.5).  In addition, £52M was invested in other child health services including teenage pregnancy services, drug and alcohol services, safeguarding services and a range of disability services that were classified under social care, education support and youth services (see Appendix 3 for full classification).

**Fig. 2.5: Reported PCT expenditure on child health, CAMHS and maternity services by service category 2007/8 (N=£5,123M)**



- Child health in the community
- Children's hospital services
- Maternity and neonatal care services
- Specialist CAMHS
- Children's social services
- Other children's services
- Individual care
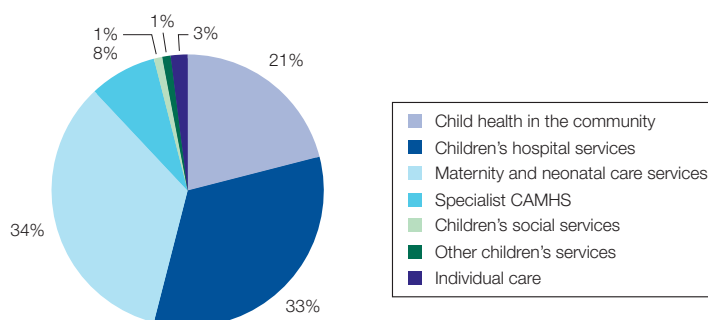
2.20 The largest reported growth in expenditure was in children's hospital services that increased by 9% from £1,538M in 2006/7 to £1,679M in 2007/8. Expenditure on maternity and neonatal services increased from £1,654M in 2006/7 to £1.733M, growth of 5% (Fig. 2.6). Spending on the range of child health services in the community increased 1% from £1,166M in 2006/7 to £1,175M in 2007/8. Expenditure on CAMHS and individual care both showed a decline and are discussed below.

**Fig. 2.6: PCT spend on child health, CAMHS and maternity service by service category 2004/5 to 2007/8**
*Note: Spend in neonatal care was included with children's hospital services in 2004/5.*
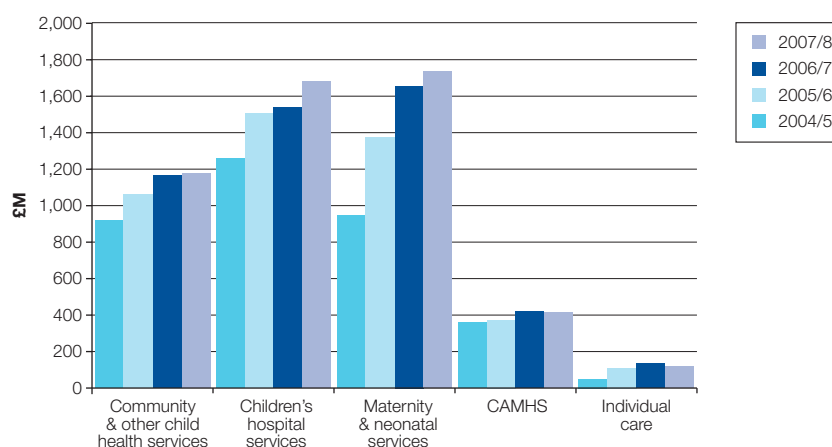


## Spend per child on children's health services

2.21 The national PCT child health spend per child of the population aged 0 to 17 years of age was £257 in 2007/8 compared to £245 in 2006/7 and £232 in 2005/6, an increase of 5%. The inter-quartile range for PCT spend per child in 2007/8 was £177 to £356 compared to a range of £196 to £331 in 2006/7 and £180 to £322 in 2005/6. Part of the explanation for the extension in the inter-quartile range in 2007/8 was variations in response rates year-on-year. The variation was evident in average spend per child for SHAs which ranged from £155 to £372 and saw sharp declines in spend per child in two SHAs (Fig. 2.7).

**Fig. 2.7: PCT spend per child aged 0 to 17 on child health services 2005/6 and 2007/8**
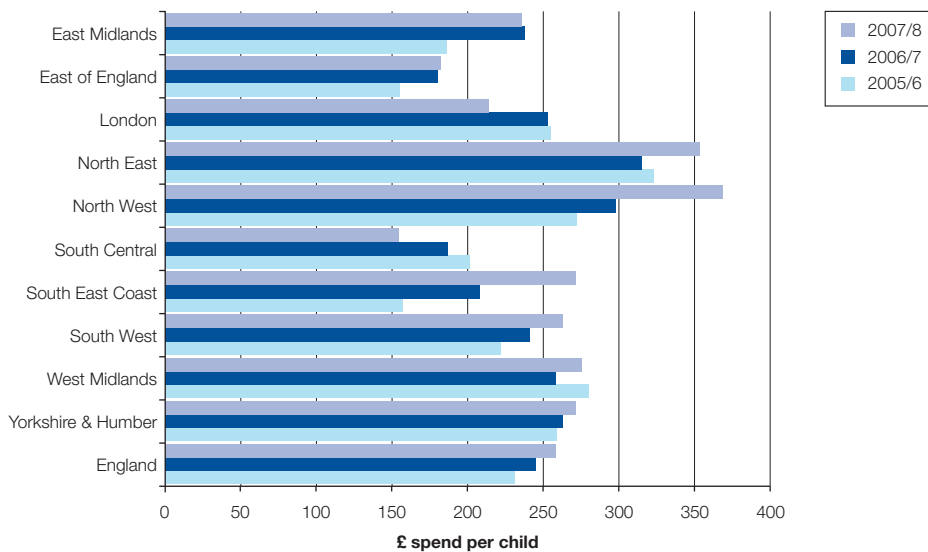


## Spend per birth on maternity services

2.22    The total reported spend on maternity services in 2007/8 was £1,234M and the number of births was 638,799 giving an average spend per birth of £1,932.  However, this was a reduction on the £2,057 spend per birth reported in 2006/7.  The cause of the reduction was that only 82% of PCTs disaggregated their expenditure on maternity services in 2008 compared to 96% in 2007.

## CAMHS expenditure

2.23    Reported expenditure on CAMHS tiers 2-4 (see Appendix 5) in 2007/8 was £415M.  This was a 1% reduction on the £419M reported in 2006/7.  The average spend per child of the resident population aged 0 to 17 on CAMHS in 2007/8 was £39.1 (inter-quartile range £29 to £53).

**Fig. 2.8: Trends in PCT CAMHS commissioning spend and budget 2002/3 to 2008/9**
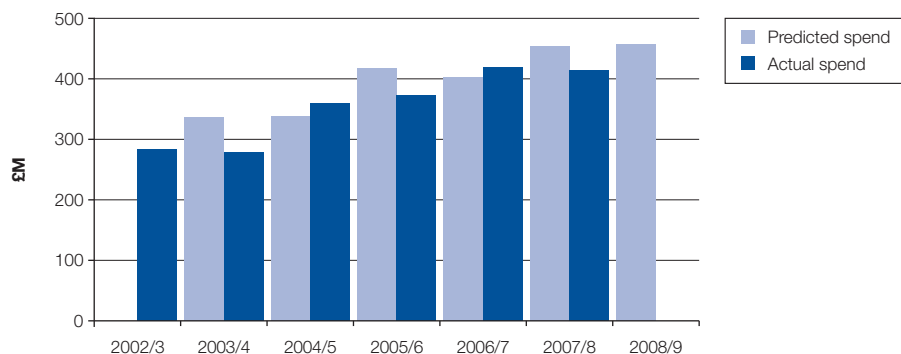
## Individual care expenditure

2.24 Expenditure on individual care packages, often termed 'spot' purchasing was £120M in 2007/8 compared to £136M in 2006/7 and £110M in 2005/6. 32% of this expenditure in 2007/8 was not disaggregated to indicate the purpose of the spend, often because it supported children and young people whose needs crossed a number of categories. Of the remaining 68% of spend, 29% (£35M) was spent on CAMHS, 25% (£29M) on the care and treatment of children who are disabled, have complex needs or require palliative care and 10% (£12M) on children who are ill or have long term conditions (Fig. 2.9).

**Fig. 2.9: PCT spend on individual care by key service area 2007/8 (N=£120M)**
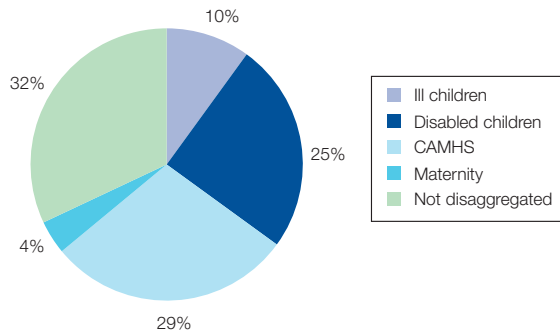


2.25 There was considerable variation in the distribution of spending on individual care by SHA, especially in expenditure on CAMHS (Fig. 2.10).

**Fig. 2.10: PCT spend on individual care on key services areas by SHA 2007/8 (N=£120M)**
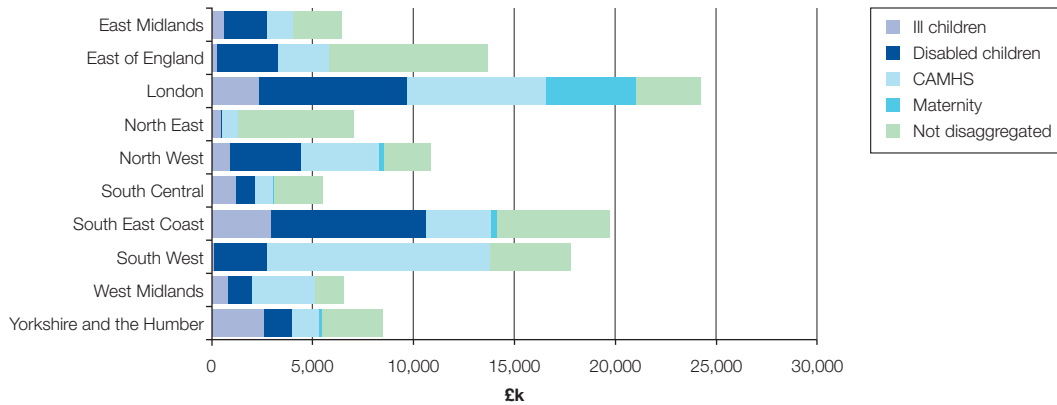
# Chapter 3.

# Children's workforce

# Introduction

3.1     This section explores the workforce of child health, CAMHS and maternity services, looking in particular at their professional make-up and the distribution of professional staff across different service categories.

3.2     The collection of workforce information is not a primary aim of the CSM exercise but as staffing is an important indicator of the capacity and capability of services, the mapping exercise has been recognised as a means of linking information on skill mix to the type of service being provided, its location and the delivery of policy drivers. However, only general workforce data is collected, without details such as staff grades and qualifications, in order to reduce the burden of data collection and to ensure the information is appropriate for open access reporting on the CSM website. Care is also taken not to duplicate data collected in other related workforce censuses.

3.3     The findings are reported as follows:

- Workforce definitions and data issues
- Summary of the children's workforce
  - Trends in the distribution of staff
  - Trends in professional staff
- Medical workforce
- Nursing workforce
- Allied health professionals
- Maternity workforce
- CAMHS workforce
  - Professionals in the CAMHS workforce
  - CAMHS care staff

3.4     For details of the completion rates of the mapping exercise, please refer to Appendix 1. Detailed tables of the data can be found and downloaded from www.childrensmapping.org.uk/reports.

# Workforce definitions and data issues

3.5     Each service is asked to record the number of staff in post on 30th November. Bank staff and other temporary staff who are filling funded posts are included. Locums who are temporarily replacing members of staff who are still in post are excluded, as are unsalaried trainees. Staff are counted in terms of whole time equivalent (wte) and headcount but only wte are reported here.

3.6     To capture the interdisciplinary nature of services, staff numbers are recorded by professional group but it is the profession required by the post that should be recorded rather than the professional background of the post-holder. For example, a full-time manager who is a fully qualified children's nurse would be recorded as a manager unless the post requires a nurse qualification and experience. Similarly, staff whose time is split between more than one post, or type of activity, should have their time apportioned accordingly. For example, a manager who works as a half-time manager and half-time nurse with clinical duties should be recorded as 0.5 wte manager and 0.5 wte nurse.

3.7     Services are also asked to apportion staff time appropriately when they work across services or units. This is particularly relevant for specialist medical, nursing and therapy staff contributing to more than one service/team on a sessional basis. Only the sessional input to a service should be counted but it has taken time for this to be understood by the many participants in the mapping exercise.

3.8    Another difficulty that has arisen in defining the child health workforce has been the identification of
       dedicated children's services.  Health professionals who work with children as part of an all-age service
       should not be included in the mapping exercise but this distinction can be difficult in services such as
       emergency departments, which have a separate environment and pathway of care for children, but not
       necessarily a separate children's staff team.

3.9    Initially a classification of staff categories/professional groups was developed for the CAMHS, child health
       and maternity workforce but with the extension of the mapping exercise to include all services that fall under
       the responsibility of Children's Trusts, a new classification has been developed against which the integrated
       children's workforce can be mapped.  This has been developed in collaboration with DCSF, the Children's
       Workforce Development Council and the Local Government Association (LGA).  It has also contributed to
       standards being set for workforce data collections involving local authorities[12] and has been reviewed
       against the DCSF 2020 Children and Young People's Workforce Strategy[13] proposals.  The integrated
       children's workforce classification is used to identify staff groups in this chapter.

3.10   Another impact of the move to an integrated CSM exercise has been the need to consider the spectrum of
       children's services in a new classification of service types (Para. 1.13) and to enable interagency working to
       be recorded.  As a result, health professionals are found to be working in a range of services that are not
       classified as traditional 'health' services and which were new to the CSM exercise in 2008.  For example,
       safeguarding services have been classified under social care services, drug and alcohol services under
       youth services and children's community services can be found recorded with children's centres.
       Consequently, year-on-year trends in staffing that have been reported in previous annual reports have been
       disrupted and should be read with caution.

## Summary of the children's workforce

### Trends in the distribution of staff

3.11   The child health, CAMHS and maternity service workforce was 122,422 wte in 2008, a 2% increase from
       120,397 wte reported in 2007.  The workforce of children's hospital services increased by 5% to 38,055
       wte but a 1% fall was recorded in the maternity and neonatal services workforce and a 2% fall in the
       CAMHS workforce (Fig. 3.1).  The largest fall was recorded in child health services in the community but this
       was expected because of classification changes.  The workforce in this category fell by 2,348 wte (6%)
       between 2007 and 2008 but the health workforce recorded in other services, such as social care, youth
       services and children's centres was 2,986 wte giving an overall increase of 638 wte.

Fig. 3.1:  Trends in child health, CAMHS and maternity workforce 2005 to 2008
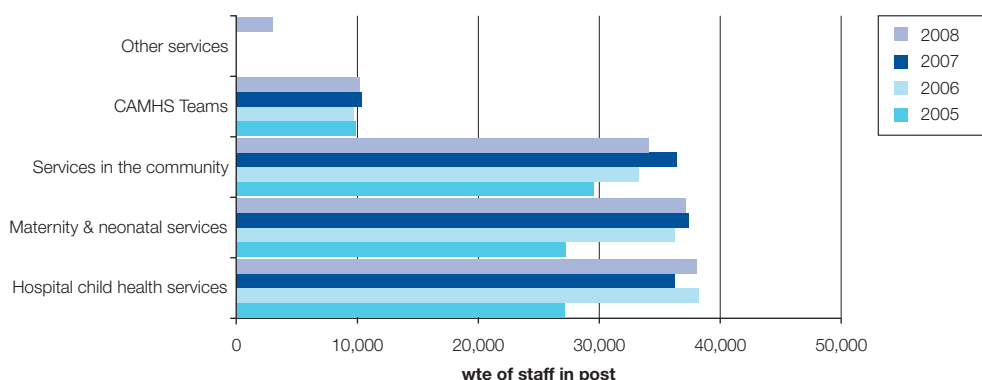
## Trends in professional staff

3.12   Changes in the way health staff were mapped across integrated children's services had an impact on the traditional health professional workforce (Fig. 3.2 and Table 3.1).  The nursing workforce reduced by 2% from 42,393 wte in 2007 to 41,356 wte in 2008.  The number of midwives fell 1% from 19,648 wte in 2007 to 19,397 in 2008.  The allied health professional workforce rose 6% from 10,162 wte in 2007 to 10,895 wte in 2007 and support workers went down 11% from 15,226 wte in 2007 to 13,518 wte in 2008.  At the same time the medical workforce rose 19% to 17,736 wte almost restoring the number of doctors recorded in 2006.

**Fig. 3.2:   Trends in child health, CAMHS and maternity services workforce by key professional groups 2005 to 2008 (wte staff in post)** *(Note: * =classification change)*
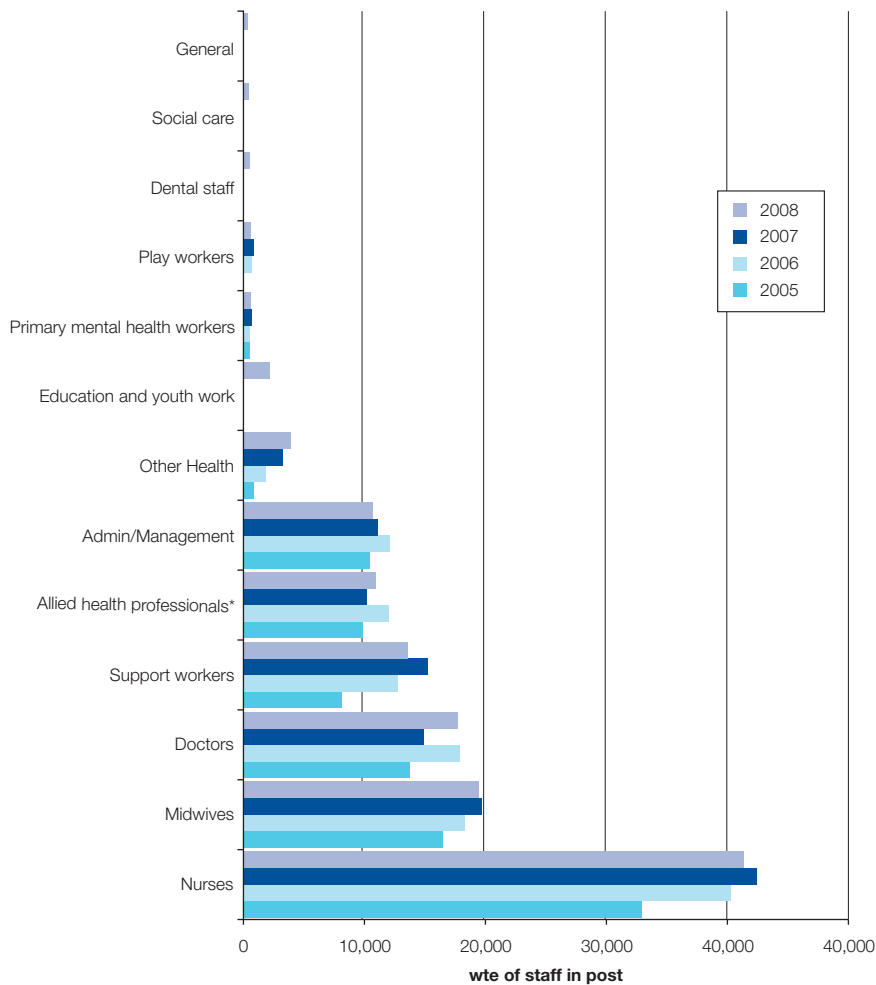


3.13   Alongside these changes new categories of workers were recorded including: 521 wte dental staff; 411 wte social care staff; 2,060 wte nursery nurses; and 3,860 wte 'other' health staff.  The numbers classified as 'other' had increased by 20% and fell into two categories.  First it included staff who wanted to record their specialty, for example, safeguarding nurses seemed reluctant to be classed as a 'nurse'.  Secondly, staff used the 'other health' category rather than be classified as a social care or education professional.

**Table 3.1:  Changes in selected professional groups 2006 to 2008 (wte staff in post)**

| Service category | Medical | | | Nursing | | | Allied health professionals | | | Support workers | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 |
| Hospital | 10,282 | 8,163 | 10359 | 17,403 | 18,180 | 18160 | n/a | 1,681 | 2,002 | 2,881 | 3,231 | 3,027 |
| Maternity | 5,112 | 4,249 | 4984 | 5,139 | 5,849 | 5423 | n/a | 402 | 301 | 4,967 | 5,887 | 5099 |
| Community | 1,374 | 1,268 | 1,160 | 15,013 | 16,045 | 14,456 | n/a | 5,969 | 6,309 | 4,512 | 5,477 | 392 |
| CAMHS | 1,064 | 1,145 | 1076 | 2,685 | 2,286 | 2347 | n/a | 2,106 | 2156 | 400 | 616 | 1080 |
| Other/not assigned | | 27 | 157 | | 33 | 969 | | 5 | 127 | | 15 | 390 |
| All categories | 17,832 | 14,852 | 17736 | 40,240 | 42,393 | 41356 | n/a | 10,163 | 10895 | 12,760 | 15,226 | 13,518 |

| Change | Medical | | | Nursing | | | Allied health professionals | | | Support workers | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service category | 2006 to 2007 | 2007 to 2008 | % Change | 2006 to 2007 | 2007 to 2008 | % Change | 2006 to 2007 | 2007 to 2008 | % Change | 2006 to 2007 | 2007 to 2008 | % Change |
| Hospital | -2119 | 2196 | 27% | 777 | -20 | 0% | | 321 | 19% | 350 | -204 | -6% |
| Maternity | -863 | 735 | 17% | 710 | -426 | -7% | | -101 | -25% | 920 | -788 | -13% |
| Community | -106 | -108 | -9% | 603 | -1589 | -10% | | 340 | 6% | 566 | -5085 | -93% |
| CAMHS | 81 | -69 | -6% | -399 | 61 | 3% | | 50 | 2% | 616 | 464 | 75% |
| Other/not assigned | | 130 | - | | 936 | | | 122 | | | 375 | |
| All categories | -2980 | 2884 | 19% | 2,153 | -1037 | -2% | n/a | 732 | 7% | 2,866 | -1708 | -11% |

## Medical workforce

3.14    Four categories of medical staff were identified in the mapping exercise.  In 2008, of the 17,736 wte doctors, 6,720 wte were consultants (38%), 2,281 wte career grade doctors (13%) and 8,678 wte trainees (49%) (Fig. 3.3).  In addition there were 57 wte GPs with a special interest in paediatrics (the only GP specialism included).  The recorded increase in all grades of doctor is set out in Table 3.2 and the rise is largely due to improved data capture in the mapping exercise as a lot of effort was made to achieve accurate data after the disappointing data returns the previous year.

**Fig. 3.3: Type of doctors in the workforce 2008 (N=17,736 wte)**



- Consultant
- Non-consultant Career Grades (NCCG)
- Trainee
- GP with special interest in paediatrics
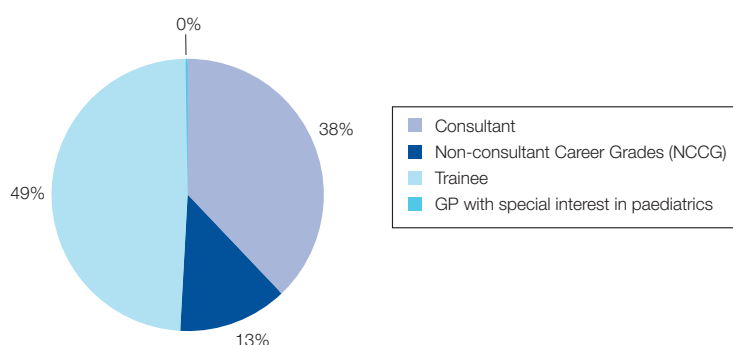
**Table 3.2: Changes in the employment of medical staff in child health, CAMHS and maternity**

| Service category | Consultant | | | Non-consultant Career Grades | | | Trainee | | | All medical staff | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 |
| Hospital | 3,750 | 2,877 | 3,874 | 1,715 | 923 | 1104 | 4,804 | 4,344 | 5365 | 10,282 | 8,163 | 10359 |
| Maternity | 1,513 | 1,333 | 1,581 | 806 | 431 | 507 | 2,790 | 2,480 | 2882 | 5,112 | 4,249 | 4985 |
| Community | 568 | 570 | 502 | 565 | 495 | 469 | 222 | 177 | 173 | 1374 | 1268 | 1160 |
| CAMHS | not asked | 668 | 666 | not asked | 179 | 157 | not asked | 295 | 252 | 1,064 | 1,145 | 1076 |
| Other/not assigned | | 6 | 97 | | 2 | 44 | | 19 | 6 | | 27 | 157 |
| All categories | | 5,454 | 6,720 | | 2,030 | 2,281 | | 7,316 | 8678 | 17,832 | 14,852 | 17736 |

| Change | Consultant | | | Non-consultant Career Grades | | | Trainee | | | All medical staff | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service category | 2006 to 2007 | 2007 to 2008 | % Change | 2006 to 2007 | 2007 to 2008 | % Change | 2006 to 2007 | 2007 to 2008 | % Change | 2006 to 2007 | 2007 to 2008 | % Change |
| Hospital | -873 | 997 | 35% | -792 | 181 | 20% | -460 | 1021 | 24% | -2119 | 2196 | 27% |
| Maternity | -180 | 248 | 19% | -375 | 76 | 18% | -310 | 402 | 16% | -863 | 736 | 17% |
| Community | 2 | -70 | -12% | -70 | -26 | -5% | -45 | -4 | -2% | -106 | -108 | -9% |
| CAMHS | | 91 | 14% | | -22 | -12% | | -43 | -15% | 81 | -69 | -6% |
| Other/not assigned | | 91 | | | 42 | | | -13 | | 27 | 130 | |
| All categories | | 1266 | 23% | | 251 | 12% | | 1362 | 19% | -2980 | 2884 | 19% |

3.15    Overall in 2008, 58% of doctors worked in children's hospital services, 28% in maternity services and 7% in children's health services in the community. 6% of doctors worked in CAMHS. Hospital services employed 58% of consultants (3,874 wte), 48% of career grade doctors (1104 wte) and 62% of trainees (5,365 wte). Maternity services employed 24% of consultants (1,581 wte), 22% of career grade doctors (507 wte) and 33% of trainees (2,882 wte).

3.16    In 2008, in CAMHS there were 666 wte consultant psychiatrists (10% of the consultant workforce) and 157 wte career grade doctors (7%). CAMHS also employed 252 wte trainee doctors (3% of the trainee workforce) and 2 wte GPs. This workforce had declined slightly between 2007 and 2008.
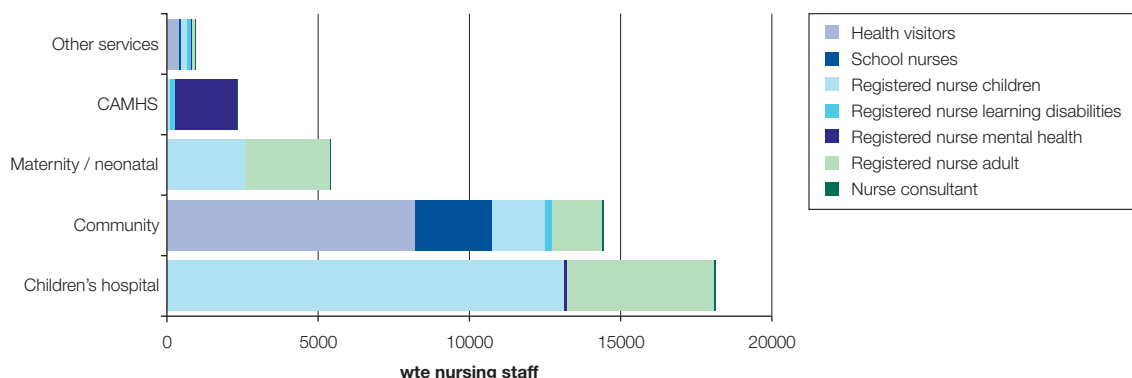
## Nursing workforce

3.17    In 2008, the nursing workforce (excluding midwives) in child health, CAMHS and maternity services was made up of 17,733 wte registered children's nurses (43%), 8,657 wte health visitors (21%), 9,386 wte registered adult nurses (23%), 2,690 wte school nurses (7%) and 2,182 wte (5%) registered mental health nurses (including community psychiatric nurses). Also 556 wte registered learning disability nurses made up 1% of the workforce (Fig. 3.4). However, it should be noted that no definitions were given for these categories of nurses beyond guidance that school nurses should include nurses registered as Specialist Public Health Practitioners – School Nursing.

**Fig. 3.4: Type of nurses in the child health, CAMHS and maternity services workforce 2008 (N=41,356 wte)**
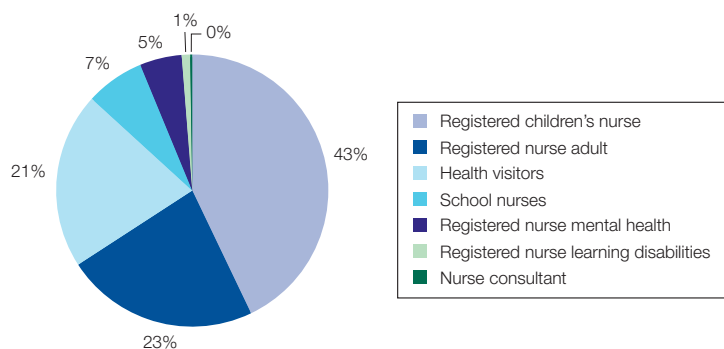


3.18    Children's hospital services employed 44% of the nursing workforce (18,160 wte), made up principally of registered children's nurses (13,073 wte) and registered adult nurses (4,867 wte) (Fig. 3.5). Children's health services in the community accounted for 35% of the nursing workforce (14,456 wte) and they employed 95% of health visitors (8,209 wte) and 95% of qualified school nurses (2,564 wte). Maternity and neonatal services accounted for 13% of nursing staff (5,424 wte), employing 30% of adult nurses (2,777 wte) and 15% of registered children's nurses (2,627 wte). Nurse consultants were distributed throughout all types of services.

3.19    CAMHS employed 6% of the nursing workforce but 92% of registered mental health nurses (2,016 wte) and 34% of registered nurses for learning disabilities (189 wte).

**Fig. 3.5:  Distribution of nursing workforce 2008 (N=42,393 wte)**



Legend:
- Health visitors
- School nurses
- Registered nurse children
- Registered nurse learning disabilities
- Registered nurse mental health
- Registered nurse adult
- Nurse consultant

Categories (y-axis): Other services, CAMHS, Maternity / neonatal, Community, Children's hospital

x-axis: wte nursing staff (0, 5000, 10000, 15000, 20000)

## Allied health professionals

3.20    In 2008, the child health, CAMHS and maternity services workforce included 10,895 wte allied health professionals.  This was an increase of 7% on the 2007 workforce but comparisons prior to 2007 are difficult as classification changes were introduced in 2008 to restrict allied health professionals to qualified staff only.  Assistants or unqualified staff were moved to the support worker/assistant category.

3.21    The number of speech and language therapists increased from 3,327 wte  in 2007 to 3,614 wte in 2008, an increase of 9% (Fig. 3.6).  1,677 wte were physiotherapists, up from 1,599 wte in 2007 an increase of 5%. The number of occupational therapists rose 19%, from 1,051 wte in 2007 to 1,255 wte in 2008.

3.22    The clinical psychology workforce rose by 10% from 1,295 wte in 2007 to 1,419 wte in 2008.  The number of family therapists rose by 2% to 333 wte and child and family psychotherapists by 7% to 309 wte.  The number of counsellors fell by 20% to 136 wte.

3.23    Services recorded 470 wte radiographers, 381 wte dieticians (a reduction of 4%), 485 wte operating department practitioners (an increase of 26%), 365 wte audiologists (an increase of 15%), 75 wte podiatrists (a decrease of over 50%), 174 wte orthoptists  (up 8%) and 130 wte art, music and drama therapists.

**Fig. 3.6: Allied health professional workforce 2007 and 2008**
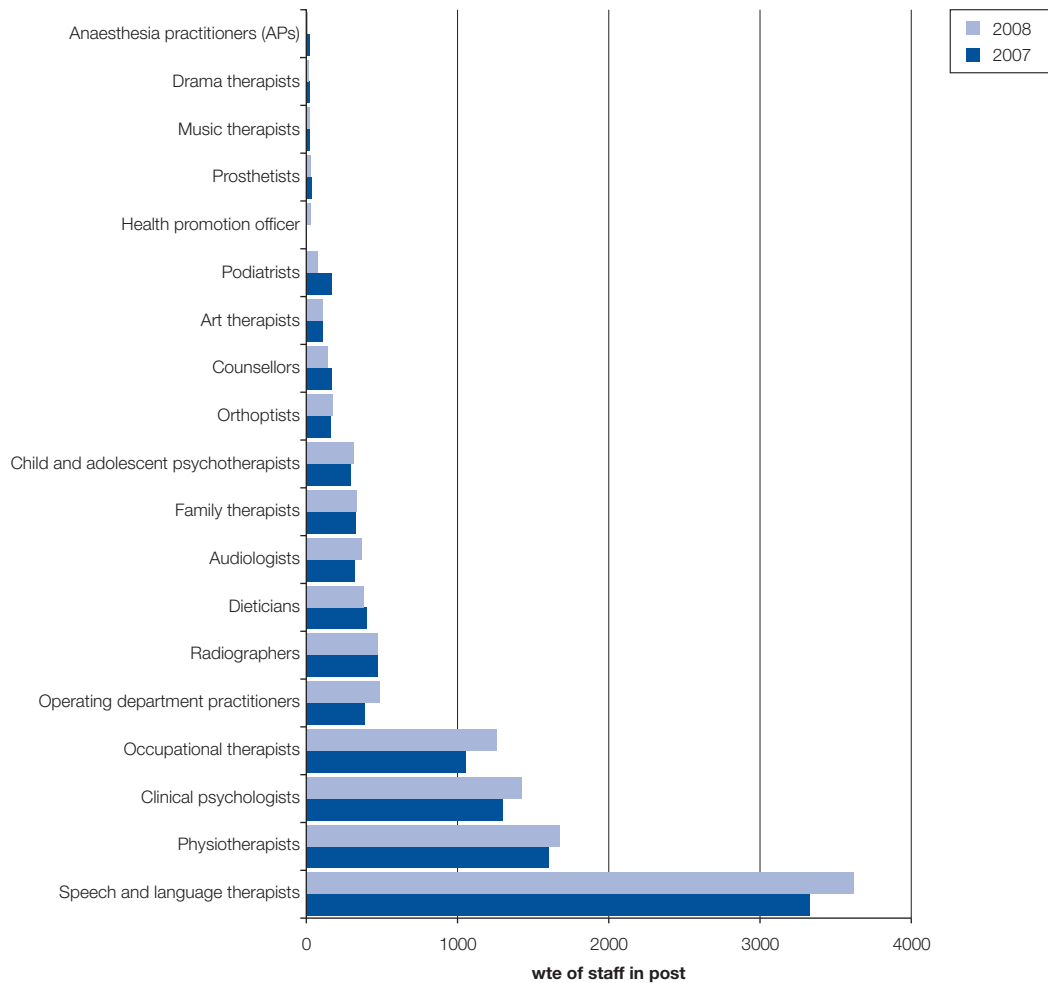


3.24  The majority (58%) of allied health professionals worked in a range of children's therapy and other targeted services working in the community (Fig. 3.7). 20% worked in CAMHS, 18% in children's hospital services and 3% in neonatal and maternity services.

**Fig. 3.7: Distribution of allied health professionals by category of services 2008 (N=10,895 wte)**
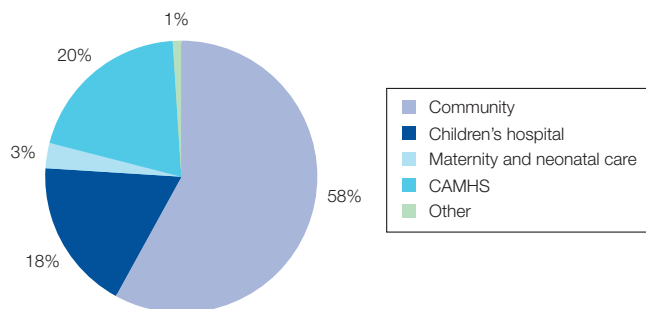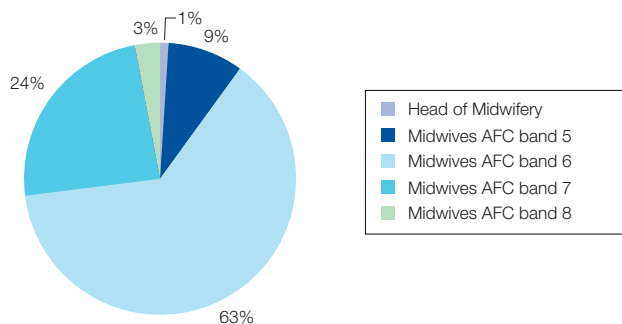
# Maternity workforce

3.25   In 2008, the midwifery workforce was 19,204 wte, a 1% decrease on 19,458 wte recorded in 2007.  The number of maternity support workers also declined from 3,322 wte in 2007 to 3,060 wte in 2008, a fall of 8% (Table 3.3).  The majority (63%) of midwives were employed on Agenda for Change band 6 (Fig. 3.8), 24% were on band 7 and 3% on band 8.

**Table 3.3:  Maternity workforce by service type 2007 and 2008**

| Service category | Head of midwifery | | Midwives | | Maternity support workers | |
|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2007 | 2008 | 2007 | 2008 |
| Maternity and neonatal services | 177 | 164 | 18,757 | 18812 | 3,171 | 2926 |
| Hospital services | 4 | 3 | 568 | 331 | 103 | 97 |
| Children's community team | 9.5 | 1 | 133 | 14 | 48 | 37 |
| Other | | 5 | | 47 | | |
| **Total** | 191 | 173 | 19,458 | 19,204 | 3,322 | 3,060 |

| Change | Head of midwifery | | Midwives | | Maternity support workers | |
|---|---|---|---|---|---|---|
| | 2007 to 2008 | % Change | 2007 | % Change | 2007 | % Change |
| Maternity and neonatal services | -13 | -7% | 55 | 0% | -245 | -8% |
| Hospital services | -1 | | -237 | -42% | -6 | -6% |
| Children's community team | -8.5 | | -119 | | -11 | |
| Other | 5 | | 47 | | | |
| **Total** | -18 | -9% | -254 | -1% | -262 | -8% |

**Fig. 3.8:  Pecentage of midwives on Agenda for Change banding 5 to 8 in 2008 (N=19,205)**



Legend:
- Head of Midwifery
- Midwives AFC band 5
- Midwives AFC band 6
- Midwives AFC band 7
- Midwives AFC band 8

# CAMHS workforce

## Professionals in the CAMHS workforce

3.26 CAMHS were staffed by a wide range of professionals in order to meet the diverse and specialist needs of children and young people with mental health problems and disorders (Fig. 3.9).  Nurses were the largest professional group in CAMHS, accounting for 23% of the workforce in 2008 (22% in 2007 and 28% in 2006).  The largest other professional groups were: administrators (14% in 2008, 15% in 2007); clinical psychologists (12% in 2008 and 2007); and doctors (10% in 2008, 11% in 2007).  Other staff groups made up a further 21% of the CAMHS workforce but this included other qualified staff ranging from qualified therapists to unqualified staff such as support workers and assistants.

**Fig. 3.9:   Total CAMHS workforce by profession 2008 (N=10,340 wte)**
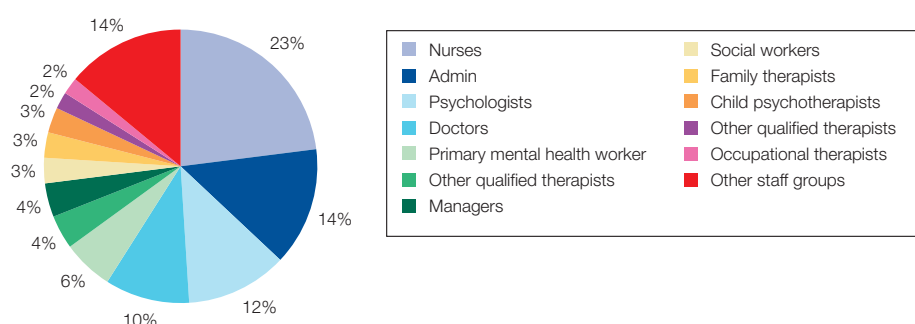


3.27 Whilst the CAMHS workforce has increased substantially since 2003, the growth has been variable amongst professional groups (Fig. 3.10).  However, some of the trends have been affected by the changes to the classification described above.  For example, primary mental health workers were first mapped separately in 2004 and family therapists in 2005.  The principal changes in 2008 were as follows:

- The nurse workforce increased 2% between 2007 and 2008 from 2,286 wte to 2,337 wte

- Administrator posts  declined from 1,563 wte in 2007 to 1,404 wte in 2008, a reduction of 10%, the first reported reduction in this group since they were first mapped in 2003

- The number of doctors fell from 1,145 wte in 2007 to 1,076 wte in 2008, a 6% reduction taking the workforce back to its 2006 size.

- There was a 28% increase in managers from 315 wte in 2007 to 403 wte in 2008 but the managerial workforce has shown considerable fluctuations due in part to the difficulties in accurately apportioning managerial and clinical duties as community staff tend to hold both roles.

- The number of social workers working in CAMHS teams reduced sharply from 657 wte in 2007 to 362 wte in 2008.  The reason for this was the integration of the children's services mapping exercise to cover local authorities.  Prior to this, CAMHS teams were mapped by CAMHS partnerships that included local authorities, but in 2008, local authorities were invited to map services themselves.  This led to a number of changes, one of which was the development of a new workforce classification encompassing the integrated children's workforce.  Another change was health trusts ceasing to map the social work workforce that provided specialist CAMHS services.

**Fig. 3.10: Trends in the CAMHS workforce by profession 2003 to 2008**
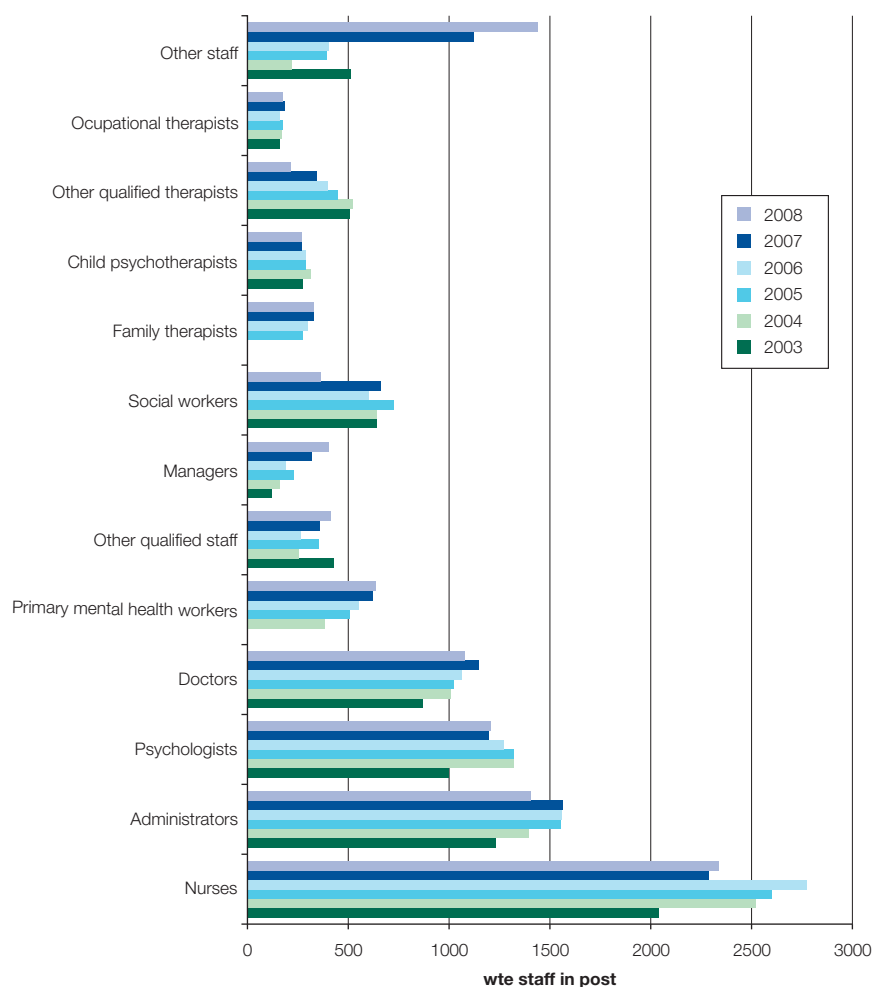


**CAMHS care staff**

3.28  Care staff are defined as all qualified and unqualified staff in post, excluding staff within the following three categories: Facilities and Support Management, General Services, and Administrative/Management.  The NSF sets out guidelines for levels of staffing in tier 3 CAMHS provision.  These propose that generic specialist multidisciplinary CAMHS at tier 3 with teaching responsibilities and providing evidence-based interventions 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[14].  However, it is acknowledged that it is not straightforward to estimate the numbers of care staff needed for viable multidisciplinary 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.

3.29  No specific tier 3 service data are collected in the mapping as the original pilot study found that teams operated across tiers and within broad team types.  Therefore local teams have been used as a proxy for tier 3 services as many deliver elements of tier 3 and deliver to a defined local population.  Counting care staff only, the number of staff per 100k population in local CAMHS teams was 11.5 wte in 2008.  A large degree of variation remains across SHA area, ranging from  and 8.6 to 16.0 wte in 2008 (see Fig. 3.11).

**Fig. 3.11: Care staff in local teams per 100k total population for comparison with NSF estimates of tier 3 requirements 2008**



wte to 100k population
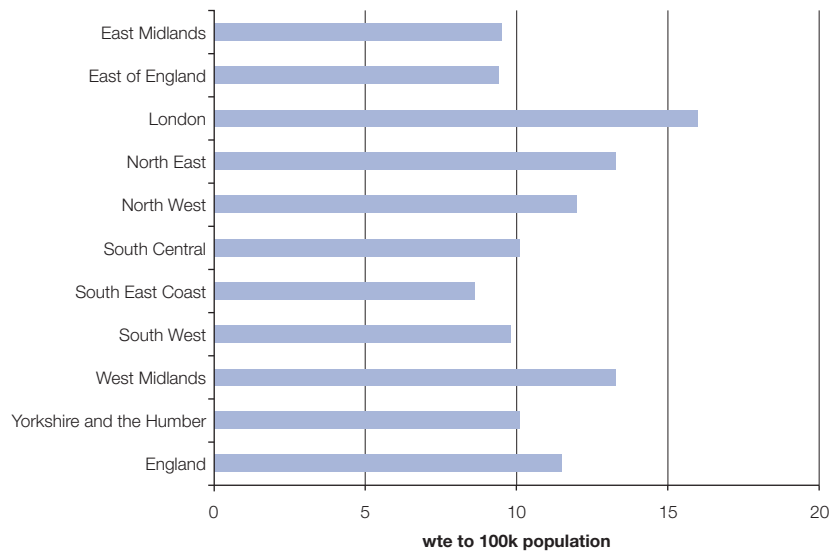
# Chapter 4.

# Service overview

# Introduction

4.1　This section provides an overview of the services reported in the 2008 mapping exercise.  It sets the scene for the following sections which provide a focus on specific service provision.  It reports responses to a series of questions that were asked of all services for the first time in 2007 about who services were designed to support, how services are targeted, which Every Child Matters outcomes services were set up to achieve and whether children, young people and their families were involved in planning, delivery and providing feedback on the services that they used.

4.2　The mapping findings reported in this section are as follows:

- Overview of child health, CAMHS and maternity services
    - Trends in the number of services mapped
    - Age range accepted in services
    - Targeting vulnerable groups

- Achievement of Every Child Matter outcomes

- Information and involvement
    - Involvement in service design
    - Collecting feedback from users of services
    - Publication of information about services.

4.3　In this chapter, the data is reported at a national level only.  Detailed tables of the data used can be found and downloaded from the mapping website at: www.childrensmapping.org.uk/reports.

# Overview of child health, CAMHS and maternity services

## Trends in the number of services mapped

4.4　In 2008, a new more comprehensive classification of services was developed (Appendix  3 ) resulting in a series of changes to the previous year's health categories.  These included:

- Universal and targeted services were merged to create a category of child health services in the community.  This followed analysis of the provision of targeted services in 2007 which showed that a large proportion of services were provided by teams of school nurses or health visitors who also provided universal services.
- New types of services were added, such as, palliative care, continence services, children's community nursing teams, equipment and wheelchair services and community dentistry.
- Services for disabled children and children in special circumstances were removed recognising that many services deliver some targeted provision and specialist care for children and young people with a disability or complex health needs, but this may not be the only function that they provide.  (See section 11 for further explanation)

4.5　As a result of these changes, trends in child health, CAMHS and maternity service provision over the four years of the mapping exercise should be read with caution.  The total number of services recorded increased from 4,813 in 2007 to 4,842 in 2008 and of these 9% fell into non-health categories.  The number of maternity services increased by 9% (due to changes in the way units were recorded – see

section 14). Children's hospital services increased by 4% and the number of CAMHS teams fell by 4% (Fig. 4.1). Child health in the community services decreased by 17% despite the introduction of new service types in this category (Fig. 4.2) but the drop was largely due to the reclassification of disability services and child health services falling within social care, education support and youth service classifications (Table 4.1).

**Fig. 4.1: Trends in the number of children's health, CAMHS and maternity services 2005 to 2008**
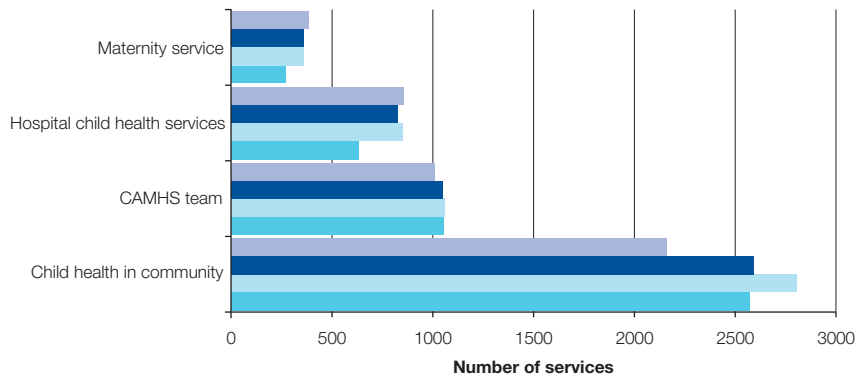


**Fig. 4.2: Child health services in the community 2008 (N=2157)**
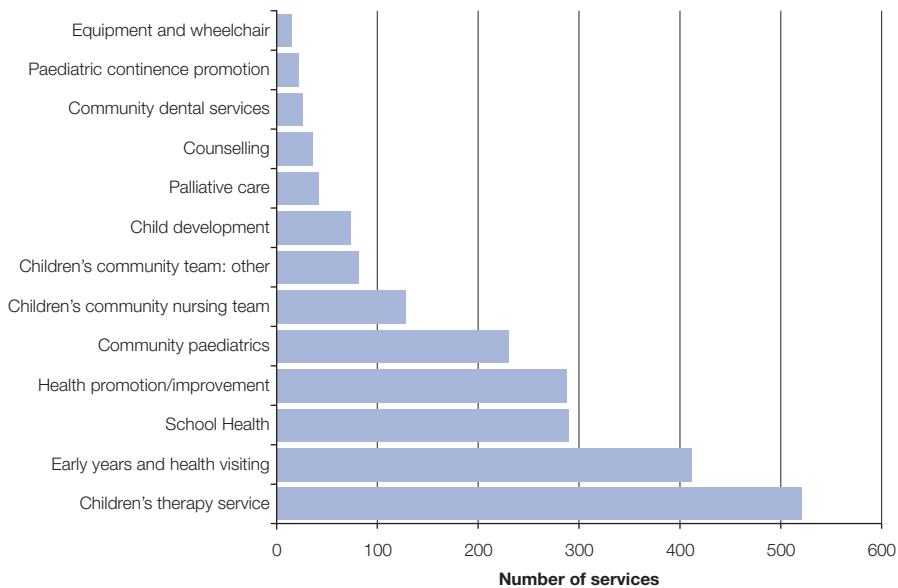
**Table 4.1: NHS child health services classified under social care, education support and youth services 2008 (N=407)**

| Type of service | Number of services |
| --- | --- |
| Safeguarding children service | 268 |
| Fostering and adoption | 8 |
| Social work team | 1 |
| Residential care and children's accommodation | 3 |
| Short Breaks | 19 |
| Family support | 3 |
| Parenting support | 2 |
| Young people's support | 4 |
| Day care | 1 |
| Sure Start Children's Centre/child care support | 7 |
| Education support | 13 |
| Youth services | 45 |
| Central support | 33 |

4.6    In the 2008 mapping exercise, 19% of services reported a change in the way the service had been recorded.  Of these:
- 132 services (3%) were newly resourced during 2008
- 279 services (6%) were new to mapping having not been mapped previously as no suitable service category was available
- 268 services (6%) had been mapped before but had been reconfigured during the previous 12 months
- 236 services (5%) had been mapped previously but described differently.

### Age range accepted in services

4.7    Information about the age band of children and young people that services provide for was recorded by 4,768 services in 2008 (98% of all services mapped).  Of those services where age information was provided, 2,836 (60%) worked with newborn babies up to the age of 28 days.  3,450 services (72%) provided for pre-school aged children, 3,521 services (74%) were provided for primary school-aged children and 3,876 (81%) for children and adolescents up to the age of 15.  These were very similar proportions to those in 2007 (Fig. 4.3).  However, in 2008 considerable growth was reported in the proportion of services for young people over the age of 16.  The number of services for young people aged 16 and 17 increased by 8%, services for 18 year olds increased by 14% and services for 19 to 25 year olds increased by 23%. Services which provided for adults aged over 25 increased by 16% and these were usually services for parents and carers as well as for children and young people.

4.8    For the first time in 2008, services were asked if they targeted parents and/or other professionals and it was found that 1,138 services (24%) worked directly with parents and 750 (16%) worked with other

professionals, often supporting both. The services most commonly working with parents were children's centres, health visiting/early years services and paediatric continence services (Table 4.2).

**Fig. 4.3:    The age of children and young people that services work with 2007 and 2008**
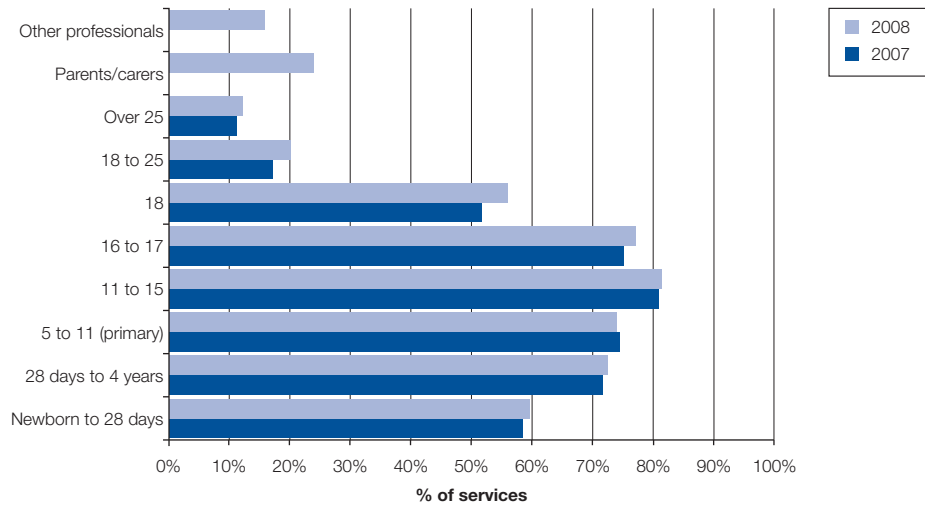
**Table 4.2:  The age bands of children and young people that services work with by service type 2008 (N=4,768)**

| Service Type | Newborn to 28 days | 28 days to 4 years | 5 to 11 (primary) | 11 to 15 | 16 to 17 | 18 | 19 to 25 | Over 25 | Parents/ carers | Other professionals |
|---|---|---|---|---|---|---|---|---|---|---|
| School health | 10% | 17% | 90% | 93% | 87% | 61% | 14% | 3% | 23% | 15% |
| Early years and health visiting | 91% | 96% | 29% | 27% | 34% | 33% | 20% | 17% | 48% | 17% |
| Children's therapy service | 70% | 94% | 96% | 95% | 88% | 72% | 18% | 8% | 25% | 24% |
| Counselling | 11% | 23% | 46% | 74% | 69% | 66% | 34% | 14% | 23% | 3% |
| Children's community nursing team | 77% | 97% | 97% | 97% | 95% | 77% | 13% | 2% | 27% | 20% |
| Community dental services | 35% | 85% | 85% | 85% | 81% | 77% | 73% | 73% | 31% | 23% |
| Palliative care | 54% | 78% | 93% | 95% | 95% | 88% | 15% | 10% | 12% | 12% |
| Paediatric continence promotion | 18% | 68% | 86% | 91% | 91% | 91% | 41% | 32% | 41% | 36% |
| Equipment & wheelchair | 21% | 93% | 93% | 93% | 93% | 79% | 64% | 64% | 21% | 21% |
| Child development teams | 55% | 99% | 62% | 48% | 45% | 36% | 5% | 1% | 14% | 11% |
| Health promotion/improvement | 52% | 66% | 71% | 85% | 81% | 68% | 36% | 21% | 22% | 20% |
| Community paediatrics | 69% | 80% | 80% | 91% | 90% | 77% | 29% | 9% | 16% | 10% |
| Other community team | 49% | 83% | 88% | 93% | 89% | 74% | 26% | 10% | 21% | 17% |
| Children's surgery | 37% | 92% | 97% | 97% | 83% | 49% | 22% | 20% | 7% | 1% |
| Specialist paediatric service | 81% | 94% | 94% | 93% | 82% | 52% | 19% | 9% | 21% | 8% |
| PICU | 89% | 100% | 100% | 100% | 81% | 30% | 4% |  | 11% | 4% |
| General paediatrics | 92% | 98% | 97% | 97% | 81% | 42% | 7% | 2% | 13% | 3% |
| Paediatric emergency service | 94% | 98% | 98% | 98% | 84% | 51% | 40% | 39% | 20% | 7% |
| Maternity unit | 96% | 7% | 1% | 52% | 65% | 65% | 65% | 65% | 38% | 6% |
| NICU | 98% | 61% |  | 1% | 1% | 1% | 1% | 1% | 14% | 2% |
| Multidisciplinary generic CAMHS team | 32% | 76% | 90% | 95% | 90% | 51% | 3% | 0% | 27% | 23% |
| Single disciplinary generic CAMHS team | 31% | 75% | 90% | 92% | 79% | 58% | 10% |  | 13% | 10% |
| Targeted CAMHS team | 22% | 57% | 77% | 91% | 88% | 54% | 12% | 4% | 24% | 23% |
| Dedicated CAMHS worker | 21% | 35% | 68% | 88% | 80% | 56% | 9% | 1% | 20% | 20% |
| Tier 4 CAMHS unit/team | 4% | 12% | 43% | 95% | 80% | 54% | 9% | 2% | 16% | 10% |
| Safeguarding children | 90% | 90% | 90% | 90% | 88% | 58% | 19% | 7% | 21% | 32% |
| Short Breaks | 37% | 68% | 95% | 95% | 100% | 79% |  |  | 5% |  |
| Sexual health |  |  | 6% | 94% | 94% | 89% | 83% | 22% | 11% | 6% |
| Teenage pregnancy | 18% |  | 9% | 100% | 100% | 91% | 36% |  | 9% | 18% |
| Drug and alcohol |  |  | 78% | 100% | 100% | 78% | 11% |  | 33% | 44% |
| Fostering and adoption | 88% | 100% | 100% | 100% | 88% | 75% | 38% |  | 25% | 25% |
| Sure Start Children's Centre | 83% | 100% | 33% | 17% | 33% | 33% | 33% | 33% | 83% | 17% |
| Youth offending |  |  | 33% | 83% | 83% | 67% | 17% |  | 17% | 17% |

**Key:**   80-100%   60-79%   40-59%   20-39%   1-19%

## Targeting vulnerable groups

4.9   In 2008, 1,399 services (29%) reported that they provided a dedicated service for one or more groups of vulnerable children and young people compared to 1,122 services (23%) in 2007. This was the second year the questions were asked and there was still evidence that services wanted to demonstrate that they were inclusive by listing as many vulnerable groups as possible instead of distinguishing where targeted services were provided. As a result the information remains unreliable but is nevertheless interesting as an indication of how children's health services contribute to the support of children and young people in particular circumstances. Disability services dominated, with 57% of services targeting children and young people with complex needs compared to 45% in 2007. 60% of services provided for learning disabilities, up from 40% in 2007, 44% of services targeted physical disability, up from 33% in 2007 and 43% of services targeted children with special educational needs (SEN) up from 34% in 2007 (Fig. 4.4).

4.10  Other groups targeted in 2008 included:
- Looked after children (576 services) and care leavers (201 services)
- Children subject to abuse (372 services), children living with domestic violence (320 services) and children involved in sexual exploitation (242 services)
- Teenage parents (242 services) and pregnant teenagers (242 services)
- Young offenders (183 services) and children at risk of offending (204 services)
- Refugees and asylum seekers (220 services) and unaccompanied minors (140 services).

**Fig. 4.4:  Vulnerable groups targeted by child health, CAMHS and maternity services 2007 and 2008**
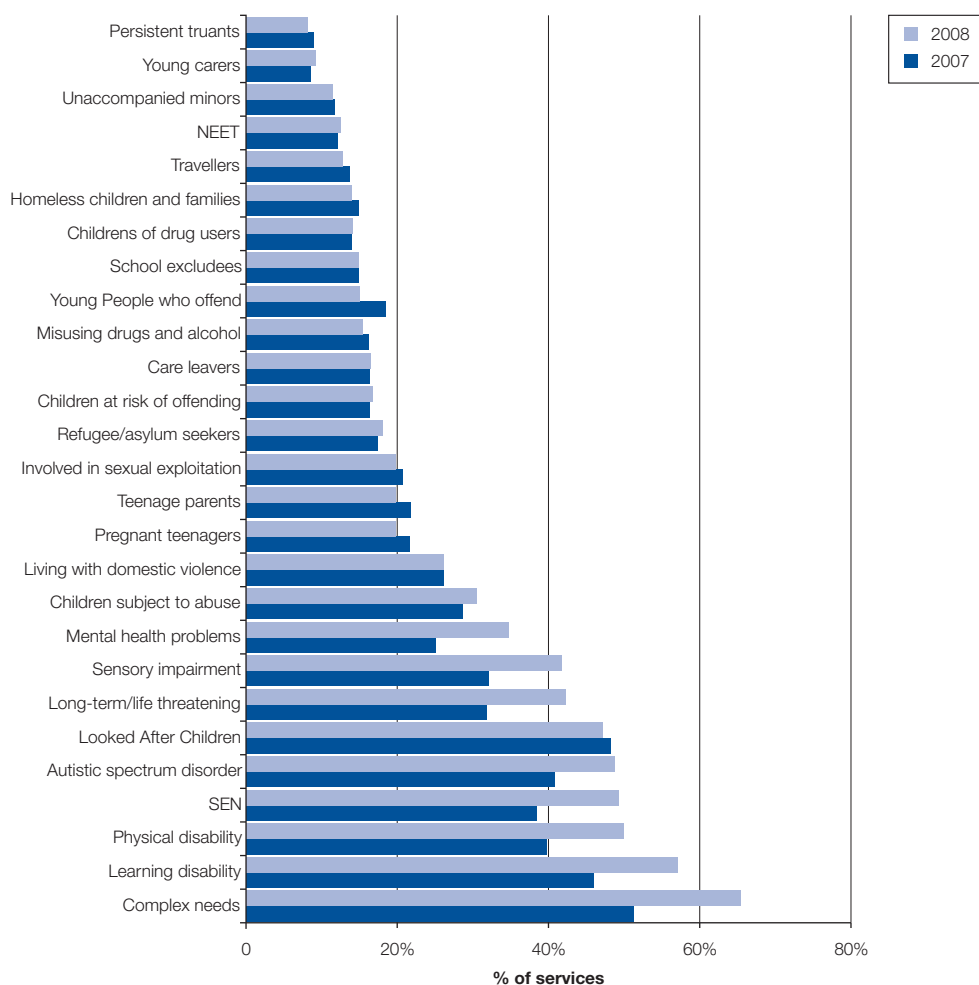
# Achievement of Every Child Matters outcomes

4.11    As in 2007, all services were asked to indicate which of the 5 Every Child Matters outcomes they aimed to achieve.  Again there was little consistency in response to the questions, some services indicating that they made a contribution to each outcome while others selected only the outcomes most closely linked to their specific service.  However, the results give an indication of the contribution children's health services make to the children's agenda (Table 4.3).

**Table 4.3:  Percentage of services in each service type achieving Every Child Matters outcomes 2008**

| Service Type | Be healthy | Stay Safe | Enjoy and Achieve | Make a Positive Contribution | Achieve Economic Well-being |
|---|---|---|---|---|---|
| School health | 94% | 89% | 87% | 81% | 48% |
| Early years and health visiting | 96% | 92% | 87% | 64% | 64% |
| Children's therapy service | 94% | 60% | 88% | 72% | 45% |
| Counselling | 89% | 74% | 83% | 80% | 31% |
| Children's community nursing team | 100% | 90% | 88% | 74% | 40% |
| Community dental services | 81% | 15% | 4% | 4% | 4% |
| Palliative care | 93% | 80% | 80% | 59% | 41% |
| Paediatric continence promotion | 95% | 91% | 95% | 86% | 23% |
| Equipment and wheelchair | 57% | 50% | 79% | 36% | 36% |
| Child development teams | 100% | 90% | 95% | 77% | 56% |
| Health promotion/ improvement | 92% | 69% | 65% | 57% | 31% |
| Community paediatrics | 95% | 86% | 80% | 67% | 43% |
| Other community team | 95% | 78% | 80% | 68% | 48% |
| Children's surgery | 94% | 61% | 29% | 19% | 10% |
| Specialist paediatric service | 91% | 64% | 63% | 48% | 34% |
| PICU | 93% | 70% | 19% | 22% | 15% |
| General paediatrics | 97% | 82% | 50% | 40% | 17% |
| Paediatric emergency service | 94% | 90% | 25% | 22% | 6% |
| Maternity unit | 88% | 82% | 13% | 22% | 22% |
| NICU | 94% | 83% | 13% | 4% | 12% |
| Multidisciplinary generic CAMHS team | 99% | 81% | 78% | 83% | 43% |
| Single disciplinary generic CAMHS team | 96% | 83% | 65% | 79% | 35% |
| Targeted CAMHS team | 97% | 82% | 79% | 85% | 44% |
| Dedicated CAMHS worker | 99% | 86% | 82% | 89% | 43% |
| Tier 4 CAMHS unit/team | 99% | 81% | 83% | 86% | 51% |
| Safeguarding children service | 69% | 93% | 35% | 35% | 22% |
| Short breaks | 105% | 105% | 100% | 79% | 26% |
| Sexual health | 94% | 94% | 56% | 56% | 22% |
| Teenage pregnancy | 100% | 82% | 82% | 100% | 82% |
| Drug and alcohol | 100% | 67% | 67% | 67% | 33% |
| Fostering and adoption | 100% | 100% | 75% | 63% | 38% |
| Sure Start Children's Centre | 100% | 100% | 100% | 83% | 100% |
| Youth offending | 83% | 83% | 50% | 83% | 67% |

**Key:**    80-100%    60-79%    40-59%    20-39%    1-19%

# Information and involvement

## Involvement in service design

4.12 The number of services reporting that they involved children, young people and/or parents and carers in the design, planning, development and delivery of their service rose sharply between 2007 and 2008 (Fig. 4.5). In 2008, 3,373 services (70%) reported that they provided some form of participation compared to 2,744 (57%) in 2007. In 2008, 2,391 services involved children and young people and 3,054 involved parents and carers – both up 29% from 2007. 2, 314 services carried out one-off, issue-based consultations, an increase of 39%. 2,046 maintained an on-going dialogue on specific service developments (33% increase) and 1,052 implemented a participation strategy that set out a plan for on-going involvement throughout the service (47% increase).

**Fig. 4.5: Number of services involving children, young people and parents in the design, planning, development and delivery of services 2007 and 2008**
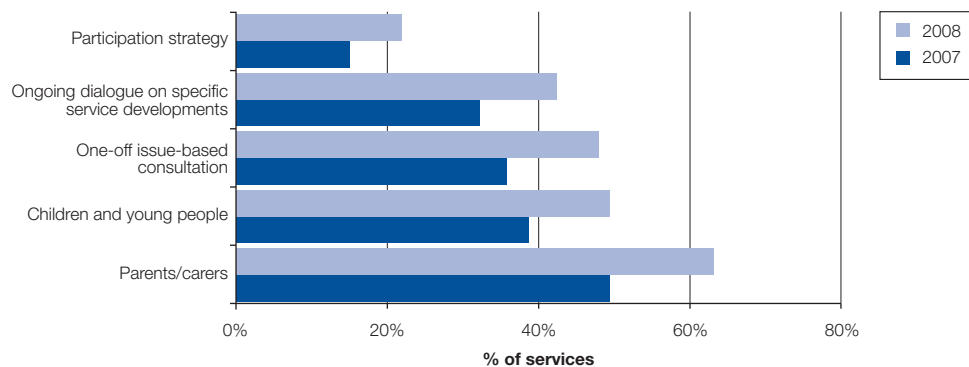


## Collecting feedback from users of services

4.13 4,363 services (90%) reported that they collected feedback from children, young people and families on their satisfaction with services, up from 3,628 services in 2007. Particularly welcome was a 26% increase in the collection of feedback from service user groups and parents' forums and an 18% increase from child health services (Fig. 4.6).

**Fig. 4.6: Methods of collecting feedback on satisfaction with services 2007 and 2008**
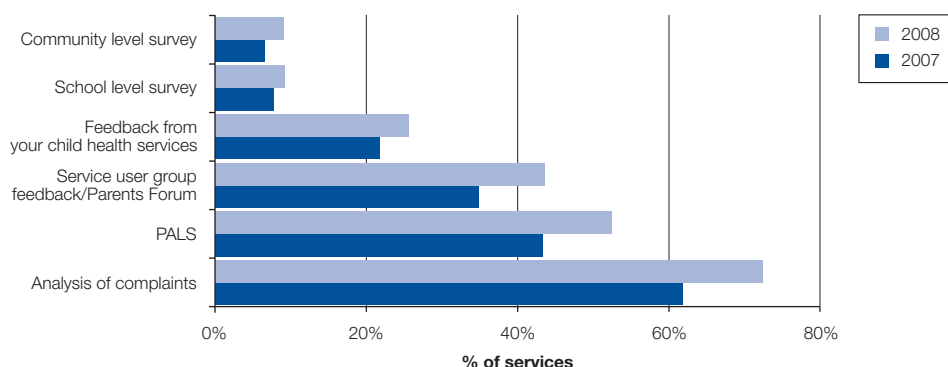
## Publication of information about services

4.14    4,073 services (85% of all services) reported the methods used to provide information for children, young people, families, carers and the wider community about the services provided.  Of the services providing information, 3,495 (86%) used leaflets, 2,127 (52%) used internet websites, 1,915 (47%) used local service directories and 924 (23%) used their Children's Information Service (Fig. 4.7).  Word-of-mouth was an important method of dissemination in 2,639 services (65%).  1,325 services (33%) had produced child-friendly versions of information and 1,609 provided translation of materials in other languages.  Only 484 services (12%) relied on just one method, the majority of services using three to five different methods to get their message across.

Fig. 4.7:    **Methods used for informing children, young people, families, carers and the wider community about services 2007 and 2008**
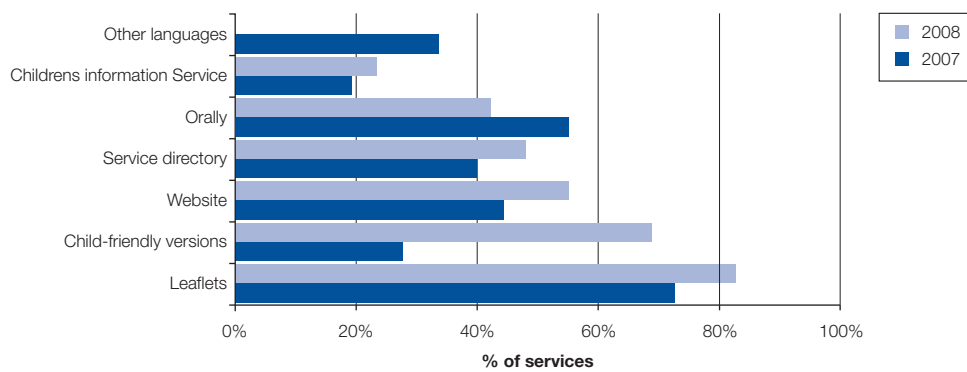
# Chapter 5.

# Maternity services, including neonatal provision

# Introduction

5.1    Standard 11 of the NSF for Children and the subsequent policy Maternity Matters[15] emphasised the importance of choice, access and continuity of care in maternity services.  In 2008, the Royal College of Obstetricians and Gynaecologists (RCOG) published a comprehensive set of maternity standards and audit indicators[16] covering the pathway of care for women from pre-pregnancy through to transition to parenthood.  The audit indicators were influenced by the Healthcare Commission review of maternity services[17].  In consultation with representatives from the Department of Health, the Royal College and the Healthcare Commission (now Care Quality Commission), new questions were developed for the 2008/09 mapping exercise taking RCOG standards into account

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

- PCT participation in planning networks and commissioning of maternity services
- Maternity service provision
    - Mapping of maternity services at service/unit level
    - Antenatal care
    - Intrapartum care
    - Maternity team care
    - Postnatal care
- Neonatal services
    - Neonatal service provision
    - Neonatal transfer.

5.3    The 2008 completion rate for both the maternity and neonatal service questionnaires was 96%.  For further details of the completion rates of the mapping exercise, please refer to Appendix 1.  Detailed tables of the data can be downloaded from the mapping website at: www.childrensmapping.org.uk/results


## PCT participation in planning networks and commissioning of maternity services

5.4    In every locality there should be an effective multidisciplinary maternity services forum such as a Maternity Services Liaison Committee (MSLC), where commissioners, providers and users of maternity services bring together their different perspectives in partnership to plan, monitor and improve local maternity services (RCOG standard 26).

5.5    Commissioners and providers must develop maternity and neonatal care networks.  This is achieved through a multidisciplinary and multi-agency approach requiring agreement with all those likely to be involved in providing care, including service managers and all relevant health and social care professionals and service user representatives.  Within a locally managed maternity network, there should be clear pathways of care and standardised protocols and guidelines, including rapid and effective communication between specialties, services and health professionals (RCOG standard 27).

5.6    144 PCT commissioners (95%) reported that they contributed to MSLCs; 137 (90%) to a neonatal care network and 112 (74%) to a perinatal care network.  The majority of MSLCs were local (80%) and were the often run jointly with the local authority (LA) (30%).  PCT participation in neonatal and perinatal care networks was mainly at a regional level (89% and 73%) (Fig. 5.1).

**Fig. 5.1: PCT commissioners participation in maternity and neonatal networks 2008**
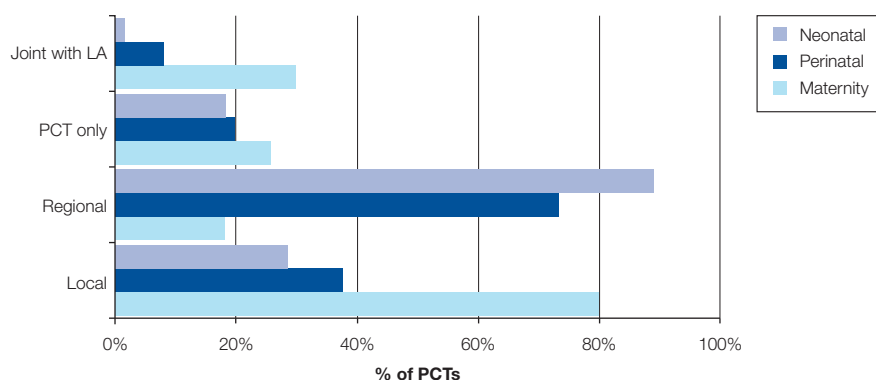


5.7     124 PCT commissioners (85% of response) had an agreed care pathway for maternity services. The Service Level Agreements (SLAs) of 110 PCT commissioners (76% of response) specifically mentioned the need for providers across the whole PCT area to offer choice to women. 10 PCT commissioners (7%) specified this across part of the PCT area and in 22 (15%) no requirement to deliver choice was specified.

## Maternity service provision

### Mapping of maternity services at service/unit level

5.8     Between 2005 and 2007, the majority of NHS providers chose to map their maternity provision as a single comprehensive trust-wide service irrespective of the number of units/sites the service was delivered from. In 2008 an attempt was made to capture a more detailed service description so that the development of midwifery-led units could be tracked and, to this end, maternity services were asked to report at unit/site level. However, few chose to do this and, as a result, 2008 has been a transitional year with a mix of comprehensive services and separate units/sites being mapped. Therefore, it has not been possible to report maternity services at unit level. Instead, this section reports provision by the 152 trust-wide maternity services that were mapped by NHS provider trusts in 2008. These 152 services all provided antenatal, intrapartum and postnatal care.

### Antenatal care

5.9     The pathway of care for maternity services begins pre-conception and therefore early access to, and engagement with, maternity services is important. Early engagement with pre- and early pregnancy services enables a plan of care to be established. For many women this may be routine antenatal care but additional support needs to be in place for those who might need it, including women with existing medical conditions. Antenatal services should be: flexible to meet a variety of needs; culturally sensitive; accessible in local settings; and provided at times of the day that suit women. Access to a midwife as the first point of contact should be widely publicised and their contact details should be easily available to all women. Integral to antenatal care are access to screening services and antenatal diagnosis testing and comprehensive programmes of education (RCOG standards 1- 10).

5.10   In 2008, 64 trusts reported the provision of pre-conception services.  Many of them were delivered in a number of settings including: 95% in hospitals; 38% in community health settings; 38% in children's centres; and 3% in extended school services.

5.11   Of the 152 NHS trusts delivering antenatal services, 133 (88%) provided women with direct access to a midwife in at least some of their units.  Only 11 trusts (7%) did not provide direct access.  The most common form of access was by direct telephone line offered by 124 trusts (93%).  Access was provided through walk-in clinics in 87 trusts (65%) and by email in 21 trusts (16%).

5.12   Dating scanning by 12 weeks was available for all women in the antenatal services in 124 services (82%) and for some women in 21 services (14%).  However, in 5 services there were antenatal units in which date scanning was not available.  Nuchal translucency testing for Downs screening was provided for all women in 68 antenatal services (45%) and for some women in a further 48 services (31%).  26 trusts reported no access to nuchal translucency testing in their antenatal services and 10 trusts gave no information on this provision.

5.13   An early pregnancy service was provided by 134 trusts (88% of antenatal services) and 136 trusts (89%) reported provision of a late pregnancy day assessment unit.  Both types of units were open during office hours but only a minority opened in the evening or at weekends (Fig. 5.2).

**Fig. 5.2:   Opening times of early and late pregnancy units 2008 (N=152)**
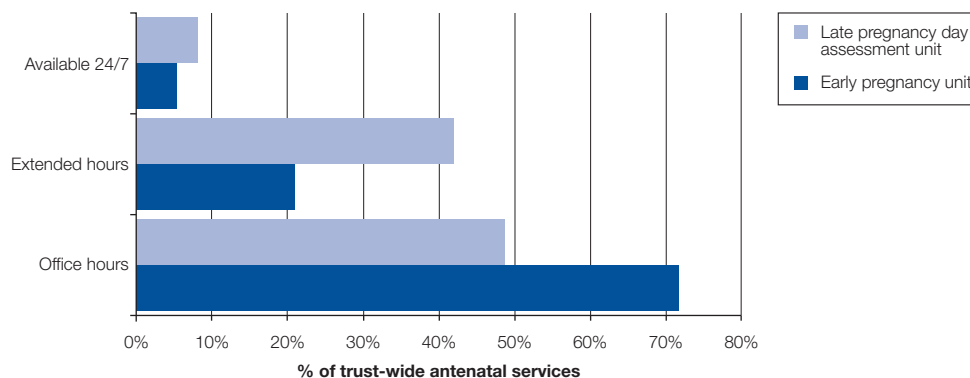


5.14   Multidisciplinary joint clinics for pre-existing medical conditions were provided by 140 antenatal service (92%), 138 of which provided clinics for diabetes.  Provision for epilepsy was available in 60 services (39%) and for cardiology in 50 (33%).

5.15   Provision of education, information and support were reported by 127 antenatal service (84%).  Partners were always involved in the services provided by 56 trusts (44%) while 66 trusts reported some involvement of partners (52%).  Of these antenatal education, information and support services, 117 (92%) included targeted provision for pregnant teenagers, 36 (28%) targeted disabled women and 34 (27%) women with learning disabilities.  In addition, 52 services (41%) were provided in community languages or for women whose first language was not English.

## Intrapartum care

5.16 Agreed standards for intrapartum care in hospital settings were set out in *Safer Childbirth*[18]. These were incorporated into the RCOG maternity care standards which also highlighted the importance of the birth environment. Facilities in birth settings should be at an appropriate standard and take account of the woman's needs. Women should be able to choose the most appropriate care and be offered a range of pain management techniques (RCOG standards 12 and 21).

5.17 Maternity services provided a total of 9,397 beds in 2008. In both 2007 and 2008, 24% of beds were in birth rooms and 76% were maternity inpatient beds (Table 5.1). The bed numbers are a snapshot taken on 30th November each year. Number of births is for the period 1st April – 31st March, regardless of setting and includes caesarean sections and home births. For the purposes of comparison with previous years' data the total number of births in Table 5.1 includes home births. In 2008, there were 16,241 planned home births and 3,022 unplanned home births reported. The total number of hospital/midwifery unit births excluding home births for 2008 was 619,536.

**Table 5.1: Number of maternity beds and births 2005 to 2008**

| | Total maternity beds | Number of birth room beds | Number of maternity inpatient beds | Total number of births | Birth-room beds per 1000 births | Births per birth room bed | Births per day per birth room bed |
|---|---|---|---|---|---|---|---|
| 2005 | 7,378 | 1,659 | 4,721 | 435,794 | 2.63 | 263 | 0.72 |
| 2006 | 8,886 | 2,174 | 6,712 | 581,427 | 3.74 | 267 | 0.73 |
| 2007 | 9,409 | 2,294 | 7,115 | 618,918 | 3.71 | 270 | 0.74 |
| 2008 | 9,397 | 2,290 | 7,107 | 638,799 | 3.59 | 279 | 0.77 |

5.18 Active birthing equipment (for example, mats, balls and ropes) was available in 138 services (91%); birthing pools in 136 services (89%) and en-suite bath or showers in every labour room by 74 services (49%). Pain relief in the form of TENS equipment was available in 143 services (94%); aromatherapy in 101 (66%); reflexology in 80 (53%) and hypnosis in 5 (3%).

## Maternity team care

5.19 Maternity team care (obstetric-led) was reported by 124 NHS trusts (82% of maternity services) However, this was likely to be an underestimate owing to widespread misunderstanding of the structure of the mapping question in 2008. Epidural pain relief was available 24/7 on demand in all services in at least one of their obstetric units. All women were cared for on a labour ward when undergoing induced labour in 45 services (36%) and some women in 78 services (63%). Obstetric theatres were within or alongside the labour ward in 123 services (99%). These were staffed by a dedicated obstetric theatre team, available 24/7, in 74 services (60%).

### Postnatal care

5.20    Maternity services should provide postnatal care to facilitate the transition to motherhood/parenthood and plans should include women being able to choose the place of postnatal care.  Mothers need to be effectively supported in the feeding method of their choice and informed of the long-term healthcare benefits of breastfeeding.  Maternity services should adhere to principles and work towards recommendations of UNICEF/WHO Baby Friendly status (RCOG standards 14, 15 and 18)

5.21    Services in 44 trusts (29%) reported achieving UNICEF baby friendly status or equivalent for their service.  Specialist breastfeeding advice was made available 24/7 by 119 postnatal services (78%).  In reporting arrangements for postnatal care, the majority of trusts reported working in a range of settings, including 143 (94%) supporting women in their own homes; 106 (70%) working from children's centres; 80 (53%) working from community clinics and 56 services (37%) from GP surgeries.

5.22    A formal handover of care from midwives to children's services was reported by 117 postnatal services (77%).  Information on the age of handover was reported by 103 trusts (68%) and the age ranged from 7 days to 66 days with the most common age being 10 days (56%).
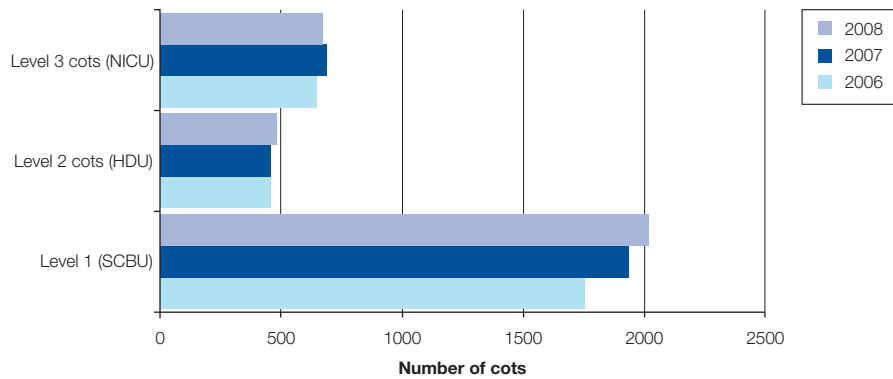
# Neonatal services

5.23    New guidance published by the Department of Health in 2009 to improve the care provided for premature and sick babies and their families[19] recommended that the types of care that babies might require should be clearly defined in 3 levels:
- Level 1 - special care
- Level 2 - high dependency
- Level 3 - intensive care.

5.24    The guidance recommends that neonatal intensive care units (NICU) may provide a full range of care but it was expected that the majority would provide high dependency and intensive care while special care baby units (SCBU) would provide Level 1 special care.  The guidance also recommended an increase in cot capacity and a strengthening of the role of SCBUs to ensure the provision of high quality special care for babies.

5.25    Timely access to an appropriate level of neonatal care and expertise results in the best possible outcome.  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 for babies being taken back to a unit near their home.  Managed maternity and neonatal care networks should include effective arrangements for managing the prompt transfer and treatment of women and their babies experiencing problems or complications (RCOG standard 17).

### Neonatal service provision

5.26    The number of NICUs increased from 109 in 2005 to 163 in 2006 and 166 in 2007. However, it should be noted that in 2006 the definition of NICU was extended to include SCBU. In 2008, 162 neonatal care services were mapped, a slight reduction but this could have been due to increased flexibilities in the mapping questions. The capacity of cots available in neonatal care in 2008 was 3,160. The total number of NICU and SCBU cots increased by 12% since 2006, from 2,854 (Fig. 5.3). Despite this overall increase, the number of level 3 cots has marginally declined since 2007.

**Fig. 5.3:    Number of NICU and SCBU cots 2006 to 2008**



**Neonatal transfer**

5.27    The transfer arrangements between maternity and neonatal intensive care units were reported as adequate by 82 services (51%).  The proportion of services giving an excellent rating increased from 21% in 2005 to 46% in 2008.  Transfer arrangements were reported as poor by 2% of services in 2008, a decrease from 4% in 2007.  All services reported having arrangements in place in 2008 (Fig. 5.4).

**Fig. 5.4:    Adequacy of NICU access to neonatal transfer 2005 to 2008**
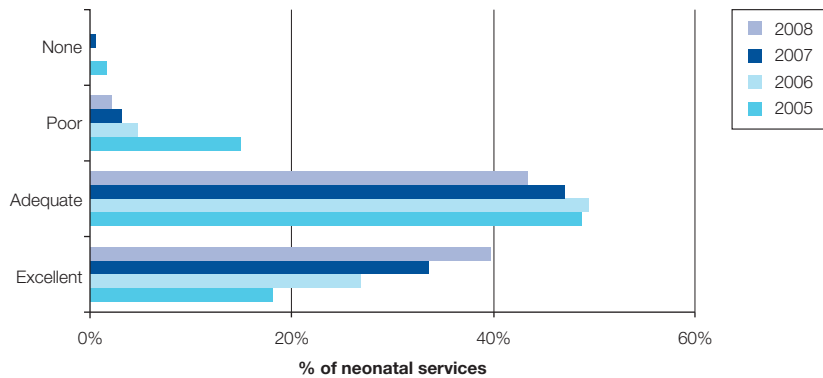
# Chapter 6.

# Early years and preventative services

# Introduction

6.1    The importance of delivering broader programmes of support for children and families that will help address wider determinants of health has been long emphasised.  The recently updated Child Health Promotion Programme[20], now known as the Healthy Child Programme, provides a guide for preventative services for women through pregnancy and for children in the first five years of life, setting out best practice.

6.2    This section reports mapping findings most related to this theme, as follows:
• Commissioning the Healthy Child Programme
• Healthy weight strategy
• Emotional well-being services.
• Child health promotion service provision
• Structured parenting programmes.

6.3    For details of the completion rates of the mapping exercise, please refer to Appendix 1.  Detailed tables of the data can be found and downloaded from: www.childrensmapping.org.uk/reports.

# Commissioning the Healthy Child Programme

6.4    PCTs have been asked which elements of the Healthy Child screening programme they commission for their population since 2006 but, in 2008, a distinction was made between commissioning for the whole population and targeting specific groups of children.  The results are set out in Table 6.1.  These show improvements in the commissioning of all aspects of the programme if targeted commissioning is taken into account.

**Table 6.1: PCTs reporting commissioning Healthy Child screening programmes 2006 to 2008**

| Screening | 2006 | 2007 | 2008 for whole child population | 2008 targeted to specific groups |
|---|---|---|---|---|
| Antenatal screening contact | 90% | 95% | 92% | 8% |
| Newborn examination | 93% | 95% | 100% | |
| Biochemical screening | 76% | 80% | 88% | 6% |
| Universal newborn hearing screening | 92% | 95% | 99% | 1% |
| Birth visit | 91% | 95% | 99% | |
| 6-8 week check | 90% | 95% | 99% | 1% |
| Full systematic assessment by 1 year of age | 77% | 80% | 83% | 12% |
| Review at 2-3 years | 72% | 75% | 70% | 26% |
| Review at 4-5 years | 64% | 64% | 58% | 35% |
| Orthoptist-led vision screening  (4-5 years) | 48% | 48% | 50% | 18% |
| Sweep hearing test (4-5 years) | 58% | 61% | 56% | 23% |
| Measure height and weight at school entry | 83% | 93% | 98% | |
| Measure height and weight at Year 6 | 78% | 93% | 96% | 1% |

## Healthy weight strategy

6.5 In 2008 for the first time PCTs were asked if they had a healthy weight strategy in place and whether it was jointly agreed with the local authority. 68% of PCTs had a healthy weight policy that had been up-dated in the previous 3 years, 9% had a policy that had not been updated and 23% had no strategy but were taking action to put one in place. Overall, 89% PCTs had developed, or were developing, their strategy jointly with local authorities.

## Emotional well-being

6.6 542 health services provided targeted emotional well-being services in 2008. Of these, 20% were dedicated emotional well-being services, 61% targeted emotional well-being through dedicated sessions and 19% had staff who specifically delivered this work. Looking at the focus of the services, 41% provided behavioural management, 32% counselling, 19% social skills programmes and 19% a range of psychological therapies. 12% provided cognitive behavioural therapy (CBT) and 8% anger management (Fig. 6.1).

6.7 Over half of the services (53%) reported that all their staff were trained to deliver the interventions provided and in 65% of services providing counselling and psychotherapy, staff were supervised by a therapist accredited by the British Association for Counselling and Psychotherapy (BACP) or other professional body.

**Fig. 6.1:   Types of targeted emotional well-being services 2008 (N=542)**
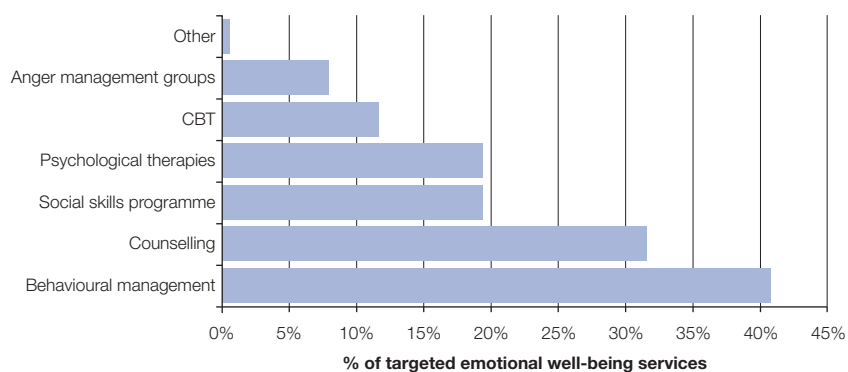


## Child health promotion service provision

6.8 A category of child health promotion service was introduced in 2008 in response to numerous requests for this from the field. These services were defined as follows:

> *Services aiming to promote and support healthy lifestyles amongst children and young people through information, education, training and publicity. This includes work targeted at health-risk behaviours and also initiatives to ensure children and young people are aware of factors that determine health. Include services with a primary function to work with children, young people and parents to prevent accidental injury and death and those which promote and educate children and young people about road, community and home safety.*

6.9    All services identified as a health promotion service were asked to indicate the areas of work delivered. Overall, 615 services indicated that they provided health promotion as all or part of their work.  Of the services recording this activity:
- 486 (81%) provided healthy weight promotion
- 427 (69%) delivered the Healthy Child Programme
- 386 (63%) were concerned with accident and injury prevention
- 382 (62%) supported smoking cessation
- 300 (49%) promoted breastfeeding.

6.10    287 services had health promotion as their primary function.  Of these, 252 services targeted  young people aged 11 to 18 (89%) and 62 services (22%) also provided support for parents and carers (Fig. 6.2), some services supporting both groups.

Fig. 6.2:    **Proportion of health promotion services targeting young people and parents and carers 2008 (N=287)**
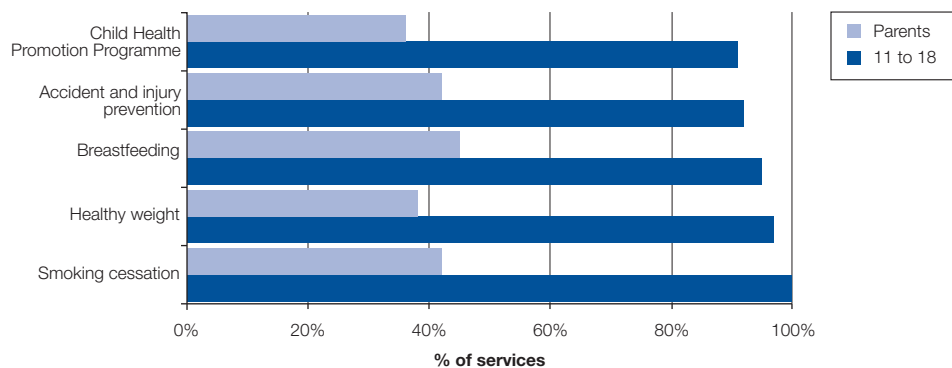


## Structured parenting programmes

6.11    1,174 services delivering structured parenting programmes were reported in 2008, an increase of 6% from the 1,112 services in 2007.  The two types of service most likely to be delivering these programmes were early years and health visiting services and CAMHS (Fig. 6.3).  22% of structured parenting programme provision was by generic CAMHS teams and 22% by early years and health visiting services.  A further 17% of provision was by other types of specialist CAMHS including targeted teams, dedicated CAMHS workers working in non-CAMHS services and tier 4 provision.  School health services provided 8% of parenting provision and maternity and neonatal services 10%.

**Fig. 6.3: Types of services providing structured parenting programmes 2008 (N=1,174)**
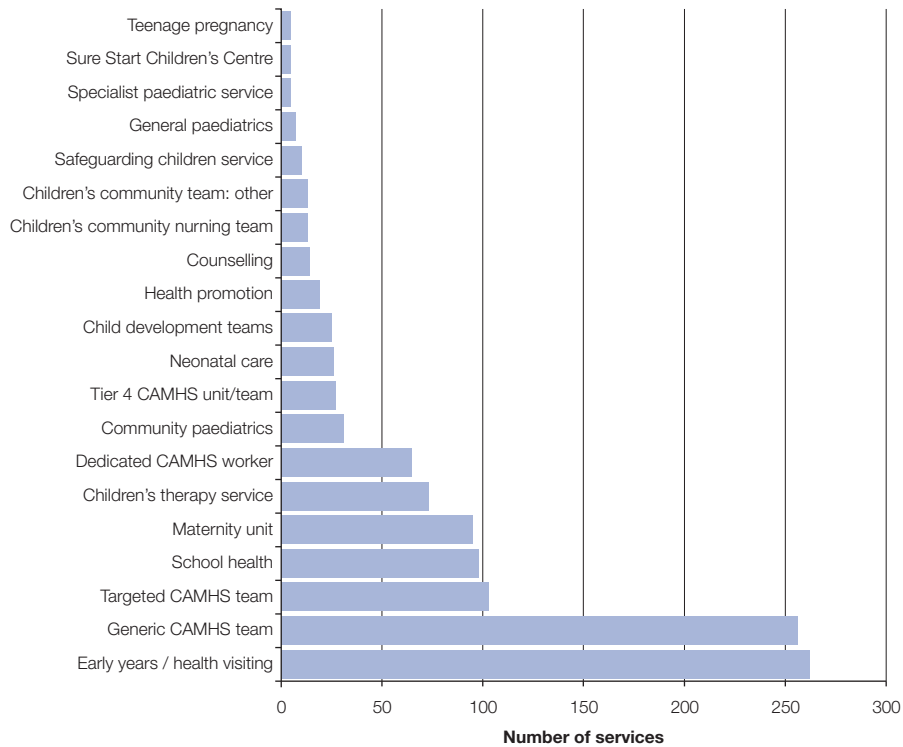


6.12    Webster Stratton remained the most frequently used programme, its use being reported in 44% of services. Triple P was used in 16% of services, and like Webster Stratton, its use was increasing.  Other programmes with increased use were Strengthening families used by 9% of services, Nurturing used by 8%, Strengthening families, strengthening communities used by 5% and Parents as first teachers used by 1% (Fig. 6.4).  Use of other programmes was shown to be declining.

**Fig. 6.4: Parenting programme provision 2006 to 2008**
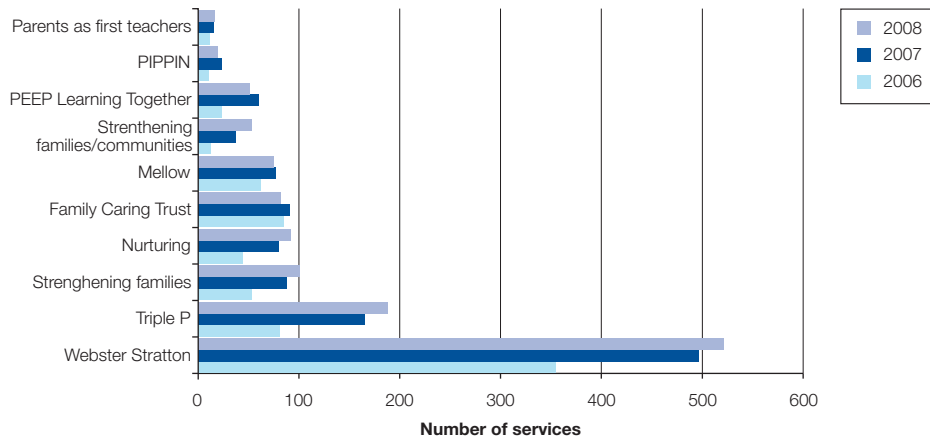
# Chapter 7.

# Paediatric services for ill children

# Introduction

7.1 Policies that have influenced care for children in hospitals include the NSF for Children, specifically standards 6 and 7, the Kennedy Report[21], the NSF for Long Term Conditions[22], the Children Act (1989 and 2004) and the Paediatric and Congenital Cardiac services review[23]. All stress the importance of child and young people friendly hospital care with appropriate provision for all levels of needs, whether it is emergency care or on-going support for complex conditions, surgery, acute illness or intensive care. The new child health strategy: Healthy lives, brighter futures – *The strategy for children and young people's health* (2009) emphasises that services for children and young people with acute or additional health needs should be of high quality and responsive to the needs of those who use them[24].

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

- Children's hospital services
- Characteristics of paediatric emergency care services
- Models of care in general paediatrics
- Diabetes care
  - Diabetes care delivered through general paediatric services
  - Age appropriate diabetes services
  - Diabetes care delivered through community paediatric services
- Paediatric surgery services
- Networks of care for critically ill children

7.3 For details of the completion rates of the mapping exercise, please refer to Appendix 1. Detailed tables of the data can be found and downloaded at: www.childrensmapping.org.uk/results

# Children's hospital services

7.4 In 2008, 851 services were reported within the service category children's hospital services. 235 of these were general paediatric services (28%), 211 specialist paediatric services (25%), 203 children's surgery services (24%), 173 paediatric emergency services (20%) and 27 paediatric intensive care units (3%) (Fig. 7.1).
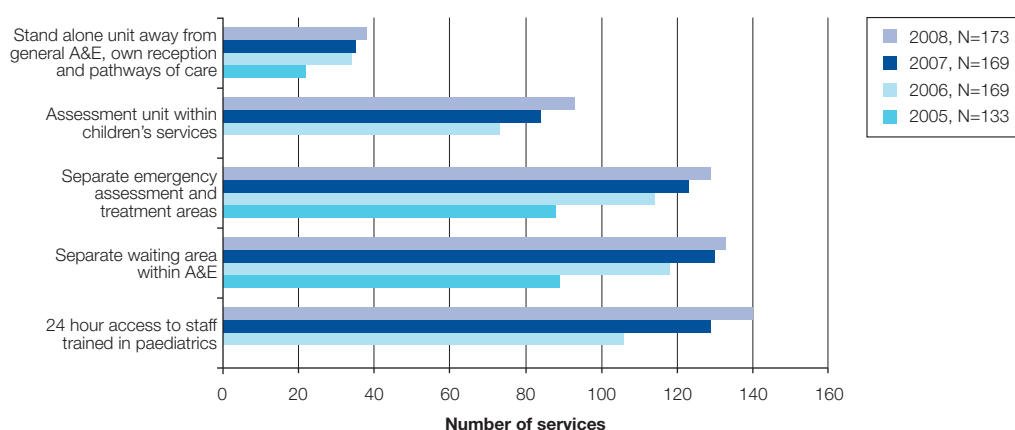
**Fig. 7.1: Children's hospital services by service type 2008 (N=851)**



Legend:
- General paediatrics
- Specialist paediatric service
- Children's surgery
- Paediatric emergency service
- Paediatric intensive care unit (PICU)
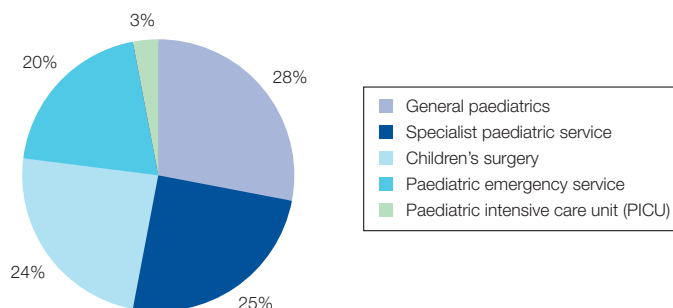
# Characteristics of paediatric emergency care services

7.5    173 paediatric emergency services were mapped in 2008, an increase of 4 services compared to the previous 2 years when 169 services were recorded. Part of the increase is explained by 2 newly resourced paediatric emergency care services.

7.6    140 paediatric emergency services (81%) reported provision of 24 hour access to staff trained in paediatrics, an increase from 129 services in 2007.  133 services (73%) had a separate emergency waiting area for children within an Accident & Emergency (A&E) department and 129 (75%) had a separate assessment and treatment areas for children within A&E.  93 services (54%) had an assessment unit within children's services while 38 (22%) provided a stand-alone unit with its own reception and pathways of care (Fig. 7.2).

**Fig. 7.2: Trends in development of paediatric emergency services 2005 to 2008**



# Models of care in general paediatrics

7.7    The Children's NSF emphasises the importance of bringing hospital services as close as possible to children and their families.  In order to achieve this, hospital services are expected to increase their accessibility by extending into the community and ensuring better links between hospital and home.  The mapping exercise examines the progress of general paediatric services in developing a range of models of care, including alternatives to hospital admissions.

7.8    The total number of general paediatric services decreased from 242 in 2007 to 235 in 2008, possibly because of NHS Trust mergers.  An increase was reported in the number of services that supported parents and carers managing their children's medicine while in hospital, from 148 services (60%) in 2007 to 152 services (65%) in 2008.  152 services (65%) had specialist nurse provision, the same proportion of services provided this in 2007 but the total number of services with specialist nurse provision dropped from 159 to 152.

7.9    134 general paediatric services (57%) had a specialist assessment unit. In 2007 111 (45%) of all general paediatric services had a community nurse attached to the inpatient unit, but in 2008 this had decreased to 93 (40%).  The number of general paediatric services providing home care for children with life threatening

illness dropped from 91 services (37%) to 79 (34%). There was also a decrease in services reporting the provision of hospital at home, 69 (29%) provided this in 2008 compared to 103 (42%) in 2007 (Fig. 7.3).

**Fig. 7.3: Trends in provision of alternative care models in general paediatrics 2005 to 2008**
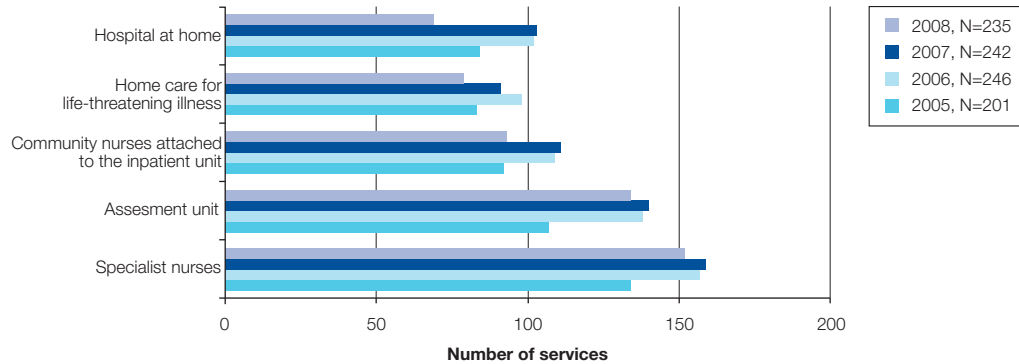


## Diabetes care

### Diabetes care delivered through general paediatric services

7.10    Standards of care for children and young people with diabetes are set out in 'National Service Framework for Diabetes'[25]. The section on care for children focuses on early clinical assessment and management, continuity of care across all settings and transition to adulthood. More recently 'Making every young person with diabetes matter'[26] provided guidance for commissioners and organisers of services, care and the workforce.

7.11    201 (85%) of the 235 general paediatric services mapped in 2008 provided some form of diabetes care, compared to 207 (86 %) in 2007.

7.12    In general the proportion of services delivering the different models of diabetes care has been relatively stable since 2006 (Fig. 7.4). Of the 201 general paediatric services providing diabetes care, 145 (72%) offered combined provision of inpatient units, outpatient services and outreach from hospital. 184 (92%) offered outpatient services, 181 (89%) offered inpatient care and 157 (77%) offered outreach service from hospitals.

**Fig. 7.4:    Trends in diabetes care 2006 to 2008**
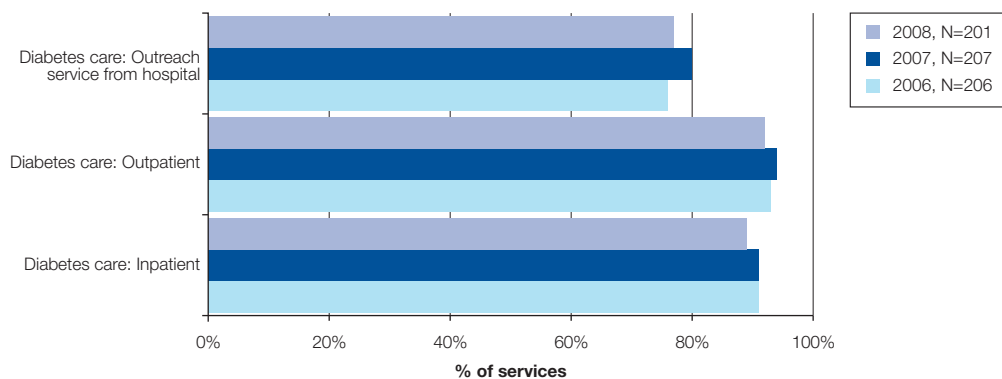
7.13    The majority of services reported that they managed both type 1 and type 2 diabetes.  199 of the services (99%) managed type 1 diabetes while 185 (92%) managed type 2.  These figures have remained fairly stable since 2006.

7.14    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.  196 services (98%) reported that children and young people with diabetes had access to a dietician (96% in 2007) and in 195 services (97%) they had access to a paediatric nurse with special interest in diabetes (as in 2007).  153 services (76%) had access to a diabetologist (as in 2007) while 119 (59%) services provided access to an endocrinologist (62% in 2007).  In both 2007 and 2008 the number of services receiving input from a child psychologist was 99 (49%) and the number of services with input from a child psychiatrist was 42 (21%) (Fig. 7.5).

**Fig. 7.5: Trends in access to particular expertise in diabetes provided in general paediatrics 2005 to 2008**
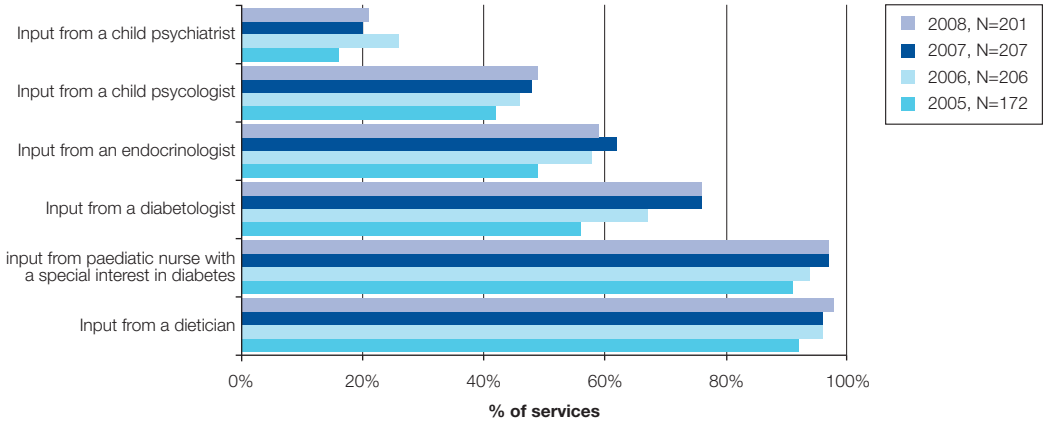


7.15    There was an increase in the proportion of services with specific diabetes provision in place.  The largest increase was found in the number of services providing retinal screening, 142 services (71%) reported provision of retinal screening compared to 115 services (56%) in 2007. 168 services (84 %) had a specific local agreement for 24 hour access to emergency advice from competent staff in place while only 155 services (75%) reported such an agreement in 2007.  157 services (78%) provided a regular documented assessment of need compared to 142 (69%) in 2007.

## Age appropriate diabetes services

7.16    General paediatric services providing diabetes care are asked if they provide services specifically designed for children and young people.  They are also asked if they have individual care management arrangements for children and transition services for young people moving from child to adult services.

7.17    171 of the 201 services (85%) provided separate diabetes care specifically designed for children, an increase from 163 (79%) in 2007.  136 services (68%) provided individual diabetes management plans for children on all occasions, 32 services (16%) provided individual management plans on most occasions while only 9 services (4%) did not have such plans available (Table 7.1).

**Table 7.1: Provision of diabetes services for children 2007 and 2008**

| Year | Diabetes service specifically designed for children | Individual diabetes management plan: | | | All paediatric diabetes services |
| --- | --- | --- | --- | --- | --- |
| | | Yes – for most situations | Yes – for most situations | No – not available | |
| **2008** | 171 | 136 | 32 | 9 | 201 |
| **%** | 85% | 68% | 16% | 4% | |
| **2007** | 163 | 123 | 27 | 10 | 206 |
| **%** | 79% | 60% | 13% | 5% | |

7.18    Of the 201 general paediatric services providing diabetes care, 147 (73%) provided a separate diabetes service specifically designed for young people,  compared to 133 (65%) in 2007.  In 2008 169 (84%) of the general paediatric services providing diabetes care had protocols in place for young people's transition to adult services, compared to 148 (71%) in 2007.  97 services (48%) indicated that diabetes transition key workers were available on all occasions, 43 (21%) had key workers available on most occasions and 10 (5%) had no diabetes transition key worker available at any time (Fig. 7.6).

**Fig. 7.6:    Diabetes provision for young people 2007 and 2008**
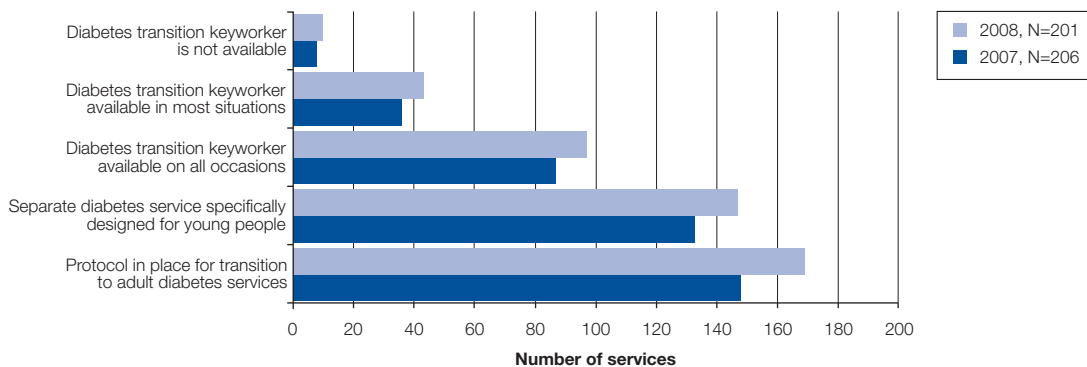


**Diabetes care delivered through community paediatric services**

7.19    In 2008 community paediatric services were asked if they provided diabetes care for the first time and 11 services reported provision.  5 services (45%) provided inpatient care, 9 (82%) outpatient and 8 (73%) outreach from hospital.  10 services (91%) managed type 1 diabetes and 6 (55%) type 2.  10 services (91%) had in-put from dietician, 8 (73%) from paediatric nurse with special interest in diabetes, 7 (64%) from diabetologist, 6 (55%) from a child psychologist, 2 (18%) from child psychiatrist and 2 (18%) from an endocrinologist.

# Children's surgery services

7.20   There were 203 paediatric surgery services mapped in 2008, as in 2007.  Of these 195 (96%) provided day case surgery, an increase of 3 services compared to the year before.  The number of services providing inpatient surgery decreased from 175 (86%) in 2007 to 169 (83%) in 2008 while the number of services providing out-patient surgery increased from 114 (56%) in 2007 to 137 (67%) in 2008 (Fig. 7.7).

**Fig. 7.7:   Models of care in children's surgery services 2006 to 2008**
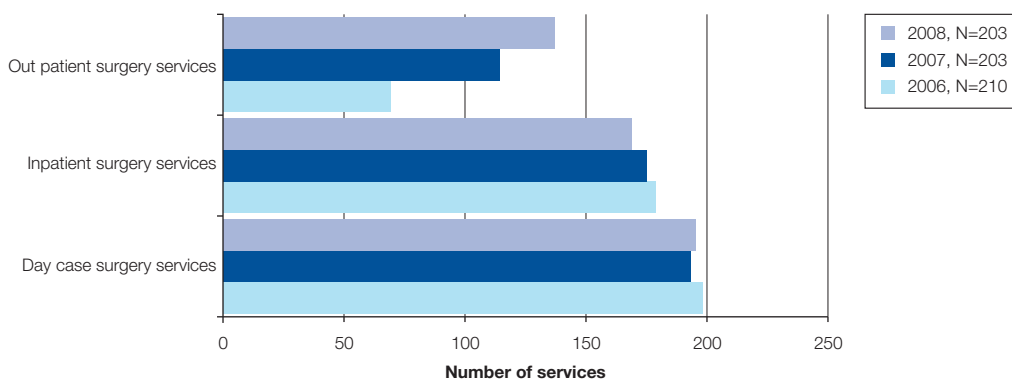


7.21   Of the 203 paediatric surgery services, 128 (63%) provided general surgery, 120 (59%) orthopaedic surgery, 111 (55%) ear, nose and throat surgery, 106 (52%) dental surgery , 96 (47%) ophthalmic surgery and 51 (24%) plastic surgery.  37 services (18%) reported that they provided other forms of paediatric surgery.

7.22   In addition to the dedicated paediatric surgery services, general and specialist paediatric services also reported undertaking paediatric surgery as one of their functions (Table 7.2).

**Table 7.2: Surgery specialities 2007 and 2008**

| Service type/ Surgery type | Children's surgery | | Specialist paediatric surgery | | General paediatrics | |
|---|---|---|---|---|---|---|
| | 2007 (N=203) | 2008 (N=203) | 2007 (N=177) | 2008 (N=211) | 2007 (N=242) | 2008 (N=235) |
| **General** | 123 | 128 | 9 | 8 | 62 | 70 |
| **Orthopaedic** | 115 | 120 | 12 | 11 | 61 | 72 |
| **ENT** | 104 | 111 | 10 | 8 | 56 | 65 |
| **Dental** | 93 | 106 | 8 | 6 | 48 | 56 |
| **Ophthalmic** | 87 | 96 | 8 | 8 | 41 | 49 |
| **Plastic** | 46 | 51 | 7 | 4 | 13 | 14 |
| **Other** | 33 | 37 | 5 | 10 | 6 | 8 |

7.23   The number of surgery cases undertaken in the 12 months from January to December 2008 was 313,479 compared to 290,688 in 2007.  The average number per 100k population aged 0-17 was 28.2 in 2008 compared to 26.2 in 2007.  The ratio of surgery cases per child in SHAs ranged from 14.2 to 39.9 (Fig. 7.8).

**Fig. 7.8:** Average number of children's surgery cases per 100k population aged 0-17 2007 and 2008



Surgery cases per year per 100k population aged 0-17
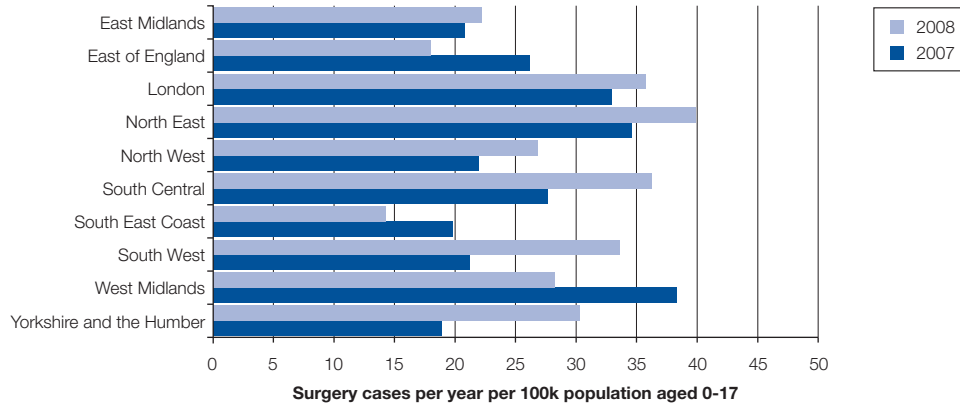
# Network of care for critically ill children

7.24   Of the 27 paediatric intensive care units (PICU) mapped, 25 (93%) reported belonging to a managed clinical network for critically ill children and 16 services (59%) led the network (Fig. 7.9)

**Fig. 7.9:** Trends in participation in networks of care for critically ill children 2005-2008



% of PICU
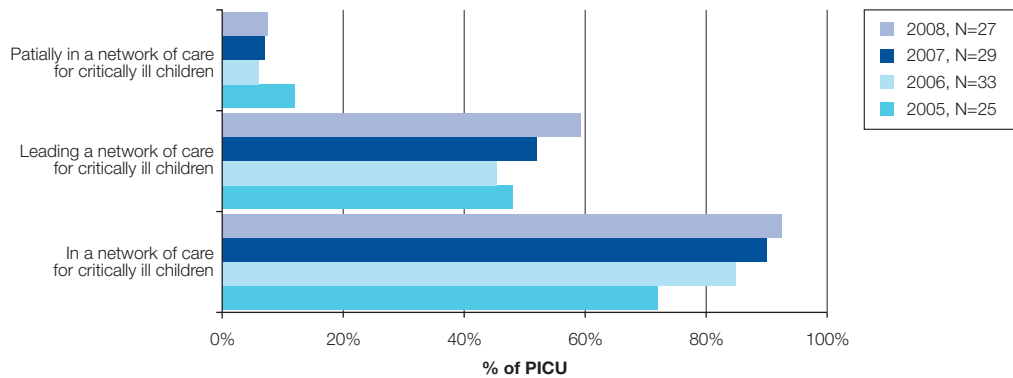
# Chapter 8.

# Services for disabled children and young people and those with complex health needs

# Introduction

8.1 In addition to standard 8 of the children's NSF, improving the quality of care and support for disabled children was further addressed in *Aiming High for Disabled Children*[27] , published as a result of the Disabled Children Review in 2007. This focused on improving both access to services and service responsiveness to individual needs. 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. For the purpose of this report, the term 'disabled children' is used to refer to children and young people who are disabled and/or those with complex health needs.

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

- Services for disabled children
  - Published eligibility criteria
  - Disability assessments
  - Staff trained to work with children
  - Key worker system for children with complex needs
  - Transition Support Programme
  - Services with some dedicated staff or sessions for disabled children.

- Palliative care

- PCT commissioning arrangements for disabled children and palliative care services.
  - PCT participation in strategic planning networks
  - PCT commissioning of specific provision for disabled children
  - PCT engagement with the Every Disabled Child Matters PCT Charter
  - PCT commissioning of palliative care services.

8.3 For details of the completion rates of the mapping exercise, please refer to Appendix 1. Detailed tables of the data can be found and downloaded from www.childrensmapping.org.uk/results

# Services for disabled children

8.4 There was a significant change in the way services for disabled children were recorded in the 2008 children's services mapping exercise. From 2005-2007 there was a service type for children with a disability and/or complex needs but it was increasingly recognised that disability services were rarely configured in the way described as the definition was based on the recipients of the service rather than what the service delivered. Teams of professionals are more commonly built around children and young people to meet individual needs. Furthermore, many other services contributed significantly to the provision of support for disabled children and young people but would not consider themselves as 'disability services'.

8.5    In an attempt to address this, the mapping exercise removed disability services from the classification of service types in 2008 and adopted a more inclusive approach.  In this, whenever a service indicated that it either delivered dedicated provision for particular types of disability or had some resource for disability in terms of dedicated staff input or sessions then the disability questions were triggered.  The types of disability triggering the questions were:

- Physical disability
- Learning disability
- Sensory impairment
- Complex needs.

Feedback from the field indicated that this change was widely welcomed.

8.6    In 2008, 915 services reported that they provided a service dedicated to disabled children and 1,020 services had some dedicated staff input or sessions for disabled children.  Children's therapy services most commonly provided either a dedicated service or some dedicated resource within their service.  Specialist CAMHS and community health services were also likely to provide either a dedicated service or some dedicated resource within their service (Fig. 8.1).

8.7    A more detailed look at specialist CAMHS showed that of the 105 targeted CAMHS teams providing a specialist disability service 78% supported children and young people with complex needs and 60% supported children and young people with learning disabilities.  Of the 67 multidisciplinary CAMHS teams with specialist disability provision, 75% supported children and young people with learning disabilities and 58% those with complex needs.

Fig. 8.1:   **Dedicated services and services with some dedicated resource for disabled children by the most common service types 2008 (N=1606)**
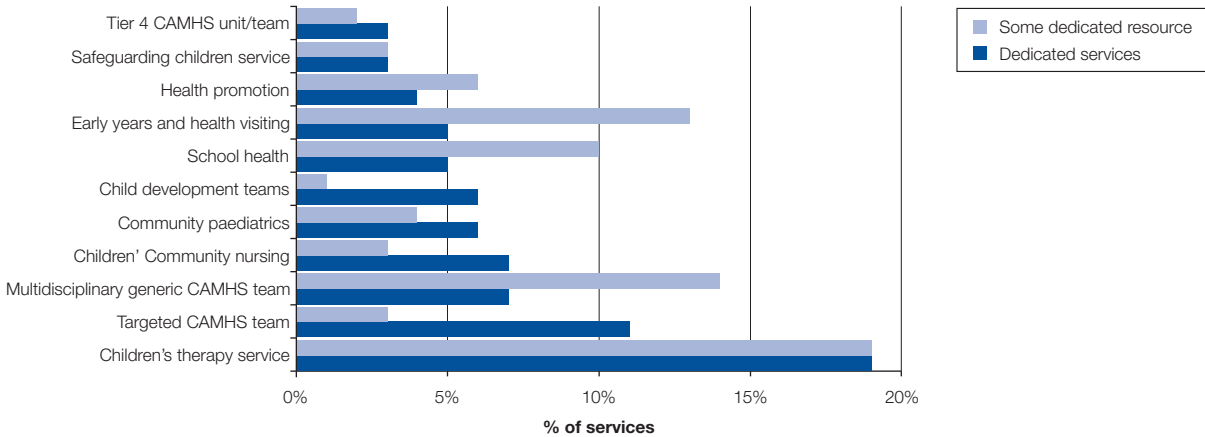


8.8    213 dedicated disability services (23%) supported only one type of disability and 432 services (47%) supported all four types.  In services with some dedicated resource for disabled children, 242 services (24%) supported one type of disability and 397 services (39%) supported all four types.  Complex needs were most frequently supported by both types of service (Fig. 8.2).

**Fig. 8.2: Types of disability supported in dedicated services and services with some dedicated resource for disabled children 2008**



**Fig. 8.3: Number of dedicated disability services by SHA 2008 (n=915)**
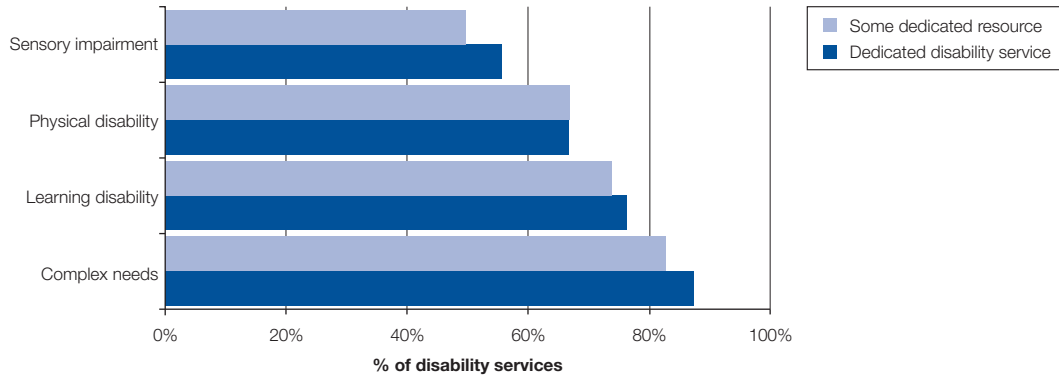


8.9    The following sections focus on the responses from the 915 services with targeting disability provision.  The distribution of these services by SHA is shown in Fig. 8.3.  The responses to those services with some dedicated resource for disabled children are summarised later in the chapter.
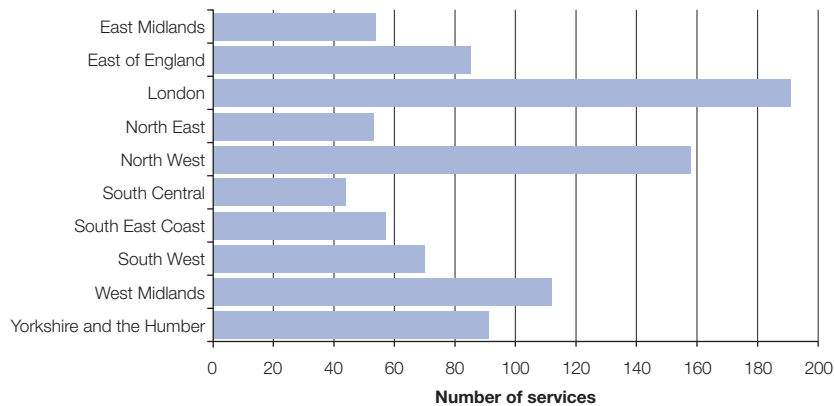
## Published eligibility criteria

8.10    *Aiming High for Disabled Children* considers that increased transparency about individual entitlements and increased availability of information at a local level should lead to greater equity in access to provision between families in the same area, through a clearer understanding of their entitlements and how they can access services.  It also identifies that at a national level, this will provide a better picture of the levels of variation in provision across local areas.

8.11    Published eligibility criteria for the provision of services for disabled children was reported by 404 dedicated disability services (44%).  This was published in paper format by 304 (75%) services, in other printed materials in 174 (43%) services and on websites in 101 (25%) services (Fig. 8.4).  Half of all services published their criteria in only one format, 122 services (30%) used two formats and 51 services (13%) published it in 3 different formats.

**Fig. 8 4:   Forms in which eligibility criteria is published in dedicated disability services 2008 (N=915)**
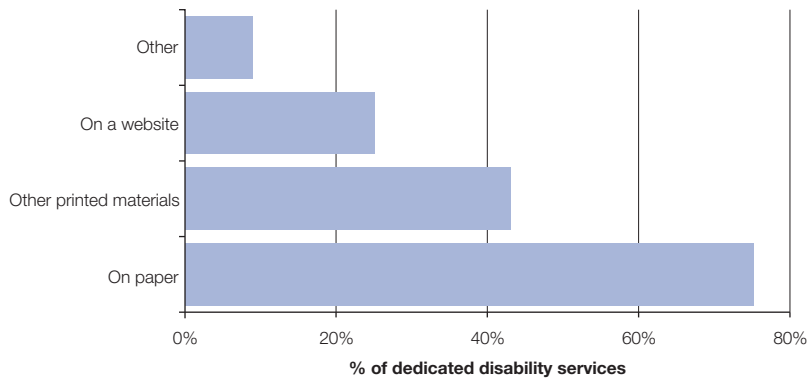


## Disability assessments

8.12  Aiming High for Disabled Children identifies that disabled children and their families should benefit from integrated assessment processes with shared information, shared basic assessments, provision of a gateway to more specialist assessments where necessary and more high-level multi-agency assessments provided in the same place at the same time.

8.13  Coordinated assessments were provided by the majority of dedicated disability services but there were differences in how these were carried out.  The most common approach, provided in 458 services (50%) was a coordinated series of individual professional assessments within an agreed timeframe in more than one location, which could include the child's home.  A further 66 services (7%) provided the same type of coordinated assessments but in a single location.  In 154 services (17%) a joint approach was taken to the provision of a coordinated assessment and this was carried out in a single location.  Uncoordinated individual professional assessments were reported by 76 services (8%) and no joint assessments by 36 services (4%) (Fig.  8.5).  Overall, 562 dedicated disability services (61%) had an information sharing agreement between all parties involved in the joint assessment.

**Fig. 8.5:   Provision of coordinated assessments in dedicated disability services 2008 (N=915)**
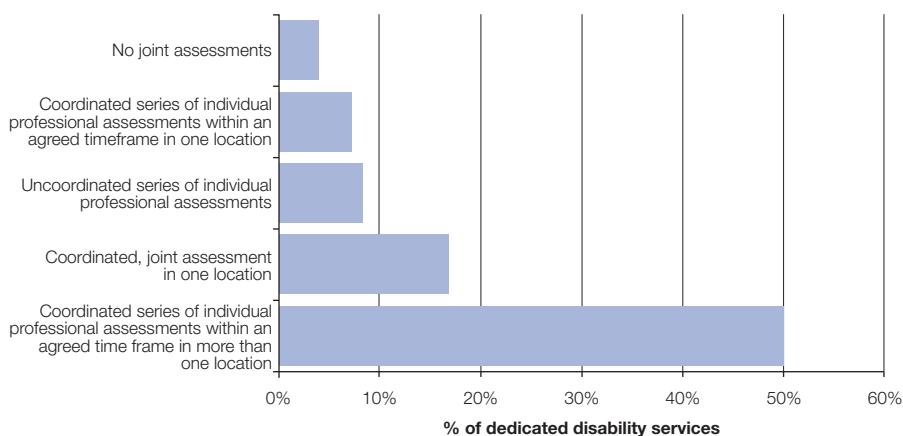
## Staff trained to work with children

8.14 652 disability services (71%) reported that all of their staff had undertaken specific training to work with children.  A further  177 services (19%) reported that some of their staff had been trained and 17 services (2%) reported that no staff had been trained to work with children (Fig. 8.6).

**Fig. 8.6:  Percentage of staff in dedicated disability services trained to work with children 2008 (N=915)**
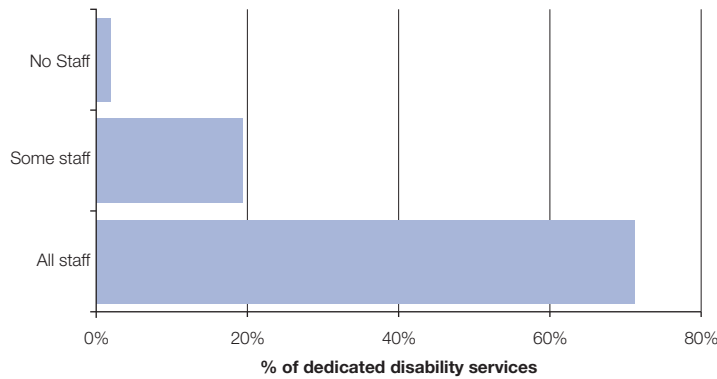


## Key worker system for children with complex needs

8.15 A key worker is both a source of support for the families of disabled children and a link by which other services are accessed and used effectively.  Key workers have responsibility for working with the family and professionals from their own and other services and for ensuring delivery of care plans for children and families.  Key workers support parents of severely disabled children by providing a single point of contact with services and a trusted, informed named person to help them access the services they require. Workers performing this role may come from a number of different agencies, depending on the particular needs of the child.

8.16 In previous years all services for children with a disability and/or special needs were asked if they had a key worker system in place.  Nationally in 2005, 47% of services reported this, this rose to 62% in 2006 and 67% in 2007.  In 2008, the key worker question asked specifically about services for children with complex needs.  Of the 800 dedicated disability services that supported children with complex needs, 356 (45%) used a key worker system.  There was some variation among regions with 54% being the highest level of services with this in place (Fig. 8.7).

**Fig. 8.7:  Percentage of disability services that target children with complex needs that use a key worker system for children with complex needs by SHA 2008 (n=800)**
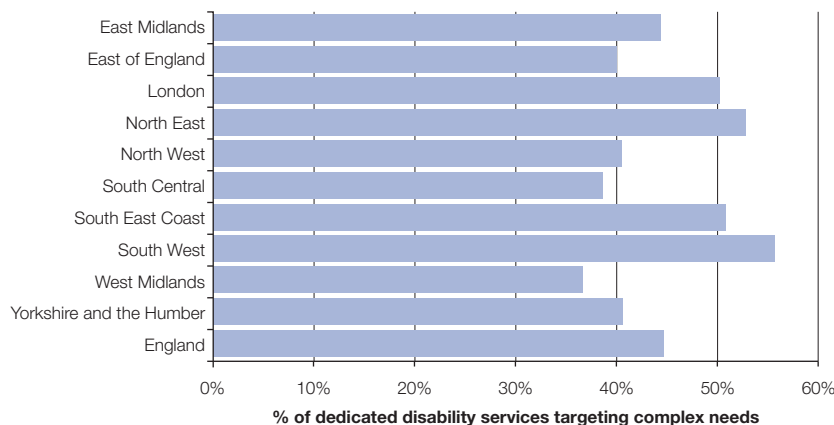
### Transition Support Programme

8.17   Children and young people with more complex needs require more carefully prepared intricate packages of support as they transfer into adulthood. The Transition Support Programme aims to provide this through a young person's information pack; access to an advisor or key worker and advocacy and support; consolidation of the person-centred planning process from age 14 and joint team working across agencies and with adult services to encourage a holistic approach, and choice and control for young people.

8.18   345 (38%) dedicated disability services reported that they provided a Transition Support Programme for disabled children, agreed between agencies. Fig. 8.8 shows the percentage of services within each SHA with this programme.

Fig. 8.8:   Percentage of disability services with Transition Support Programme agreed between agencies by SHA 2008 (n=345)
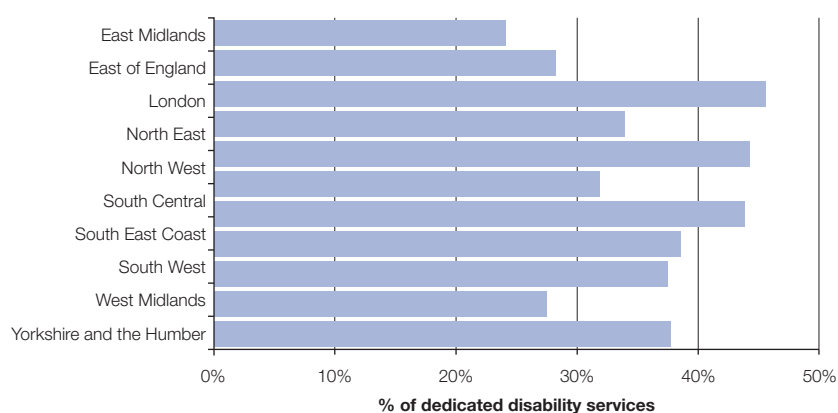


### Services with some dedicated staff or sessions for disabled children

8.19   The same follow-up questions were asked of services that had some dedicated staff input or sessions for disabled children. As these services were not primarily disability services it might be expected that specialist disability provision would be patchy. Published eligibility criteria for the provision of services for disabled children was reported by 20 services (2%). 47 services (5%) reported that all staff were specifically trained to work with children, 29 services (3%) had some staff trained and 3 had no staff trained. 35 services (3%) had a key worker system for complex needs. 20 services (2%) had a Transition Support Programme for disabled children agreed between agencies.

# Palliative care provision

8.20   Palliative care services are for children and young people with life-limiting and life-threatening conditions. Services take a total approach to care embracing physical, emotional, social and spiritual elements. They focus on enhancements of the quality of life for the child and support for the family and include the management of distressing symptoms, provision of respite and care through death and bereavement (adapted from Association for Children's Palliative Care/Royal College of Paediatrics and Child Health Guide, 2003). *Better Care, Better Lives*[28] sets out ways to improve the outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions.

8.21    Palliative care was introduced as a service type in the 2008 mapping exercise and 40 services reported this as their primary service type (0.8% of all health services mapped). In addition to these palliative services, 481 other child health services indicated that they provided palliative care as part of the service they delivered. The main providers were general paediatrics with 104 services (22%) and children's therapy and children's community nursing teams both provided 84 services (17%).

8.22    The 521 services providing palliative care provided multiple types of service. The most common type provided was access to children's community nursing, provided by 435 services (83%), followed by respite care, provided by 239 services (46%). 173 services (33%) were available 24/7 and 99 services (19%) had a lead doctor for palliative care (Fig. 8.9).

Fig. 8.9:    **Percentage of services providing different models of palliative care 2008 (n=521)**
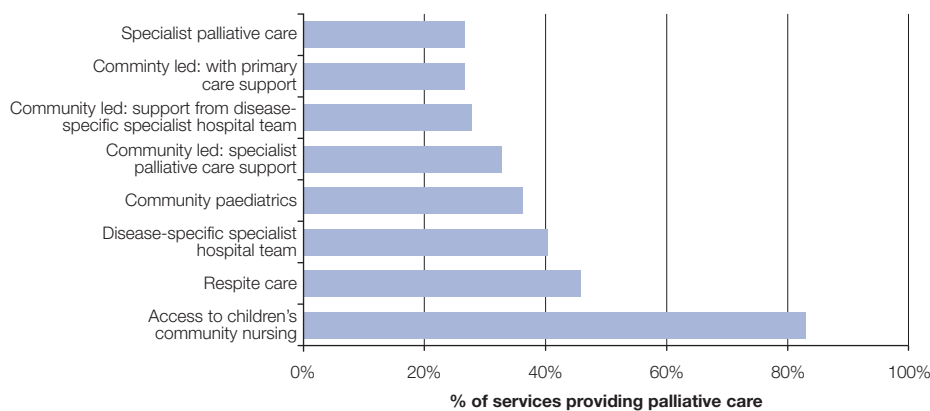


## PCT commissioning arrangements for disabled children and palliative care services

8.23    PCTs, as well as local authorities, play an important role as commissioners of services for disabled children. Recent guidance and investment have focused on improving the experience of disabled children and their families through better access to short breaks, palliative care, therapies and effective transition to adult services[29][30].

### PCT participation in strategic planning networks

8.24    146 PCTs (96%) participated in disability transition planning networks, 116 PCTs (76%) in therapy equipment networks and 138 PCTs (91%) in palliative care networks. The disability focused networks had high levels of joint arrangements with local authorities. 138 PCTs (95% of response) reported joint arrangements for disability transition networks and 95 PCTs (82% of response) for therapy equipment networks. PCTs were mostly involved in palliative care networks at a regional level (81% of response) (Fig. 8.10).

**Fig. 8.10: PCT commissioners participation in planning networks for disability and palliative care 2008 (N=152)**
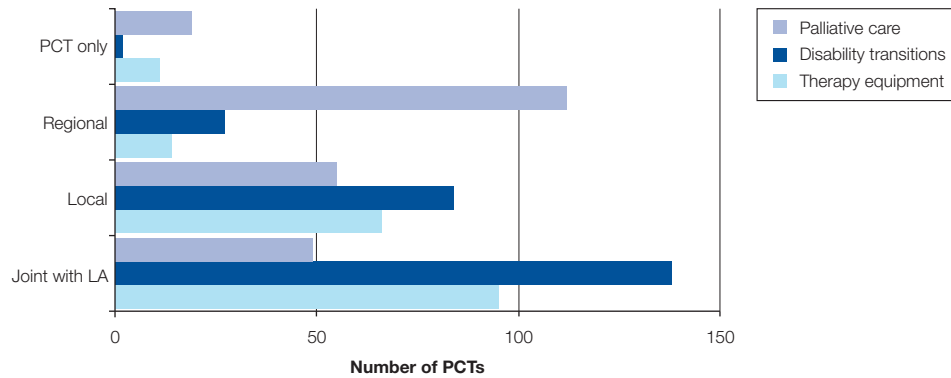


**PCT commissioning of specific provision for disabled children**

8.25     The Disabled Children Review highlighted short breaks and provision of appropriate equipment and wheelchairs, among other services, as particularly important to improving outcomes for disabled children, young people and their families.

8.26     There was a slight increase in the numbers of PCTs that reported commissioning community equipment and wheelchair services and specific services for complex needs between 2007 and 2008 (Fig. 8.11). In 2008, 81 PCTs (57% of those responding) had clear quality and performance standards around the provision of non-bespoke equipment. Of these, 67 (83%) monitored the standards.

**Fig. 8.11: Number of PCTs commissioning specific provision for disabled children 2007 and 2008 (N=152)**
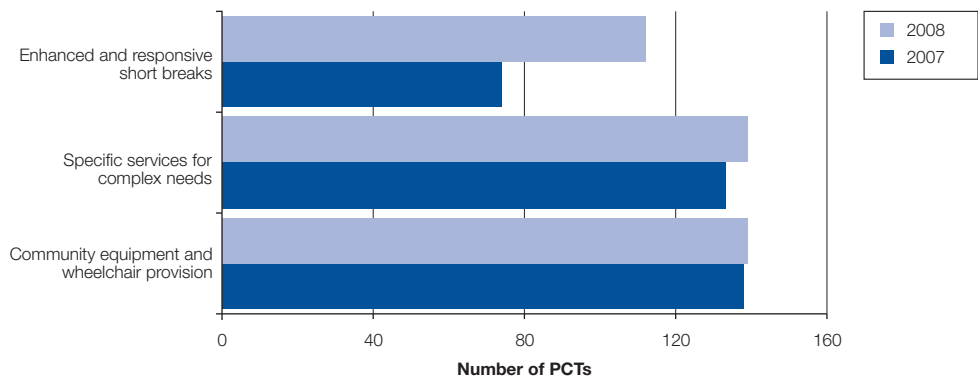


8.27     The number reporting commissioning of enhanced and responsive short breaks rose from 74 PCTs in 2007 to 112 in 2008. In 2008, 101 PCTs (69% of those responding) had identified funding for short breaks for children in their baseline budget. 82 PCTs reported the proportion of the short break allocation intended for use on children. Of these, 57 PCTs (70%) had allocated 100% for spend on children, 19 PCTs (23%) had not allocated anything for children and 6 PCTs had allocated between 20% and 90%. The national average for the proportion of children with complex needs within the PCTs catchment area with access to short breaks was 62% but this included 61 PCTs reporting 100% access and 21 PCTs reporting no access. 27 PCTs returned no information.

## PCT engagement with the Every Disabled Child Matters PCT Charter

8.28 The Every Disabled Child Matters PCT Charter was a series of commitments, framed around NSF Standard 8, that the Every Disabled Child Matters campaign asked PCTs to make by December 2009. It prioritised health services for disabled children and young people across England setting out 9 commitments for PCTs to sign up to including identification of a children's lead with specific responsibility for disabled children and demonstrating effective partnerships with local authority partners and adult service providers.

8.29 71 PCTs (49% of those responding) had an action plan for the Every Disabled Child Matters PCT Charter agreed and in progress; 50 PCTs (35%) had agreed to sign up and 23 PCTs (16%) had taken no action.

## PCT commissioning of palliative care services

8.30 94 PCTs (65% ) had identified funding for palliative care in their baseline budget. The national average proportion of the allocation intended for use on children was 38%. 81 PCTs (57% ) had an agreed care pathway for palliative care for children and 88 PCTs (63% of those responding) commissioned palliative care services against 'Better care, better lives'.

# Chapter 9.

# Child and adolescent mental health services

# Introduction

9.1 The recently published CAMHS Review re-states the important messages originally set out in Every Child Matters and standard 9 of the NSF for Children but with renewed emphasis on the importance of working together and putting the voice of the child first in the development of appropriate care packages. For this reason, CSM will continue to report against those aspects of provision which define a comprehensive service and monitor the progress made towards equality of provision across England.

9.2 This chapter reports the following:
- Towards comprehensive CAMHS provision
    - Trends in CAMHS tier 2 to 4 provision
    - Tier 4 services
    - On-call and emergency response
    - Services for people aged sixteen and seventeen
    - Learning disability provision
    - ADHD and autistic spectrum disorder provision
- Functions and interventions
    - Assessment
    - Interventions
- Use of outcome measures
- CAMHS caseload
    - National summary and trends
    - New cases seen
    - Cases waiting and length of wait

9.3 For details of the completion rates of the mapping exercise, please refer to Appendix 1.  Detailed tables of the data can be found and downloaded from www.childrensmapping.org.uk/results

# Towards comprehensive CAMHS provision

**Team type definitions**

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

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

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

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

## Trends in the provision of specialist CAMHS

9.4 In 2008 a total of 1,063 specialist CAMHS teams were reported, a 2% increase on the 1,047 teams reported in 2007. 2007 remains the only year since CAMHS mapping began in 2002 where the number of CAMHS teams fell. Targeted teams continued to increase, with the number of teams growing to 335 in 2008, a 7% increase on the 314 in 2007 (Fig. 9.1). There were a total of 114 tier 4 teams (tertiary services providing hospital inpatient care and intensive treatments) reported in 2008, this is the first increase reported in tier 4 teams since CAMHS mapping began. The number of generic CAMHS teams and dedicated CAMHS staff working in non-CAMHS settings continued to decline by 1% and 4% respectively.

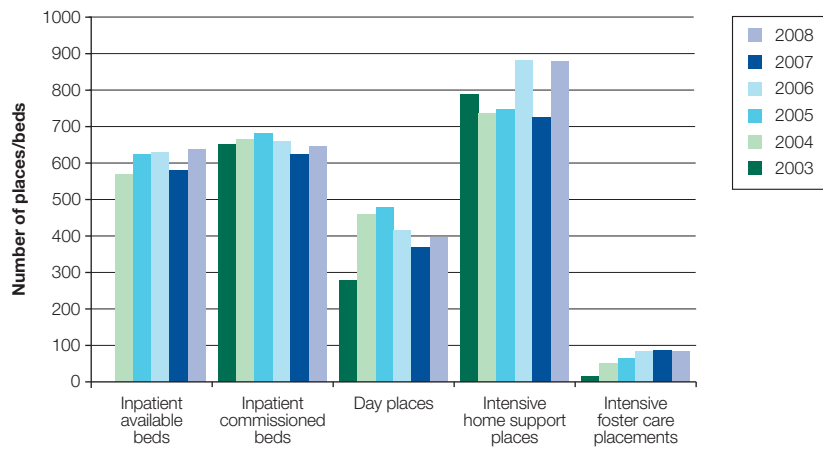Fig. 9.1: Trends in provision of CAMHS tier 2 to 4 provision 2003 to 2008
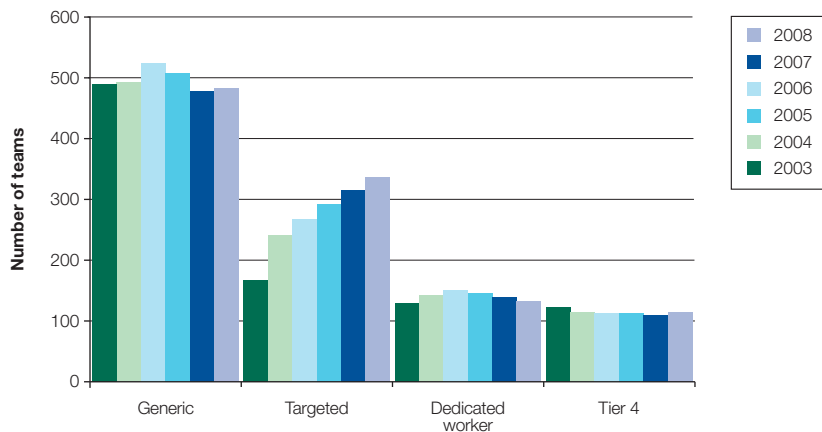


## Tier 4 services

9.5 The number of tier 4 teams increased by 5% between 2007 and 2008. Included in the new tier 4 teams were national secure forensic mental health service, a tier 4 unit for 16/17 year olds and a community inreach team. It is important to note that mapping only collects NHS and not independent sector provision[1]. The number of reported commissioned inpatient beds was 646 in 2008, an increase of 25 beds on 2007. The number of commissioned beds had previously fallen from the 2005 high of 680 to 659 in 2006 and 621 in 2007. There was, however, an even larger increase in available tier 4 beds from 579 in 2007 to 638 in 2008. Day places increased to 394 in 2008 after dropping from 478 in 2005, to 415 in 2006 and 368 in 2007 (Fig. 9.2). During the same period the provision of intensive home support showed considerable fluctuations rising to 879 in 2006, falling back to 724 places in 2007 only to increase again in 2008 to 876. Much of this variation was due to a single unit being removed from the database in 2007 and being restored again a year later but there was also evidence of a number of new intensive home support teams being reported in 2008. The number of intensive foster care places fell to 84 places after previously increasing from 64 in 2005 to 83 places in 2006 and 86 places in 2007.

---

[1]For information on independent sector provision a list of providers and units is available from The Royal College of Psychiatrists at: http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/qnic/camhsdirectory.aspx

**Fig. 9.2: Trends in the capacity of CAMHS tier 4 provision 2003 to 2008**



### Alternatives to inpatient care

9.6    In addition to tier 4 provision, alternatives to inpatient care were provided by generic, targeted and dedicated worker teams (at tiers 2 and 3).  In total, 374 (40%) CAMHS tier 2/3 teams were providing alternatives to inpatient care, an increase from 359 reported in 2007.  Altogether, in 2008, 212 teams were providing early intervention services, 158 intensive home support, 88 intensive foster care, 41 intensive day support and 132 teams provided other forms of intensive outreach (Fig. 9.3).

**Fig. 9.3:    Provision of alternatives to inpatient care 2006 to 2008**
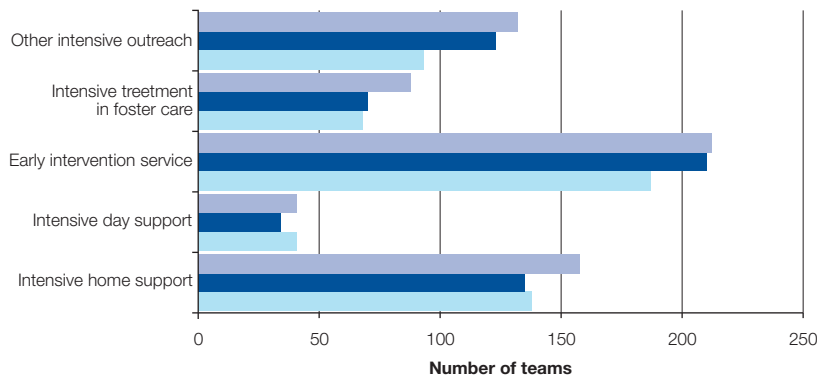


### On-call provision and emergency response

9.7    CAMHS providers were asked about their organisation-wide provision of key aspects of a comprehensive CAMHS using a four point scale (similar to that used in the collection of local authority NI51 data).  2008 was the second year that providers were asked to use the four-point scale, previously they had simply answered yes or no.  Any health and social care provider organisations reporting one or more CAMHS team was asked about their organisation-wide provision of CAMHS.  A total of 133 organisations reported one or more CAMHS teams.  With regard to the provision of a CAMHS on-call service, 8 providers (6%) provided no services and had no plans in place to provide these services.  6 of these providers were PCTs and 2 were NHS provider trusts, all had limited CAMHS provision and are unlikely to be the 'main' CAMHS provider in their area.  Two providers (2%) had plans and protocols in place, but services have yet to be put in place, 30% had some on-call services in place with some still to be developed and 62% had a fully comprehensive on-call service available.  71% of on-call services were staffed by CAMHS professionals.

9.8    Emergency next working day appointments for children and young people needing emergency care or assessment were offered in 93% of the CAMHS provider organisations.  75% of organisations had fully comprehensive services in place and 18% had some services in place, with some still to be developed.  2% of organisations had plans and protocols, but no services in place and 5% reported no services, protocols or plans in place for a next day response.  Four organisations did not answer this question.

9.9    Local authorities continued to report improvements (Fig. 9.4) in on-call provision.  70% of local authorities had fully implemented on-call services available throughout their area (up from 65% in 2007) while a further 29% had plans and protocols in place and partially implemented services.  Only 1 local authority had plans and protocols but no services in place and no local authorities had nothing in place.

Fig. 9.4:    **Trends in local authority responses on the provision of CAMHS on-call and emergency response 2005 to 2008 (N=150)**
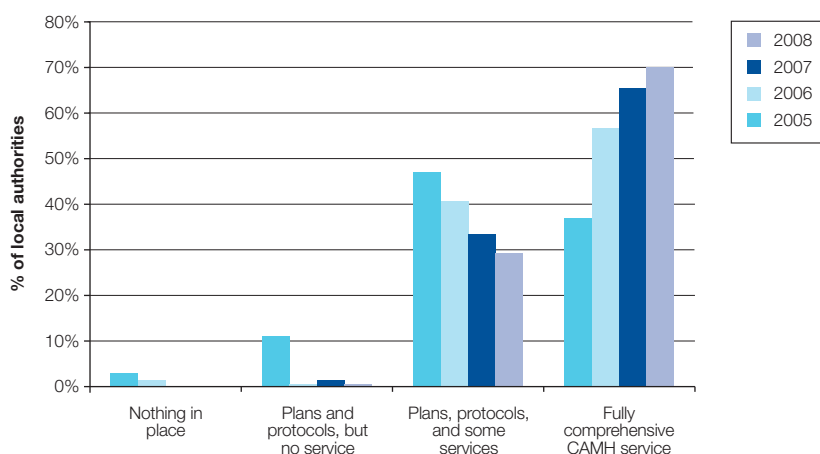


9.10    A total of 489 (46%) CAMHS teams contributed to the on-call provision.  Of the teams contributing to an on-call response, 60% were generic multi-disciplinary teams, 19% were tier 4 teams, 17% were targeted teams and 3% were dedicated worker teams.


### Services for people of sixteen and seventeen years of age

9.11    The provision of age appropriate services for 16 and 17 year olds became a proxy measure for the provision of a comprehensive CAMHS in response to national concerns about the adequacy of the service to meet the particular mental health needs of young people of this age in transition between children and adult services.  There is no prescription of the services to be provided but key elements should include:
- Services appropriate for the developmental needs of 16 and 17 year olds
- Local arrangements for handling referrals
- Smooth transition between CAMHS and adult services at the appropriate age
- Collaboration with early intervention teams for young people with early onset psychosis
- The use of the Care Programme Approach for young people leaving inpatient care
- Appropriate attention to child protection needs of young people.

9.12 A total of 83% of CAMHS providers had age appropriate care for young people aged 16 and 17. 51% of providers had fully comprehensive age appropriate CAMHS and 33% provide some services, with other services still to be developed. 3% of organisations had plans and protocols in place, but were yet to implement them, while 14% had no services, plans or protocols for age appropriate 16/17 CAMHS provision – the majority of these providers would not be classed as the 'main CAMHS provider' for their area.

9.13 The number of individual teams reporting appropriate provision for 16 and 17 year olds increased from 338 (32%) in 2005 to 553 (52%) in 2006, 738 (71%) in 2007 and 802 (75%) in 2008. There were 19,452 young people aged 16 to 18 on the CAMHS caseload, 18% of all cases with age details identified during the caseload collection sample period.

9.14 Local authorities were also asked about the provision of services to 16 and 17 year olds who require mental health services appropriate to their age and level of maturity within the council area. 84 local authorities (56%) had fully comprehensive CAMHS for 16 and 17 year olds across the whole council area, up from 25 (17%) in 2005, 61 (41%) in 2006 and 78 (52%) in 2007. 65 (43%) local authorities, had plans, protocols and some services and 1 (1%) had plans and protocols but no services (Fig. 9.5). There were no local authorities with nothing in place.

Fig. 9.5: **Local authority development of CAMHS appropriate for 16 and 17 year olds 2005 to 2008 (N=150)**
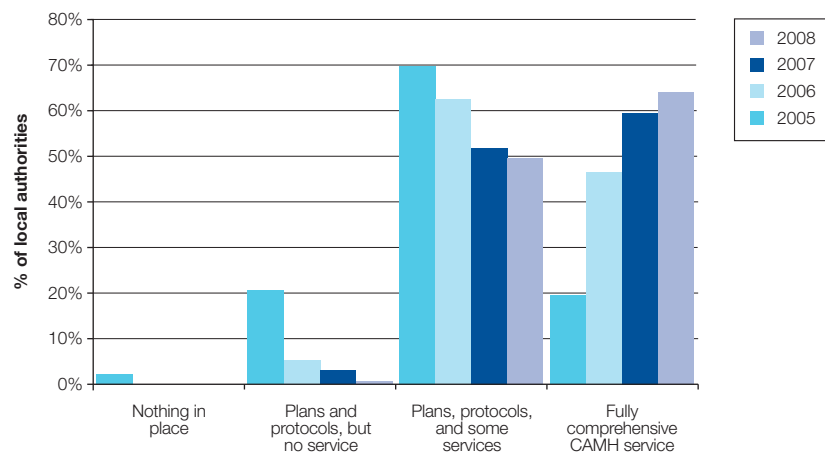


## Learning disability provision

9.15 The NSF stresses the importance of equity of access to CAMHS for children and young people with both mental health needs and learning disabilities. 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.

9.16 A total of 112 organisations provided specialist services for children and young people with mental health problems and learning disabilities (85% of all organisations providing one or more CAMHS team). 55 of these had a fully comprehensive service and 57 had some services in place, with others still to be developed. 2 organisations had plans and protocols but no learning disability services and 18 had no

services, plans or protocols, again the majority of these organisations are unlikely to be the 'main CAMHS provider' in their area.

9.17    In 2008 a total of 186 CAMHS teams (17%) provided a specialist learning disability service, 579 (54%) did not and a further 105 (10%) responded not applicable (199 teams did not answer the question, 19%). This is a significantly different response to previous years and can partially be explained by a slight change to the question with the addition of the not applicable option. This change meant that the responses from the previous year were not transferred as is the usual practice, and this would explain the high non-response rate, but it is less clear why there is such a large fall in the number of teams reporting this type of provision. In 2007 a total of 722 CAMHS teams (69% of all teams) provided specialist learning disability care, an increase from 590 (55%) teams in 2006 and 346 (33%) teams in 2005. In the 2008 sample period, CAMHS worked with 10,806 children and young people with a learning disability. The proportion of the CAMHS caseload identified as learning disabled increased from 8% in 2005 to 9% in both 2006 and 2007 and 10% in 2008.

9.18    63 (42%) local authorities had fully comprehensive provision for learning disabled children and young people with mental health problems and 83 (55%) had plans and procedures in place but were yet to ensure provision throughout the local authority area (Fig. 9.6). 3 (2%) local authorities reported no specialist learning disability and mental health provision but plans were in place and one local authority had nothing in place.

**Fig. 9.6:    Local authority arrangements for and provision of CAMHS learning disability services 2005 to 2008 (N=150)**
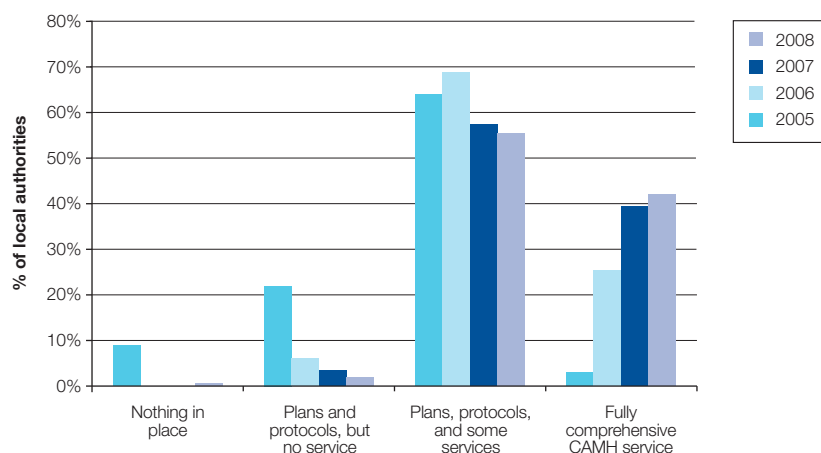


### Early Intervention

9.19    2008 was the first year that local authorities reported on arrangements for a full range of early intervention services delivered in universal settings and through target services for children from CAMHS. There were 49 (33%) local authorities with fully comprehensive provision throughout their area and a further 85 (57%) local authorities had plans and procedures in place but services that were not fully developed. 15 (10%) local authorities had plans and procedures but no services and 1 had neither services nor plans (Fig. 9.7).

**Fig. 9.7:   Local authority arrangements for a full range of early intervention support services delivered in universal settings and through targeted services for children from CAMHS 2008 (N=150)**
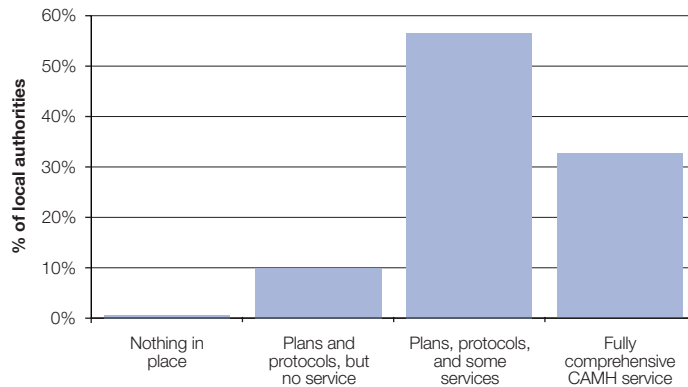


## ADHD and autistic spectrum disorder provision

9.20   In the child health section of the children's services 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 172 (74%) of the 231 community paediatric services and 183 (79%) ran ASD clinics.

# Functions and interventions

## Assessment

9.21   The team classification used in CAMHS mapping was designed to give a broad description of the types of teams provided but it does not describe the work that teams undertake.  Therefore, questions were added to the mapping exercise in 2006 to explore what functions and interventions were provided.  With regard to assessments, eight different types were investigated.  Overall, 974 CAMHS teams (91%) provided general initial assessments, 861 of these teams (88%) providing initial assessments on a regular basis at least weekly.  High risk assessments were provided by 863 teams (81%), psychological assessments by 842 (79%), psychiatric assessments by 691 (65%) and assessment for court proceedings by 531 (50%) (Fig. 9.8).

**Fig. 9.8:   Percentage of CAMHS teams providing assessment functions 2008 (N=1,063)**
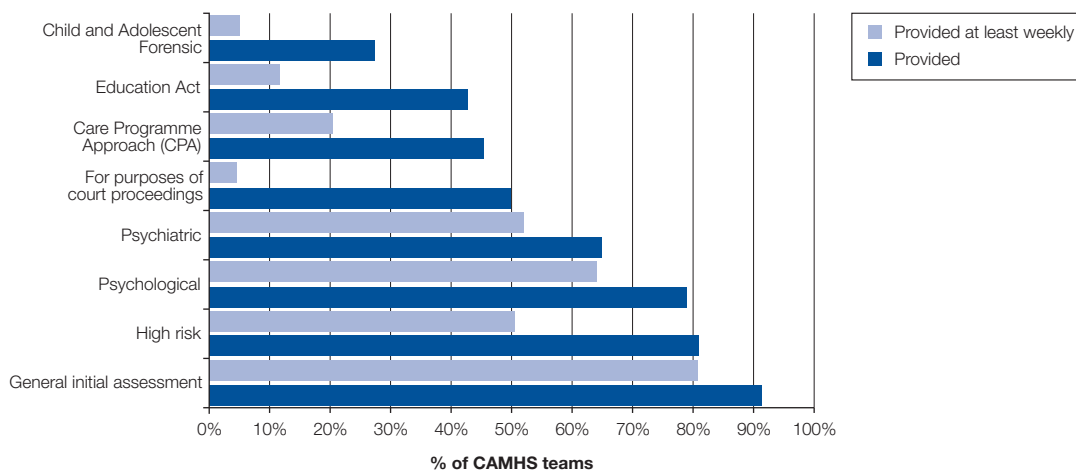
### Interventions

9.22 Each CAMHS team was asked what therapeutic interventions or particular therapeutic orientations were provided by the staff. Teams most commonly provided advice and information (95%), behaviour management (91%), individual psychological therapy (86%), CBT (85%), systemic approaches (84%), and counselling (74%) (Fig. 9.9). Play, art, drama and music therapy were the least likely to be provided.

**Fig. 9.9: Percentage of CAMHS teams providing a range of specific interventions 2008 (N=1,063)**



% of CAMHS teams

## Outcomes measures

### Use of outcome measures

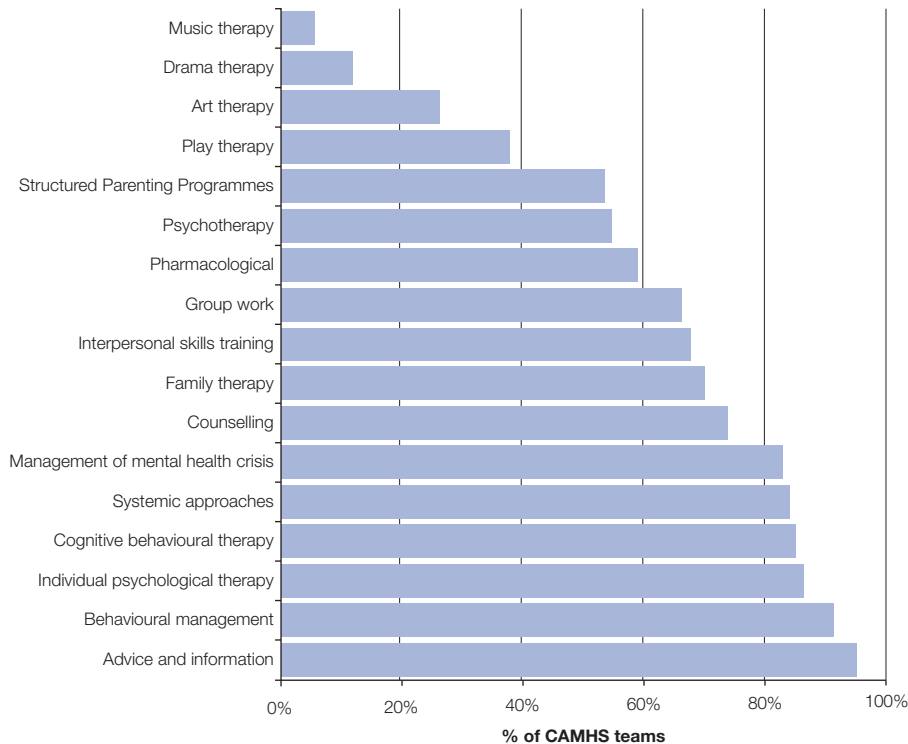9.23 In order to evaluate the outcome of CAMHS, teams are being encouraged and supported to use standard measures to routinely collect information about changes in children's emotional wellbeing and experiences of services. The measures collect information from three perspectives, those of children and young people, parents and clinicians. In 2008 changes were made to the questions asked of CAMHS teams in order to establish at what point outcome measures were being employed. Teams were asked if outcome measures were used at the beginning of treatment, six months into treatment and at the end of treatment.

9.24 In 2008, 599 teams (56%) reported the use of at least one standard outcome measure. This was a reduction from the 704 teams (67%) reporting the use of at least one outcome measure in 2007 but this could be caused by the more precise nature of the questions. In 2008, 124 teams (21% of those using outcomes measures) used just one measure, 113 teams (19%) used 2 measures, 161 teams (27%) used 3 measures and 201 teams (34%) used 4 or more measures. A total of 590 teams (98%) used at least one outcome measure at the beginning of treatment, 373 teams (62%) used at least one outcome measure six months into treatment and 542 teams (90%) used at least one outcome measure at the end of treatment.

9.25 The outcome measures used were as follows (Fig. 9.10):

- The SDQ for Parents and Children (Strengths and Difficulties Questionnaire) are used to assess change in the strengths and difficulties encountered by children. The children's questionnaire is used with 11 to 18 year olds and the parents' questionnaire with the parents/carers of children aged 3 to 16. In 2008, 40% used SDQ for parents, down from 49% in 2007. In 2008, SDQ for children was used by 42% of teams at the beginning of treatment, 26% of teams six months into treatment, and 38% of teams at the end of treatment. SDQ for parents was used by 40% of teams at the beginning of treatment, 24% six months into treatment and 35% at the end of treatment.

- CGAS, the Children's Global Assessment Scale, is a measure completed by practitioners to capture change in difficulties. It can be used on children and young people of all ages and is a way of rating the extent of child and family difficulties at the start of contact and six months later in order to evaluate change. It was used by 24% of teams in 2006, 29% in 2007 27% in 2008. In 2008, 26% of teams used CGAS at the beginning of treatment, 18% six months into treatment, and 25% at the end of treatment.

- Use of the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was reported by 21% of teams in 2006, 25% in 2007 and 19% in 2008. In 2008, 19% of teams recorded using HoNOSCA at the beginning of treatment, 12% six months into treatment, and 18% at the end of treatment.

- CHI-ESQ, the Commission for Health Improvement Experience of Service Questionnaire, is a method of capturing the views of children and parents on their experiences of services. It is used with children and young people over the age of 9 and with the parents of younger children. Use with parents was reported by 19% of teams in 2006 rising to 21% in 2007 and 19% in 2008. It was used with children by 18%of teams in 2006, 20% in 2007 and 21% in 2008. 9% of teams used CHI-ESQ for parents at the beginning of treatment, 9% six months into treatment, and 18% at the end of treatment. 11% of teams used CHI-ESQ for children at the beginning of treatment, 11% six months into treatment, and 19% at the end of treatment.

**Fig. 9.10: Use of outcome measures by CAMHS teams 2006 to 2008**
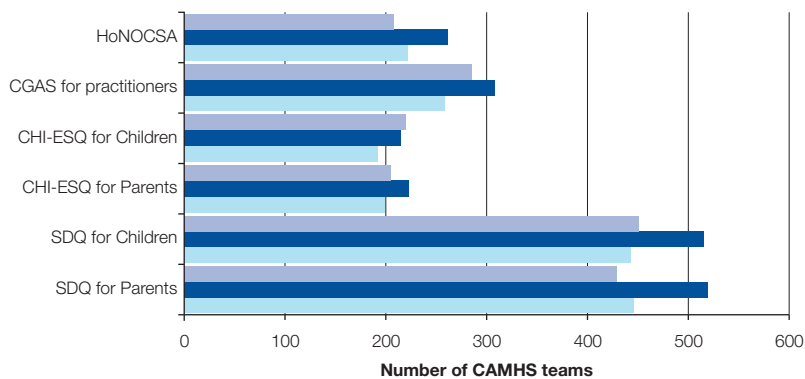
# CAMHS caseload

9.26 A number of additions were made to the caseload collection in 2008. Traditionally, changes have been kept to a minimum, but after consultation with the Expert Working Group and DH advisers the following additions were agreed: a count of the annual number of referrals to the team, a count of the number of times cases were seen, a count of the number of presenting problems of the caseload and the total team caseload on 30th November 2008 (in addition to the existing total active caseload in the sample period question). The mapping continued to collect information on caseload size, the length of time cases have waited to be seen and the length of treatment, and key characteristics of the children and young people who make up the caseload. Each year the data is collected for a sample period only, the calendar month of November for tier 2 and 3 teams and the 6-month period 1st June to 30th November for tier 4 teams.

## Definitions for caseload

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

**Active work:** Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion.

**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 2008.
**Tier 4 teams:** caseload data were collected for the six-month period June 1st to November 30th 2008.

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

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

### National summary and trends

9.27 A total of 109,315 cases were recorded in the 2008 sample periods, with an additional 54,660 consultations carried out by CAMHS staff during the same months. This amounts to a total of 163,975 cases seen or consulted on during the 2008 sample periods. There has been a high level of stability in the active cases seen in the sample periods over the last three years, with small increases from 108,825 cases in the 2006, 109,131 in the 2007 and 109,315 cases in the 2008 (Fig. 9.11). The trend in the number of consultations is more volatile with an 8% increase in the number of consultations between the 2007 and 2008 sample periods and a 16% reduction on the number of consultations recorded between the 2006 and 2007 sample periods. Although comparisons with previous years' findings should be treated with care as the distinction between active casework on the team caseload and consultations was only made for the first time in 2006, it is interesting to note that the total caseload (including consultations) in the 2005 sample periods was 112,984.

**Fig. 9.11:   Trends in cases seen, new cases and cases waiting in the sample periods 2003 to 2008**
*Note: This shows the active caseload in 2006, 2007 and 2008 excluding consultation.*
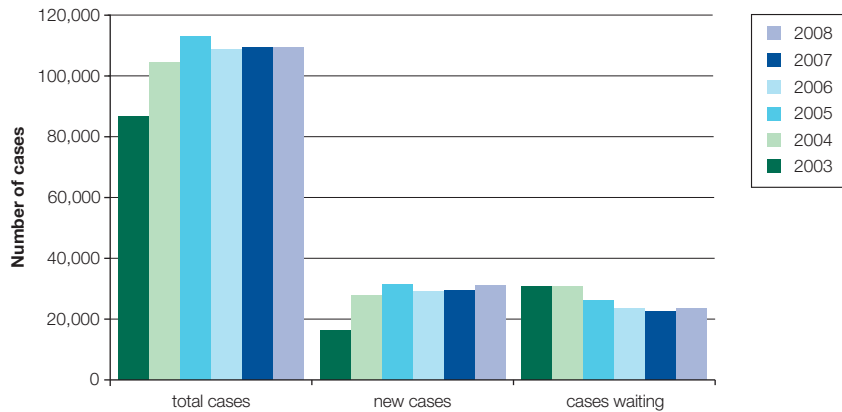


## New cases seen

**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.

*Note: A change was made to the length of wait category in 2008 with the 14 to less than or equal to 26 week category being split into 14 to less than or equal to 18 weeks and 19 to less than or equal to 26 weeks.*

9.28   In total 31,061 new cases were recorded in the 2008 sample period, compared to 29,170 new cases recorded in 2007 and 29,078 in 2006.  The majority of new cases (54%) had to wait less than 4 weeks to be seen by a CAMHS team (53% in 2007 and 48% in 2003).  35% of new cases waited for 5 to 13 weeks in 2008, 6% for 14 to 18 weeks, 3% for 19 to 26 weeks and 2% for over 6 months.  Therefore, 95% of new cases seen during the sample periods had waited for 18 weeks or less and overall (since 2003), waits of more than 3 months have reduced steadily (Fig. 9.12).

**Fig. 9.12:  Trends in percentage of new cases seen in the sample periods and the length of wait 2003 to 2008**



Percentage of new cases seen (y-axis)
Duration of wait (x-axis): < 4 weeks, 5 to <= 13 weeks, 14 to <= 16 weeks, > 26 weeks
Legend: 2008, 2007, 2006, 2005, 2004, 2003
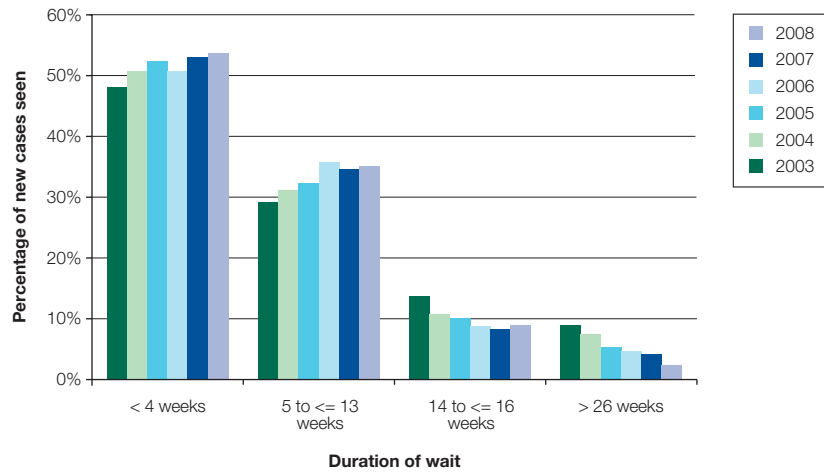
### Cases waiting and length of wait

9.29    The number of cases waiting to be seen by a CAMHS team at the end of the sample period (30th November) increased by 5% from 22,592 in 2007 to 23,650 in 2008.  Previously, the number of cases waiting at the end of the sample period has fallen annually since 2004 (Fig. 9.13).  It fell by 15% between 2004 and 2005, by 10% between 2005 and 2006 and by 5% between 2006 and 2007.  As a proportion of the total number of cases still waiting to be seen, the number of cases waiting for 4 weeks fell for the first time since 2003.  The proportion of cases waiting over 26 weeks increased to 12% in 2008, from 8 % in 2007.  A total of 83% of those cases waiting to be seen by a CAMHS team at the end of the sample periods had waited for less than, or equal to, 18 weeks.

**Fig. 9.13:  Trend in the length of wait of the cases still waiting at the end of the sample periods 2003 to 2008**



Percentage of cases waiting (y-axis)
Length of wait (x-axis): < 4 weeks, 5 to <= 13 weeks, 14 to <= 16 weeks, > 26 weeks
Legend: 2008, 2007, 2006, 2005, 2004, 2003
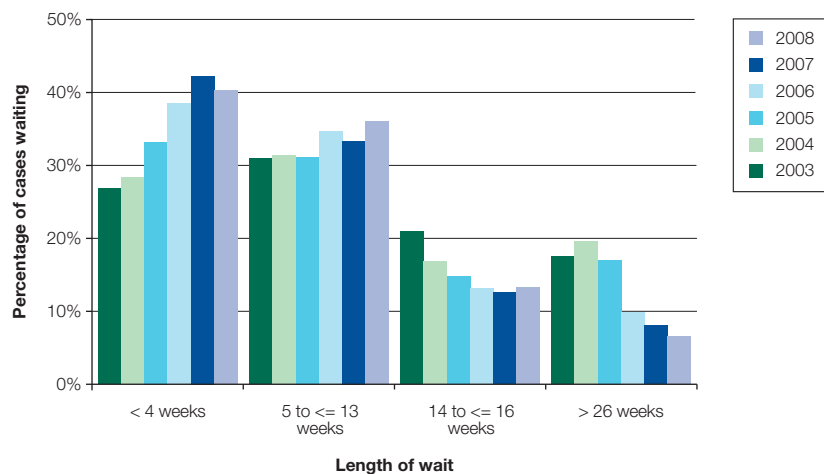
# Chapter 10.

# Safeguarding Services

# Introduction

10.1 Promoting the welfare of children and keeping them safe from harm are key drivers in the national policy agenda for children. Legislation for safeguarding is set out in the Children Act 1989 and 2004 and policy in Every Child Matters and Standard 5 of the *National Service Framework for Children, Young People and Maternity Services*[31]. In addition, successive revisions of *Working Together to Safeguard Children*[32] have included statutory and non-statutory guidance to assist health and social care providers and commissioners to work together effectively to safeguard and promote the welfare of children.

10.2 This chapter examines provision of the safeguarding responsibilities placed on NHS organisations in Working Together. It focuses on arrangements for key professionals and the medical assessment and examination of children and young people suspected of experiencing physical or sexual abuse. These questions were first asked at an organisational level in 2007 but widespread change in the recording of safeguarding provision in 2008 has made comparisons between the years difficult. There were two reasons for these changes:

1. Greater clarity was introduced into the mapping questionnaires about the commissioning and provision of medical examinations of suspected child abuse
2. PCTs were in a state of transition separating their commissioning and service provision activities and, in some cases, setting up separate organisations.

Analysis of the providers of assessments and examinations for suspected sexual abuse revealed that there had been a 40% alteration in the providers of services. Therefore, the information reported below refers to 2008/09 data unless otherwise indicated.

10.3 Since the 2008 mapping exercise was launched, the legal case relating to the death of Baby Peter and subsequent investigations resulted in the Care Quality Commission carrying out a thorough review of child protection systems in NHS organisations. Their report, published in July 2009[33], gives an update and further detail to the findings reported below. CSM will be incorporating the wider range of issues addressed in this review in the next data collection exercise

10.4 This section reports the following:
- PCT responsibilities
  - Provision of designated and named professionals
  - Safeguarding standards in commissioning
  - Safeguarding lead on PCT Board

- NHS provider trust responsibilities
  - Leadership for safeguarding
  - Availability of named professionals for safeguarding
  - Provision of medical assessments and examinations for suspected physical abuse
  - Provision of medical assessments and examinations for suspected sexual abuse

- Safeguarding children's service provision.

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

# PCT responsibilities

### Provision of designated staff

10.6 PCTs are responsible for identifying a senior paediatrician and senior nurse to undertake the roles of designated professionals for safeguarding children across the health economy. Designated doctors and nurses are to provide a strategic professional lead on all aspects of the health service contribution to safeguarding children across the area that they serve, including all health providers working within the PCT area. Designated professionals should also work with the Local Safeguarding Children's Board (LSCB) and ensure appropriate information sharing between key agencies.

10.7 Of the 152 PCTs, 142 (93%) had a designated doctor for safeguarding in post, up from 138 (91%) in 2007 (Fig. 10.1). These provided a total of 49.9 wte hours in their safeguarding role, an increase of 5 wte on the previous year and equivalent to 0.33 wte per PCT. The number of designated doctors that were paediatricians had fallen. In 2008, 6 were GPs compared to 1 in 2007 and one designated doctor was recorded as 'other'. 145 PCTs (95%) had a designated nurse for safeguarding, unchanged from the previous year but their hours dedicated to this role had increased substantially from 117 wte in 2007 to 139 wte in 2008 or 0.91 wte per PCT. 97% of designated nurses were on senior staff grades.

10.8 From 1 April 2008, LSCBs had a duty to collect and analyse information about the deaths of all children in their area in order to identify matters of concern about the safety and welfare of children and to trigger a serious case review when necessary. 133 PCTs (88%) had a designated doctor for child death reviews in post, an increase of 32 PCTs in 2007. Of the 133 doctors in post, 121 (91%) were paediatricians, 2 were GPs and 9 were recorded as 'other'.

10.9 PCTs are also expected to have designated staff to work with local Councils with Social Services Responsibilities (CSSRs) to ensure that the health needs of looked after children (LAC) are met. These designated doctors and nurses should provide strategic and clinical leadership and advice to defined (PCT) populations . In 2008, 119 PCTs (78%) reported having a designated doctor for LAC and 135 (89%) reported having a designated nurse for LAC. In total these designated doctors provided 41 wte or 0.27 wte per PCT while designated nurses for LAC provided 124 wte or 0.82 wte per PCT.

**Fig. 10.1: PCT provision of designated staff for safeguarding, looked after children and child death reviews 2007 and 2008**
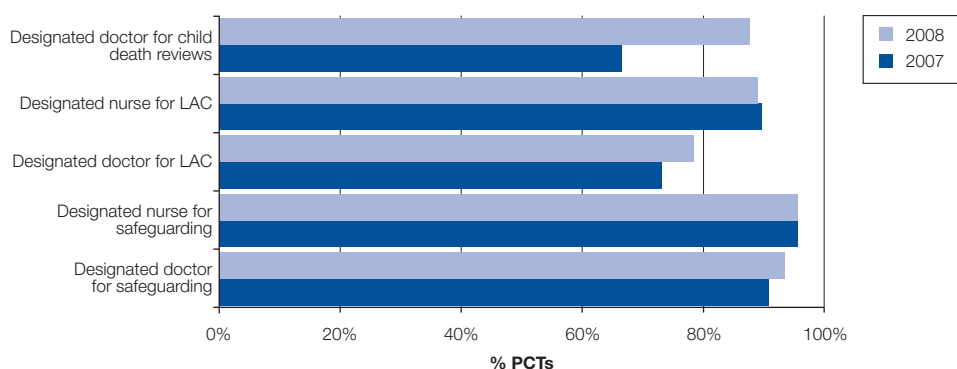
### Safeguarding standards in commissioning contracts

10.10 PCTs are expected to ensure that safeguarding and promoting the welfare of children are integral to clinical governance and audit arrangements. Therefore, service specifications drawn up by PCT commissioners should include service standards for safeguarding. 126 PCTs (83%) reported that standards for safeguarding were specified in commissioning contracts for children's health services compared to 108 PCTs (71%) in 2007. Of these PCTs, 120 (95%) ensured that performance against the standards was monitored, up from 87% in 2007.

### Safeguarding lead on PCT Board

10.11 Within PCTs, responsibility for safeguarding children should be held by a nominated director at board level. In 2008, 46 PCTs (30%) had a dedicated safeguarding lead. In 34 PCTs (22%) this responsibility was held by the Director of Public Health and in 12 PCTs (8%) by the Children's Lead. Overall, 127 PCTs (84%) reported that their children's safeguarding lead was a member of the PCT board.

## NHS provider trust responsibilities

### Leadership for safeguarding

10.12 Of the 362 NHS trusts (including PCTs) that provide child health, CAMHS and maternity services, 335 (92%) had a lead for safeguarding on the trust board and of these and 259 (77%) were members of the LSCB.

### Availability of named professionals for safeguarding

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

10.14 319 NHS trusts reported having a named doctor for safeguarding in post, a reduction from 2007 (Table 10.1) but this could be due to a number of PCTs becoming commissioning organisations only and no longer providing services. In all, there were 408 named doctor posts. Named nurses provided a total of 414 wte and named midwives 89 wte. Named doctor posts were often shared between more than one professional. In 66% of trusts named doctors were paediatricians, in 12% they were GPs, in 11% GPs worked in partnership with paediatricians. In 11% of trusts, the post was filled by psychiatrists. In total 331 (91%) NHS trusts had a named nurse, and 176 (49%) a named midwife.

**Table 10.1: Provision of named professionals for safeguarding 2007 and 2008**

|  | 2007 | | | 2008 | | |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Number of trusts** | **% trusts** | **Number/ wte of staff** | **Number of trusts** | **% trusts** | **Number/ wte of staff** |
| **Named doctor** | 328 | 90% | 451 | 319 | 88% | 408 |
| **Named nurse** | 339 | 93% | 467 | 331 | 91% | 414 |
| **Named midwife** | 176 | 48% | 140 | 176 | 49% | 89 |
| **Total NHS providers** | 363 | | | 362 | | |

## Provision of examination and assessment for suspected physical abuse

10.15  211 PCTs and provider trusts provided specialist assessments and examinations of children referred for suspected physical abuse.  No availability was given for 9 of the services but of the remaining 202 services, 75% were available on a 24/7 basis, 5% in the daytime and evening and 20% within normal office hours only (Fig. 10.2).  The service was provided by the on-call general paediatrician rota in 72% of services, by a specific paediatric child abuse rota in 38%, A&E staff in 9% and by the medical examiner in 9%.  Some services recorded more than one option.

**Fig. 10.2:  Availability of specialist assessments and examination of suspected physical abuse 2008**



24/7
Office hours
Office hours and evenings
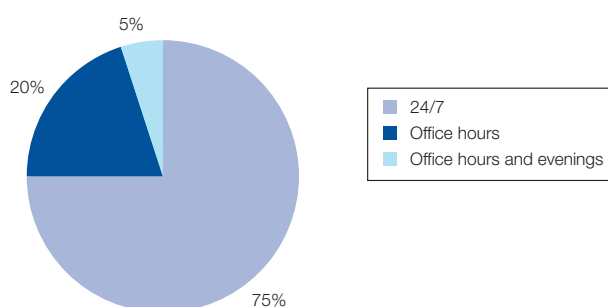
## Provision of examination and assessment for suspected sexual abuse

10.16  172 PCTs and provider trusts provided specialist assessment and examinations of children referred for suspected sexual abuse, a reduction of 6 reported in 2007.  Of these services, 43% were available on a 24/7 basis, 11% in the daytime and evening and 32% within normal office hours only.  In 14% of trusts there was more limited accessibility to assessments carried out in the local service but arrangements were in place to transfer children and young people to nearby centres (Fig. 10.3).

**Fig. 10.3:  Availability of specialist assessments and examination of suspected sexual abuse 2008**



24/7
Office hours
Office hours and evenings
Other
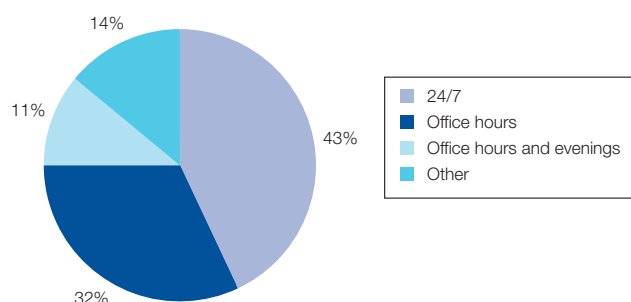
10.17  Information on who carried out the assessment and examination was provided for 157 services.  Of these, assessments were carried out by a specific paediatric child sexual abuse rota in 53% of services, by the on-call general paediatrician rota in 37% of services, by the medical examiner in 24% and by A&E staff in 3%.  In 11% of services other arrangements were reported such as specially trained community paediatricians, designated or named doctors or tertiary units.  Assessments and examinations were always carried out by two doctors in 34% of services, by one doctor in 14% and by sometimes one and sometimes two in 52%.

For those services in which the examination was carried out by more than one doctor, 55% reported the involvement of a specific paediatric child sexual abuse rota, 55% the medical officer and 53% the general paediatric rota.

10.18 Examinations were carried out in more than one location in many services with 67% being carried out in designated areas in children's outpatient departments, 44% in a designated area in children's acute inpatient units, 16% in a general sexual assault referral centre (SARC), 15% in a children's SARC and 15% in a designated suite in a police station (Fig. 10.4). An additional 2% of services used designated areas in the gynaecological department.

**Fig. 10.4: Location of specialist assessments and examination of suspected sexual abuse 2008**
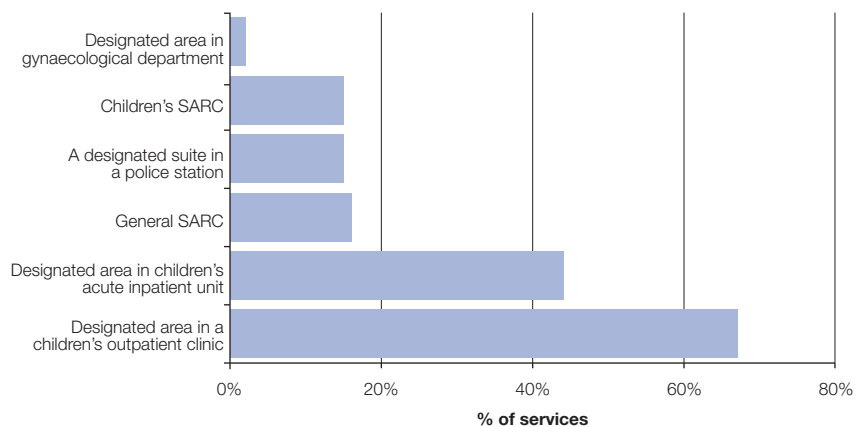


10.19 The availability of equipment for specialist examinations of suspected sexual abuse varied, with 83% of services having access to a colposcope, 78% to microbiological studies, 80% to pregnancy testing and 74% to digital photographic recording. Change since 2007 is shown in Fig. 10.5.

**Fig. 10.5: Equipment available for specialist assessment and examination of suspected sexual abuse 2007 and 2008**
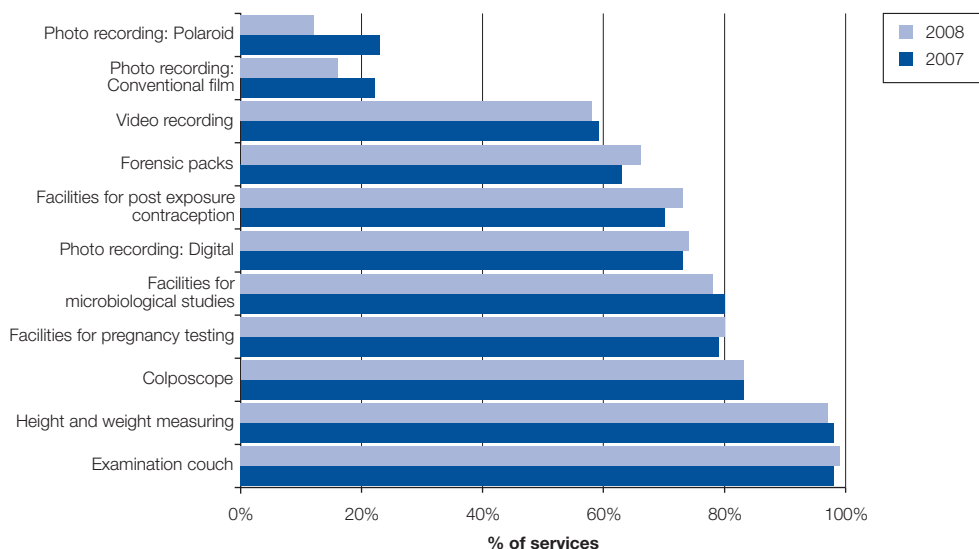
10.20  Nurses were available to support children and young people during assessments and examinations for suspected sexual abuse in 86% of services during office hours but only 55% of services on a 24/7 basis. Play workers were available in 49% of services during the day and in only 8% out of office hours. This showed a slight improvement on 2007 (Fig.10.6).

**Fig. 10.6: Availability of nurses and play workers during specialist assessments and examination of suspected sexual abuse 2007 and 2008**
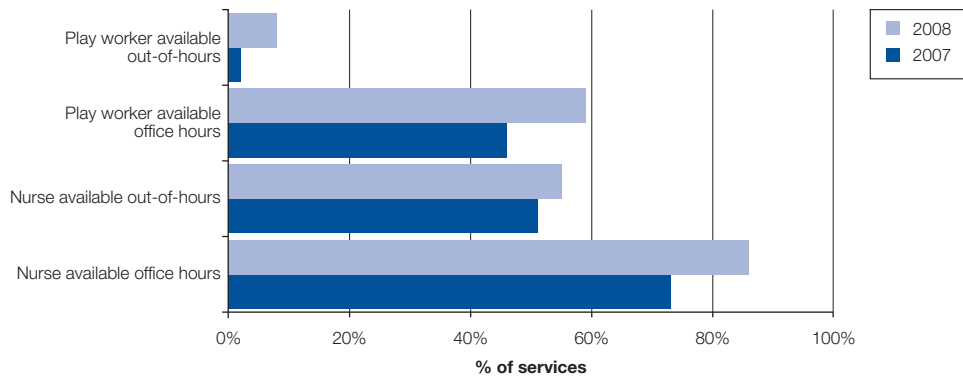


## Provision of dedicated safeguarding services

10.21  The number of dedicated safeguarding services mapped in 2008 was 268, a slight decrease from 277 services in 2007 and 303 in 2006. In 2008, 174 services (65%) provided safeguarding training, 137 (57%) provided child protection services and 38 (14%) provided a therapeutic service. 63% of services were multipurpose, 15% were dedicated safeguarding training and 22% did not define their function.

# Appendices

# Appendix 1:

## Completion rates in child health, CAMHS and maternity service mapping 2008

### A.1 Completion rates

Children's services mapping (CSM) is a voluntary data collection exercise that is carried out annually. All PCTs and NHS child health, CAMHS and maternity services providers are invited to take part as well as all local authorities. Despite being a voluntary exercise, high participation rates are achieved but response varies year-on-year both in the number of agencies entering data and the completeness of the data reported.

Three measures indicate the completeness of data entry:
1. Rates of registration on the mapping website
2. Rates of sign-off by the Chief Executive Officer (CEO) and Directors of Children's Services (DCS) of participating agencies to confirm completion of their agency's submission
3. Rates of sign-off of each individual service questionnaire and finance spreadsheet to confirm that it is complete.

Rates of response in each of these measures is given below for the 2006, 2007 and 2008 mapping exercises.

### A.2 Completion rate 1: Registration rates

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

**Table 1:    Rates of registration for the mapping exercise 2006 to 2008**

|  | 2006 | | | 2007 | | | 2008 | | |
|---|---|---|---|---|---|---|---|---|---|
|  | Total in England | Number registered | Registration rate | Total in England | Number registered | Registration rate | Total in England | Number registered | Registration rate |
| PCTs | 152 | 152 | 100% | 152 | 152 | 100% | 152 | 152 | 100% |
| NHS Provider Trusts | 211 | 210 | 99.5% | 212 | 210 | 98.1% | 210 | 210 | 100% |
| LAs | 150 | 150 | 100% | 150 | 150 | 100% | 150 | 150 | 100% |
| **Total** | **513** | **510** | **99.8%** | **514** | **510** | **99.2%** | **512** | **512** | **100%** |

### A.22 Completion rate 2: CEO sign off rate

Every year, Chief Executive Officers of NHS trusts and Directors of Children's Services in local authorities are asked to 'sign off' the mapping data that is being reported by their agency. This signifies that the CEO/director has been presented with a report of the data (set up on the mapping website for this purpose) and agrees with the data going forward as a description of the agency's relevant service provision and investment. Separate sign off reports are prepared for finance, child health and maternity services provision, CAMHS provision and performance indicators. The rates of sign off in 2006, 2007 and 2008 are shown in Table 2.

**Table 2: Rates of sign off by CEO and Directors of Children's Services 2006 to 2008**

| | 2006 | | | 2007 | | | 2008 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Number of agencies registered | Number signed off | Sign off rate | Number of agencies registered | Number signed off | Sign off rate | Number of agencies registered | Number signed off | Sign off rate |
| PCT finance data | 152 | 132 | 87% | 152 | 144 | 95% | 152 | 137 | 90% |
| Child health and maternity service data | 316 | 267 | 84% | 316 | 292 | 92% | 320 | 274 | 86% |
| CAMHS data | 110 | 95 | 86% | 110 | 101 | 92% | 112 | 112 | 100% |
| Children's hospital services | n/a | n/a | n/a | 163 | 156 | 96% | 160 | 158 | 98% |
| LA PAF 70 proxy indicator | 150 | 107 | 71% | 150 | 106 | 71% | 150 | 150 | 100% |

## A.33 Completion rate 3a and b: Questionnaires and spreadsheets confirmed complete

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

**Table 3a: Rates of sign off of finance spreadsheets by PCTs and local authorities 2006 to 2008**

| | 2006 | | | 2007 | | | 2008 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Spreadsheets completed | Confirmed complete | % confirmation rate | Spreadsheets completed | Confirmed complete | % confirmation rate | Spreadsheets completed | Confirmed complete | % confirmation rate |
| PCT | 1639 | 1575 | 96% | 1888 | 1786 | 95% | 2116 | 1932 | 91% |
| LA | 212 | 186 | 88% | 304 | 288 | 94% | 203 | 168 | 83% |
| **Total** | **1851** | **1761** | **95%** | **2192** | **2074** | **95%** | **2319** | **2100** | **91%** |

**Table 3b: Rates of sign off of service questionnaires 2006 to 2008**

| | 2006 | 2007 | 2008 |
|---|---|---|---|
| Number services mapped | 5057 | 4813 | 4841 |
| Services confirmed complete | 4588 | 4507 | 4534 |
| % confirmation rate | **91%** | **94%** | **94%** |

**Table 3c:  Rates of sign off of service questionnaires  2008 by service type**

| Service category | Service Type | Services Provided | Services Confirmed Complete | Sign off rate |
|---|---|---|---|---|
| Child health in the community | School health | 289 | 262 | 91% |
| | Early years and health visiting | 411 | 363 | 88% |
| | Children's therapy service | 520 | 485 | 93% |
| | Counselling | 35 | 27 | 77% |
| | Children's community nursing team | 128 | 126 | 98% |
| | Community dental services | 26 | 24 | 92% |
| | Palliative care | 40 | 34 | 85% |
| | Paediatric continence promotion | 22 | 20 | 91% |
| | Equipment and wheelchair | 14 | 13 | 93% |
| | Child development teams | 73 | 71 | 97% |
| | Health promotion | 287 | 250 | 87% |
| | Community paediatrics | 230 | 210 | 91% |
| | Children's community team: other | 81 | 77 | 95% |
| Children's hospital services | Children's surgery | 203 | 193 | 95% |
| | Specialist paediatric service | 211 | 203 | 96% |
| | Paediatric intensive care unit (PICU) | 27 | 27 | 100% |
| | General paediatrics | 235 | 229 | 97% |
| | Paediatric emergency service | 173 | 167 | 97% |
| Maternity and neonatal care | Maternity unit | 219 | 211 | 96% |
| | Neonatal care | 162 | 157 | 97% |
| Specialist CAMHS | Multidisciplinary generic CAMHS team | 405 | 399 | 99% |
| | Single disciplinary generic CAMHS team | 48 | 47 | 98% |
| | Targeted CAMHS team | 307 | 300 | 98% |
| | Dedicated CAMHS worker working in a non-CAMHS team | 133 | 131 | 98% |
| | Tier 4 CAMHS unit/team | 113 | 111 | 98% |
| Children's social services | Safeguarding children service | 268 | 236 | 88% |
| | Fostering and adoption | 8 | 8 | 100% |
| | Social work team | 1 | 1 | 100% |
| | Residential care and children's accommodation | 3 | 1 | 33% |
| | Short Breaks | 20 | 18 | 90% |
| | Family support | 3 | 3 | 100% |
| | Parenting support | 2 | 1 | 50% |
| | Young people's support | 4 | 4 | 100% |
| | Day care | 1 | 1 | 100% |
| | Sure Start Children's Centre | 6 | 6 | 100% |
| | Childcare support (including training for childminders) | 1 | 1 | 100% |

| Service category | Service Type | Services Provided | Services Confirmed Complete | Sign off rate |
|---|---|---|---|---|
| Education and learning support | SEN support | 4 | 4 | 100% |
| | Support to schools | 2 | 2 | 100% |
| | Portage | 4 | 4 | 100% |
| | Alternative provision | 1 | 1 | 100% |
| | Pupil referral unit | 1 | 1 | 100% |
| | Adult and community learning | 1 | 1 | 100% |
| Youth services | Youth services | 1 | 1 | 100% |
| | Youth offending | 6 | 3 | 50% |
| | Drug and alcohol | 9 | 8 | 89% |
| | Sexual health | 18 | 18 | 100% |
| | Teenage pregnancy | 11 | 11 | 100% |
| Children's central support services | Management | 9 | 9 | 100% |
| | Administration – records, information | 17 | 14 | 82% |
| | Performance and quality | 1 | 1 | 100% |
| | Media and publicity | 1 | 1 | 100% |
| | Training | 2 | 2 | 100% |
| | Commissioning | 2 | 2 | 100% |
| | Family Information Service | 1 | 1 | 100% |
| | No primary service type defined | 41 | 33 | 80% |
| | **Total** | **4841** | **4534** | **94%** |

# Appendix 2:

## Technical notes on the mapping exercise

This Appendix provides an outline of the children's services mapping methodology.

### A2.1  Basic mapping concepts

Key characteristics of children's services mapping include:
- Data collection takes an annual snapshot of service provision and investment
- Online data collection input by all NHS trusts that provide or commission child health, CAMHS and/or maternity services and local authority children's services in England
- Service provision is mapped to defined service/team types (Appendix 3)
- Services are mapped at the level of services or teams that make up those services
- Expenditure on child health and maternity services entered by PCT commissioners and local authorities
- All data is made publicly available in reports at: www.childrensmapping.org.uk.

### A2.2  Brief description of data collection process

- Introductory training delivered regionally
- Telephone/email helpdesk is provided throughout the data collection and reporting period
- Nominated Mapping Leads register on the website and obtain a unique password giving access to their NHS organisation or local authority's data set
- The Mapping Lead registers colleagues to support the mapping process as appropriate (as Assistant Mapping Leads or Service Group Heads) on the website to take responsibility for inputting specified areas of services or finances
- Service Group Heads review the data submitted in the previous year, making changes and revisions where necessary
- Service Group Heads either complete team data or 'delegate' completion to the appropriate team manager
- Commissioning leads complete the commissioning data
- Data are collected on-line through the Internet
- Data collection opened on 1st November 2008 and the annual snapshot was taken on 30th November
- Data are checked and confirmed correct by chief executive officers
- Data collection was frozen on 28th February 2009 but corrections were accepted beyond this date.

### A2.3  Changes to deliver children's services mapping in 2008:

The mapping exercise is kept as similar to the previous year's data collection as possible.  However, the significant changes were introduced in 2008 in order to launch the integrated children's services mapping exercise that included all services that fall under the responsibility of Children's Trusts.  These changes included:
- Extending the classification of services
- Developing a classification for the integrated children's workforce
- Identifying services for children and young people with a disability as all services that provide targeted work in this area.

## A2.4  Changes to the child health and maternity exercise in 2007:

Changes introduced in 2007 included:

- Enabling mappers to select more than one service type in order to reflect the plurality of service provision
- New questions were added to the PCT commissioner and provider organisation-wide questionnaire on NHS safeguarding provision
- All services were asked to indicate which of the Every Child Matters outcomes they were seeking to deliver
- Questions were introduced for all services on whether the whole or part of the service was targeted to particular groups of children and young people
- Services were asked to indicate if they routinely collected feedback from service users on their satisfaction with the service and if they encouraged users to participate in the design, development or delivery of services.
- Data was collected for the Healthcare Commission to contribute to the Annual Health Check.  This concentrated on a number of indicators arising around from the 2005 review of children's hospital services.

## A2.5  Changes to the child health and maternity exercise in 2006:

The changes that were introduced in 2006 included:

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

## A2.6  Checks and reliability

- Summary reports automatically screen data for completeness and plausibility
- Standardised codes and selection from pre-defined lists wherever possible
- Summaries giving overall view of the data entered and are signed off by the organisation's chief executive officer
- Data scrutinised by Durham team during preparation of atlas and problems checked with local informants.

# Appendix 3:

## Service classification 2008

### Child health in the community services
- School health
- Early years and health visiting
- Children's therapy service
- Counselling
- Children's community nursing team
- Community dentistry
- Palliative care
- Paediatric continence promotion
- Equipment and wheelchair
- Child development teams
- Health promotion (health improvement, advice and support)
- Community paediatrics
- Children's community team: other
- Children's hospital services
- Children's surgery
- Specialist paediatric service
- Paediatric intensive care unit (PICU)
- General paediatrics
- Paediatric emergency service

### Maternity and neonatal care services
- Maternity unit
- Neonatal intensive care unit (NICU) and Special care baby unit (SCBU)

### CAMHS (specialist tiers 2-4)
- Multidisciplinary generic CAMHS team
- Single disciplinary generic CAMHS team
- Targeted CAMHS team
- Dedicated CAMHS worker working in a non-CAMHS team
- Tier 4 CAMHS unit/team

### Children's social services
- Safeguarding children service
- Fostering and adoption
- Social work team
- Residential care and children's accommodation
- Short breaks
- Family support
- Parenting support
- Young people's support
- Young carers' support
- Rights and inclusion
- Day care

## Education and learning services

- Sure Start Children's Centre
- Childcare support (including training for childminders)
- SEN support
- Education welfare
- Support to schools
- Portage
- Educational psychology
- Teaching advisors
- Learning promotion and support (including English as an additional language)
- Race, equality and diversity
- Pupil tracking
- Inspection and monitoring
- Alternative provision
- Pupil referral unit
- Adult and community learning
- Extended schools service
- Entry to employment training
- Vocational training

## Youth services

- Youth services
- Connexions
- Youth offending
- Drug and alcohol
- Sexual health
- Teenage pregnancy

## Children's leisure services

- Out of school/holiday activities
- Play development
- Outdoor residential activities
- Performing arts service (e.g. music, arts, drama)
- Sports development

## Children's central support services

- Management
- Administration – records, information
- Planning, policy and research
- Performance and quality
- Finance
- Media and publicity
- Training
- IT support
- Commissioning
- Procurement
- Family Information Service

# Appendix 4:

## Integrated children's workforce classification 2008

### Facilities and Support Management
- HR officer
- Research / data analyst
- Fin ance officer
- ICT/Technical support officer
- Policy/ Planning officer
- Project officer
- Quality and performance officer
- Communications (PR) officer
- Health and safety officer
- Contracts and procurement officer

### General
- Training officer
- Caretaker/ maintenance staff/ handyman
- Cleaner
- Cook
- Catering assistant
- Other qualified staff
- Fire-fighter
- Driver

### Social Care
- Advisors and rights workers
  - Welfare benefits advisor
  - Children's rights officer/worker
  - Advocacy worker
  - Independent review officer
  - Information worker
- Social work
  - Field/community social worker
  - Day care social worker
  - Residential social worker
- Housing
  - Housing/placement/resettlement worker
  - Rehabilitation worker
- Childcare
  - Childcare advisor

## Health Staff

- Nursing staff
  - Health visitors
  - School nurses
  - Registered Nurse Children
  - Registered Nurse Learning Disabilities
  - Registered Nurse Mental Health
  - Registered Nurse Adult-o        Nurse Consultant
- Medical staff
  - Consultant
  - Non-consultant career grades (NCCG)
  - Trainee
  - GP with special interest in paediatrics
- Midwifery
  - Head of midwifery
  - Midwives AFC band 5
  - Midwives AFC band 6
  - Midwives AFC band 7
  - Midwives AFC band 8
- Allied Health Professionals
  - Occupational therapists
  - Physiotherapists
  - Speech and language therapists
  - Radiographers
  - Clinical psychologists
  - Audiologists
  - Operating department practitioners
  - Podiatrists
  - Dieticians
  - Orthoptists
  - Art therapists
  - Drama therapists
  - Music therapists
  - Prosthetists
  - Family therapists
  - Child and adolescent psychotherapists
  - Counsellors
  - Anaesthesia practitioners
  - Health promotion officers
- Primary Mental Health Workers
- Scientific / Technical Staff
- Paediatric pathologists
- Paediatric incontinence advisor
- Other staff
  - Other qualified
  - Other staff (text box for description)

## Youth Offending

- Police Officer (Sergeant and below)
- Community Police Officer
- Youth offending officer
- Bail support officer
- Court liaison officer
- Victim liaison officer

## Education and Youth Work

- Teachers
  - Teacher (general)
  - Specialist teacher behaviour support
  - Teacher advisor
  - Portage teacher
  - Additional language teacher
  - SEN teacher
- Education
  - Educational psychologist
  - Librarian
  - Education welfare officer
  - Education employment worker
  - School support officer
  - School governor support officer
  - Statement, assessment and review officer
  - Parent advisor
  - Youth and community development worker
  - Personal advisor
  - Learning mentor
  - Careers advisor
  - Tutor
  - Nursery nurse

## Sport, Fitness, Leisure, Play Work Outdoors

- Play specialists
- Play development officer
- Sport and leisure worker
- Sport development officer
- Arts officer

## Support workers/assistants

- Administrative assistant
- Social care assistant/ Support worker
- Play assistants
- Behaviour support worker
- Classroom assistant
- Health support worker
- Maternity support worker
- Support worker youth offending
- Education welfare support assistant
- Youth work assistant
- Childcare assistant
- Assistant occupational therapists

- Assistant physiotherapists
- Assistant speech and language therapists
- Nursing assistants
- Assistant psychologists
- Other assistant therapists
- Family health workers
- Other unqualified staff

## Admin/ Management
- Service/ team manager
- Site manager
- Business manager
- Administrator /Clerical officer /Secretary

# Appendix 5:

## Working definition of CAMHS tiered system provion

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

### Tier 1

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

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

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

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

The roles of PMHWs include:

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

### Tier 2

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

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

Tier 2 services offer:

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

The purpose of tier 2 services is to:
- enable families to function in a less distressed manner,
- enable children and young people to overcome their mental health problems,
- diagnose and treat disorders of mental health,
- enable children and young people to benefit from their home, community and education,
- enable children, young people and their families to cope more effectively with their life experiences.

## Tier 3

A specialist service for the more severe, complex and persistent disorders. Because of the complexity of the work that they undertake, staff usually work in a multidisciplinary team or service working in a community child mental health clinic or child psychiatry outpatient service. Tier 3 services might have input from the following professionals:
- Social workers
- Clinical psychologists
- Systematic family therapists
- Community psychiatric nurses
- Child and adolescent psychiatrists
- Art, music and drama therapists
- Child psychotherapists
- Occupational therapists.

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

## Tier 4

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

Tasks undertaken in tier 4involve:
- 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.*

# Appendix 6:

## Child Health, CAMHS and Maternity Services Mapping Steering Group 2008/09

### Remit:

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

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

### Membership:

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

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

# Appendix 7:

## Child Health, CAMHS and Maternity Service Mapping Expert Reference Group 2008/09

### Remit:

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

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

### Membership:

| | |
|---|---|
| Alcuin Edwards | Department of Health |
| Amanda Robson | George Elliot Hospital |
| 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 |
| 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 |
| Dr Lynda Brook | Alder Hey Hospital |
| Lynne Leyshon | South Devon Healthcare NHS Trust |
| Mark Cain | County Durham Primary Care Trust |
| Mohammed Kibirige | James Cook University Hospital |
| Paula Carr | North Stoke Primary Care Trust |
| Sue Welsh | Northumberland, Tyne and Wear SHA |

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

# Appendix 8:

## References and policy documents used in the preparation of this report

1  Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health/Department for Education and Skills.

2  Department for Education and Skills (2004) *Every Child Matters*.  London: DfES.

3  Department for Children, Schools and Families (2007) The Children's Plan. London: DCSF.

4  Department of Health and Department for Children, Schools and Families (2009) *Healthy lives, brighter futures: The strategy for children and young people's health*. London: Department of Health.

5  Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service.* London: Department of Health.

6  Department of Health and The Home Office, The Victoria Climbié Inquiry, Report of an Inquiry by Lord Laming, Cm 5730, January 2003.

7  The Lord Laming (2009) The Protection of Children in England: A progress report.  London: The Stationery Office

8  HM Treasury and Department for Education and Skills (2007) *Aiming high for disabled children: better support for families.* Crown copyright.

9  As above.

10  Department of Health and Department for Children, Schools and Families (2009) Securing better health for children and young people through world class commissioning. *A guide to support Healthy lives, brighter futures: The strategy for children and young people's health.* London: Department of Health.

11  Department for Children, Schools and Families (2008) *Children's Trusts: statutory guidance on inter-agency cooperation to improve well-being of children, young people and their families.*  Crown Copyright.

12  Department for Children Schools and Families, Children's Workforce Development Council and Local Government Association (2009), *Proposed Harmonised Data Standards and Definitions for the Children's and Young People's and Local Government Workforce.*
http://www.dcsf.gov.uk/consultations/index.cfm?action=consultationDetails&consultationId=1629&external=no&menu=1

13  Department for Children Schools and Families (2008) *Children and Young People's Workforce Strategy*. London: DCSF.

14  Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health/Department for Education and Skills. Standard 9.

15  Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service.* London: Department of Health.

[16] Royal College of Obstetricians and Gynaecologists (2008) *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press.

[17] Healthcare Commission (2008) Towards better births: *A review of maternity services in England, Commission for Healthcare Audit and Inspection.*

[18] Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press.

[19] Department of Health (2009) *Toolkit for high quality neonatal services*. London: Department of Health.

[20] Department of Health and Department of Children, Schools and Families (2008) *Child Health Promotion Programme: Pregnancy and the first five years of life*.  London: The Stationery Office.

[21] HM Government (2001). *Report of the Public Inquiry into Children's Heart Surgery at Bristol Royal Infirmary 1984-1995: Learning from Bristol*. London: The Stationery Office. Chairman: Ian Kennedy.

[22] Department of Health (2005) *National Service Framework for Long Term Conditions*. London: Department of Health.

[23] Department of Health (2002) *Report of the Paediatric and Congenital Cardiac Services Review Group*. London: Department of Health.

[24] Department of Health (2009), *Healthy lives, brighter futures – The strategy for children and young people's health.*

[25] Department of Health (2003), *National Service Framework for Diabetes*. London: Department of Health

[26] Department of Health (2007). *Making every young person with diabetes matter.* London: The Stationery Office

[27] HM Treasury and Department for Education and Skills (2007) *Aiming high for disabled children: better support for families*. Crown copyright.

[28] Department of Health (2008) *Better care, better lives: Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions*. London: Crown copyright.

[29] The NHS Operating Frameworks for 2008-09 and 2009-10

[30] Department of Health and Department for Education and Skills (2008) *Healthy Lives, brighter futures: The strategy for children and young people's health.*  London: Department of Health and Department for Education and Skills.

[31] Department of Health and Department for Education and Skills (2004) *The national service framework for children, young people and maternity services*. London: TSO.

[32] HM Government (2006) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*.  London: TSO.

[33] Care Quality Commission (2009) *Safeguarding children: A review of arrangements in the NHS for safeguarding children*.  London: Care Quality Commission.

[34] Department of Health (2002) *Promoting the health of looked after children*. London: TSO.

# Acknowledgements

We would like to thank everybody who has contributed to this children's services mapping exercise. We thank:

- our sponsors for their support which has extended well beyond funding
- our expert advisors and national policy leads for their guidance on the design of the exercise, its interpretation and how it should be reported
- the practitioners and managers who have participated in the exercise for their time and hard work in collecting the data
- Bob Foster, Claire Hartley and Pauline Dowson in the National Mapping Team for their vision, drive and commitment.

Without your help we would not have been able to develop the mapping into a resource that is increasing understanding of service provision and supporting work to improve outcomes for children and young people.

# Metadata

| | |
|---|---|
| Coverage.Spatial | England |
| Coverage.Temporal | Start date of capture: 2008-11-01<br>End date of capture: 2009-02-27 |
| Creator | Durham University, School of Applied Social Sciences, help@childrensmapping.org.uk |
| Date.Issued | April 2010 |
| Date.UpdatingFrequency | Annually |
| Description | Report of the 2008/09 children's services mapping exercise in England |
| Format | Text |
| Language | ISO 639-2 eng |
| Publisher | Durham University Mapping Team, School of Applied Social Sciences,<br>Durham University, Elvet Riverside II, New Elvet, Durham, DH1 3JT,<br>0191 334 1489, help@childrensmapping.org.uk |
| Website | http://www.childrensmapping.org.uk |
| Rights.copyright | © Durham University, Durham University Mapping Team, 2009 |
| Subject | Child health, child and adolescent mental health and maternity services |
| Subject.Category | Mental Health, children's health, maternity provision |
| Title | A Profile of Children's Health, CAMHS and Maternity Services in England 2008/09 |

April 2010

designed@**belong**creative.co.uk