CLINICAL TEAM OPERATIONAL FRAMEWORK

Cambridgeshire County & Peterborough City Councils

Clinical Team: Helping Children to Feel Happy, Healthy and Heard

Children have an innate drive towards independence and self-direction, needing permissiveness and acceptance from significant people in their lives to accept and value themselves (Axline, 1969)

1. Purpose

1.1. The purpose of this document is to provide a unified Standard Operating Framework for Cambridgeshire and Peterborough Clinical Team.

1.2. The document outlines the core components of the service. This operational framework is informed and supported by Cambridgeshire and Peterborough policies, procedures, practice guidance and other general information informed by local and national policy drivers.

2. Background

2.1. Many children and young people in care have suffered adverse childhood experiences alongside having to manage the impact of not being able to live within their birth families. This means that many will require additional specialist support at times during their lives. Sometimes, this will be best provided through Child and Adolescent Mental Health and similar services.

2.2. There will also be occasions when it will be important for children and young people, as well as those who care for them, to have direct access to specialist clinical support, as provided by our clinical specialist staff. Briefly, key areas of priority activities include providing:

2.3. A joint service that works with children and young people in care, foster carers and children and young people on the edge of care in both authorities;

2.4. A model of practice where clinicians work within an integrated clinical model, where systemic practice is a part, rather than the predominant element of the work;

2.5. A service that works with all children and young people in care, regardless of the stage of their care experience;

2.6. A service that continues to work closely with foster carers, providing training and support, including providing direct advice and support to our foster carers in developing strategies that enable children in their care to settle, reducing the risk of placement breakdown.

3. Overview

3.1. Children's Services work with the most vulnerable children, young people and families, including those on the edge of care, within the care system and preparing for independence. The primary function for the Clinical Team is to enhance relational social work practice, our carers' therapeutic abilities, and to improve outcomes for children who are in care.

3.2. The Clinical Team contribute expertise at all levels of the wider service structure, to ensure that adults and professionals with the most influence in a child's life, are informed by evidence-based models relevant to the emotional health and wellbeing of children who are in care.

3.3. They also contribute to the assessment of children's emotional health and wellbeing to inform care planning. This involvement may also include supporting decisions about contact with birth family, placement suitability, safety planning, reunification planning, sibling assessments and SDQs.

3.4. Foster carers, including some of our most experienced carers, can struggle with managing challenging behaviour on a daily basis; it can be exhausting. One of the key aims of the revised clinical offer is therefore to increase the support that we can provide to our carers.

3.5. The overall aim being to reduce the need for out of county placements, minimising unnecessary disruptions and improving the child's care and family experience.

4. Delivery Framework

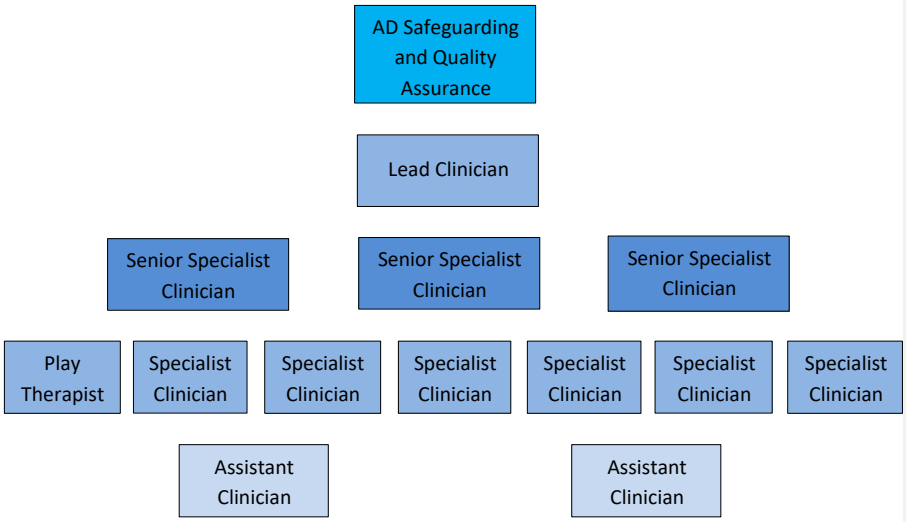
4.1. The Clinical Team will employ a developmental trauma informed framework to deliver support to the network and child.

4.2. Developmental trauma is an umbrella concept for a spectrum of specific difficulties, resulting from the impact on the brain development, due to early trauma. This complex spectrum of difficulties means that parenting and educating a child with developmental trauma is commonly challenging and fraught.

4.3. It is a complex, fluid spectrum which the child can move along as life and family stressors and protective factors change. Quite often the child will have secondary difficulties that require intervention as Care experienced children are commonly anxious, sad, show ADHD, disordered eating, self-harm and autistic traits. (This list is not exhaustive.)

4.4. This spectrum of difficulties tends to ripple into the systems surrounding the child or young person. This is characterised by high levels of distress and emotional dysregulation in the child and network supporting the child.

5. Clinical Team Structure



6. Clinical Team

6.1. The Clinical Team are made up of 11.6 Whole Time Equivalent (WTE) staff, who draw from a range of evidence-based approaches.

6.2. Clinicians will hold a caseload of 10-12 cases per 1 Whole Time Equivalent postholder (pro-rata).

6.3. All clinicians have monthly Clinical Supervision from an appropriately qualified professional within their core profession.

6.4. Appraisals and CPD are agreed aligned to CCC policy.

6.5. Managerial supervision is provided monthly by the Clinical Lead.

6.6. The team therefore consists of specialist clinicians that offer Systemic Family Therapy, Dyadic informed Developmental Therapy (DDP), Video Interaction Guidance (VIG) , Foundations for Attachment, Circle of Security, Eye Movement Desensitization Reprocessing (EMDR), Cognitive Behavioural Therapy, all of which seek to develop adaptive coping strategies, improve emotional dysregulation in the child and support therapeutic responses aligned to the child's needs from the professionals network around their care.

6.7. The team also offer Integrative and Person-Centred Therapy, Play Therapy, Mental Health Nursing Interventions – aligned to the stepped care approach for children and young people, psychoeducation as well as sensory integration work through an

occupational therapist. (The offer of different modalities is subject to change due clinician skill mix available at the time.)

7. Operating Model

7.1. The delivery model focusses on therapeutic approaches that are relational, that build strong relationships around the child, increase family regulation, parental sensitivity, attunement, and attachment security to their primary carers, as well as stronger relationships between siblings, and wider family network.

7.2. Due to the spectrum of need within Developmental trauma, and how the impacts ripple out into the systems surrounding the child, there is no one approach which will be sufficient to meet the complexity of need.

7.3. Therefore, the service will be agile and respond to need in a way that draws upon different theoretical models but will not be restricted to the application of a single theoretical basis.

7.4. Early trauma can have a significant impact upon the development of the nervous system, which can then have lasting effects on sensory processing and attachments across the lifespan. Sensory integration helps the child or young person by exposing them to sensory stimulation in a structured, repetitive way. The theory behind it is that over time, the brain will adapt and allow the child to process and react to sensations more efficiently.

7.5. This model of supporting children in care is not a replacement to CAMH services but is complimentary to it. Many children in care, for example, experience attachment difficulties. These are a common source of placement breakdowns. Local CAMH services are not commissioned to address attachment difficulties, but this area will be a significant focus for the revised clinical service within the local authority.

7.6. The model of practice is entirely additional to any statutory obligation. Cambridgeshire and Peterborough Councils are committed to maintaining a clinical service because we recognise that many children in care do have additional needs, and that being able to provide a rapid response in order to address these is likely to be beneficial to the child concerned in a number of ways.

8. Who we work with:

8.1. Our Clinicians work directly with the network around the child to provide clinical consultation, supervision and training to other Children and Families Services staff, foster carers, Special Guardians and in some cases adopters. Families where there are concerns about a child's:

- emotional wellbeing
- behaviour

Commented [AB1]:

- development or
- mental health; within the context of presenting difficulties including family and community stressors
- educational difficulties
- offending behaviours
- abuse and neglect
- trauma
- attachment difficulties
- parenting difficulties
- deliberate self-harm and substance misuse problems

9. How we help

9.1. The Clinical Team provides a number of specialist assessments and interventions, relating to parents/carers, young people and children (including Care Leavers) related to:

- parenting
- mild to moderate neurodevelopmental issues
- attachment issues
- self-harm risk
- sexually harmful behaviours
- developmental trauma
- cognitive functioning and
- attention/concentration difficulties
- reunification

9.2. Specialist Interventions cover a range of evidence-based approaches, reflecting children and families' broad range of presenting needs, preferences and circumstances.

9.3. Clinicians contribute to detailed joint assessments within the Reunification and Placement Stability Service (RAPSS) of risk and protective factors, using the NSPCC Reunification Framework, working towards a child or young person in care returning home to their birth family when safe to do so. This offer is also extended to Fostering and Adoption support as well as other service functions within CIC services that require clinical input.

9.4. These include psychologically informed and cross-agency interventions to address issues such as:

- CSE (Child Sexual Exploitation) risk
- gang involvement
- domestic violence

- placement breakdowns and
- post-adoption support

10. Inclusion Criteria

10.1. The service is open to any child in care or on the edge of care, the latter will more likely be adolescents. The following criteria will be applied, however, there will always be some flexibility:

10.2. Any child or young person who is or has experience of care, is at risk of placement breakdown, family placement breakdown or multiple placement breakdown.

10.3. Carers of children experiencing care to develop and support their therapeutic parenting skills and maintain placement stability.

10.4. Consultation to Social work teams and the network around the child where they are experiencing challenges supporting the child and carers.

11. Exclusion Criteria

11.1. Any child or family that live out of area. In such cases the social worker needs to discuss the support needed with Commissioning to ensure the appropriate package is in place and being implemented for the child/young person.

11.2. The clinical team do not hold a budget for funding therapy therefore will not accept referrals from any of the children social care teams requesting funding for therapy.

11.3. Requests to complete life story work – completed by the supervising social worker.

11.4. Any parents/carers or child with significant mental health needs that meet the threshold for secondary mental health services and therefore are unable to engage meaningfully with the Clinical Teams Interventions.

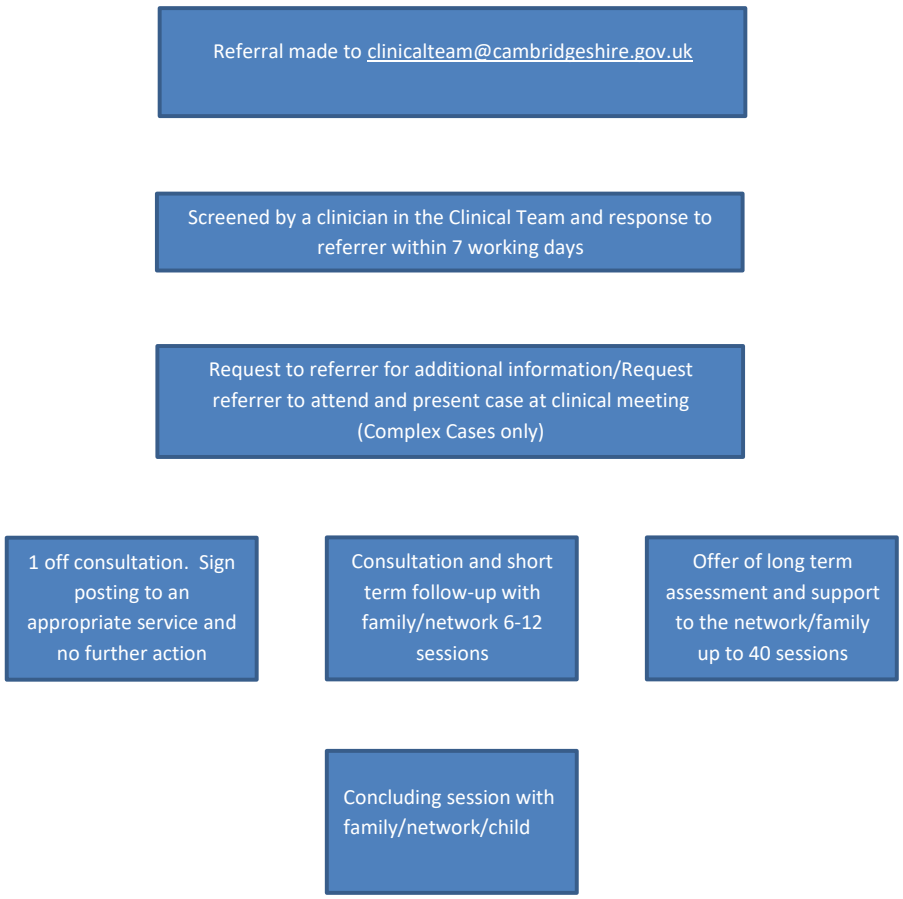
11.5. Any family/child with moderate to profound autism, learning disabilities or behaviour that challenges that preclude meaningful therapeutic engagement with the Clinical Team.

11.6. In such cases the Clinical team will review needs with the network to refer the child or young person to the appropriate mental health service.

12. Indicative Referral Process and Pathway

12.1. All referrers must complete the Clinical Team Request Form and submit it to **clinicalteam@cambridgeshire.gov.uk**

13. Clinical team must be given full access to notes on Liquid Logic, genogram and most recent assessment to inform input



14. Clinical Team Meetings

14.1. Clinical Team Meetings are held in the last week of each month for 2 hours on alternate Wednesdays and Thursdays to accommodate clinicians with different working days. All clinical staff are expected to attend or send apologies if they cannot make it and it is their working day.

15. The primary function of the Clinical Team Meeting is to:

15.1. To provide a forum, which promotes open communication between clinicians in the Corporate Parenting Clinical Team, as a means of facilitating best practice standards in the formulation, development and implementation of individualised care plans for individuals or families referred to the service and the network surrounding their care;

15.2. To increase the transparency and consistency of care as a vehicle to evidence robust governance and quality of care;

15.3. Facilitate multidisciplinary working practice, shared risk management and problem solving;

15.4. To provide an opportunity for team members to learn about the skills that others have to offer, with opportunities available for ongoing education and development;

15.5. Ensure effective communication to disseminate information to and from staff;

15.6. Identify and implement service developments;

15.7. Receive and respond to national guidelines and disseminate as appropriate;

15.8. Make recommendations to senior management team to address issues and concerns identified through this meeting. **(See Terms of Reference for full details.)**

16. Clinical Outcome Measures and Tools

16.1. Foundation for Attachment Evaluation (Start/Mid-Point and Conclusion)

16.2. Goals Based Outcome Chart

16.3. Child Goal Progress Chart

16.4. CORE 10 (adapted for children)

16.5. PSDP Tools – Social GRRAAACCEEEESSS and the LUUUT model (sic)

16.6. Protective Factors and Risk Factors

17. Governance

17.1. All clinicians report to the Clinical Lead who in turn reports to the Assistant Director of Safeguarding and Quality Assurance.

17.2. The governance framework for the Clinical Team is structured as follows:

18. Safeguarding Statement/Commitment

18.1. We are committed to safeguarding and promoting the welfare of children and young people. All clinicians are required to understand and demonstrate this commitment.

19. Appendix 1

Documentation
All contact, reports and sessions are to be recorded on Liquid Logic by the clinician seeing the family or the network to keep accurate and contemporaneous records of support and interventions offered
Liquid Logic Link: https://protocolcam.syhapp.com:11000/web/login.htm

New Starters
Internal staff are required to complete training before they are given access. A manager must complete the **Set up New Employee** form to request access to the system. Liquid Logic access must be requested in the section **(Any further information).**
If access has not been requested through the above form the **Update Employee Information** form must be completed. Go to the Lets Go Direct page ----> Click on **IT** ----> Select **Submit a Form**

User Login ID
Your User Login ID is how you identify yourself to the system.
If your password or secret questions have been compromised, you should change them immediately. You can do this by logging in and selecting Update My Profile from your home page.

Security Check
The address bar at the top should start with https, identifying a secure page.
If it does not, or there is no address bar, you may be about to give away your security details.
DO NOT CONTINUE TO INPUT YOUR DETAILS

Unauthorised Access
Any unauthorised attempt to access this system will be monitored and may be subject to legal action.

Documentation of Sessions
Notes of sessions need to be documented following each session, rather than pulled together in a single summary at the end of clinical involvement.

Reports
Stand-alone reports of clinical involvement are only to be completed in exceptional circumstances and this will be with oversight from the CL Team.

IT and HR Support
Logging IT, HR, Payroll Issues is accessed via the Lets Go Direct tab on Desktop: LANDESK Self Service - CCC Log an Incident. (lgss.co.uk)

Shared Drive - Children's Services Portal:
CCCandPCC Childrens Portal - Documents - All Documents (sharepoint.com)

If this does not work, then follow the following process

- Clinicians Folders:
- Go to CCC CSC
- Go to Non client based ND
- Go to Clinical resources (clinical admin)
- Go to Corporate Parenting Clinical Team

20. Appendix 2

Dyadic Developmental Psychotherapy – DDP is based on and brings together attachment theory, what we understand about developmental trauma, the neurobiology of trauma, attachment and caregiving, intersubjectivity theory and child development.

Eye Movement Desensitization and Reprocessing (EMDR) – EMDR therapy is a phased, focused approach to treating traumatic and other symptoms by reconnecting the client in a safe and measured way to the images, self-thoughts, emotions, and body sensations associated with the trauma, and allowing the natural healing powers of the brain to move toward adaptive resolution.

Integrative counselling and psychotherapy is a type of talking therapy that recognises that people are diverse and complex, so that it may be helpful for a therapist to draw on more than one counselling approach, in order to meet the individual needs of each client.

Play therapy is a method of therapy that uses play to uncover and deal with psychological issues. It can be used on its own, particularly with children, or along with other therapies and medications.

The term psychoeducation as it applies to the treatment of emotionally disturbed children usually refers to an approach which attempts to balance educational and clinical influences "with educational decisions made after considering. the underlying motivation of children." Psychoeducation also applies to the process of providing education/information related to mental health and wellbeing in order to promote awareness and greater understanding.

Secondary Mental Health Services – Takes place in a hospital or in the community and usually provided by a mental health NHS Trust. Interventions may consist of counselling from a psychologist or psychotherapist, or some form of online mental health support (e-health). People with more serious or complex psychiatric disorders, like ADHD, clinical depression, schizophrenia or severely impaired by anxiety disorders, are referred to secondary mental health care.

Sensory Integration

Sensory integration is the ability to take in information through the senses of touch, movement, smell, taste, vision, and hearing and combine them with prior memories and knowledge already stored in the brain. Dysfunction occurs when a disorder or an injury causes the brain to take in the senses normally, but they are perceived or processed abnormally. Sensory integration therapy or sensory re-training is a form of therapy in which special exercises are used to help a person's under- or over-sensitivity to the sense of touch, movement, sight, or sound and to help a person's sense of balance (vestibular) and where their body is in space (proprioceptive). These exercises can include various alerting, organizing, and calming techniques.

Sensory re-training has also been shown to improve function following nerve injury or nerve damage following surgery. At the proper time, exercises are introduced to decrease pain associated with hypersensitivity and to improve touch discrimination and touch localization.

Touch discrimination involves the ability to tell the difference between varying degrees of softness or roughness and localization is the ability to tell where the sensation is being applied to the body. The improved sensory function helps to improve coordination and function in all activities of daily living.

The following are some signs of sensory integration dysfunction:
Overly sensitive to touch, movements, sights, or sounds. Behaviour issues: distractible, withdrawal when touched, avoidance of textures, certain clothes, and foods. Fearful reactions to ordinary movement activities such as playground play. Sensitive to loud noises. May act out aggressively with unexpected sensory input.

Under-reactive to sensory stimulation. Seeks out intense sensory experiences such as body whirling, falling and crashing into objects. May appear oblivious to pain or to body position. May fluctuate between under and over-responsiveness.

Unusually high/low activity level. Constantly on the move or may be slow to get going, and fatigue easily. Tendency to be easily distracted or difficulty in making transitions from one situation to another.

Coordination problems. May have poor balance, may have great difficulty learning a new task that requires motor coordination, appears awkward, stiff, careless, or clumsy.

Systemic and Family Psychotherapy – Systemic therapy is a form of family therapy. This approach helps to uncover communication and behaviour within the family system, also assuming that the individual's emotional issues are a result of difficulties within the family dynamic, and relationships outside of the family with origins in history.

Systemic practice attends specifically to systems, power, difference, context, engagement, process of change, relational processes, family life cycles, family processes, hierarchies, sibling relationships, family conflict, domestic and child to parent violence, non-violent resistance-NVR approaches, loss and transitions, attachment narratives, (birth) family loyalty binds, family scripts, couple processes, networks, hypothesising, shared formulation, mentalisation and reflexivity. It is the particular therapy which works jointly with family members, in contexts of high conflict, so not simple units of communication

Children and Young People in Care Out-of-Area Mental Health Protocol CiC protocol.pdf