Agenda Item No: 9

Clinical Services

To:	Corporate Parenting Sub-Committee
Meeting Date:	14 July 2021
From:	Alison Bennett, Assistant Director – Safeguarding & Quality Assurance
Electoral division(s):	All
Forward Plan ref:	n/a
Key decision:	No
Outcome:	To brief Members on the clinical services offer available to children in care in Cambridgeshire, following the service being brought in house.
Recommendation:	The Sub-Committee is invited to review and comment on the report

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1. Summary

1.1. This report is to provide an update on the progress in setting up the clinical team and the offer available to children in care in Cambridgeshire, following the service being brought in house.

2. Background

2.1. The clinical support offered to children in care within Cambridgeshire was previously be delivered by Cambridgeshire and Peterborough NHS Trust (CPFT).

2.2. Careful consideration was given to the question of whether to renew the contract with CPFT to deliver these services on behalf of the local authority. The eventual decision was taken to develop an in-house service. The main reason was the view that in these particularly challenging and changing times, we wanted to retain the flexibility of being able to adapt the service should we need to.

2.3. The changes being proposed in Cambridgeshire required a formal consultation to take place. The consultation in Cambridgeshire ended on 14 January 2021, with a formal response published by the People and Communities Directorate.

2.4. During the period of review and consultation, clinical services for individual children and young people in care in Cambridgeshire continued to be delivered.

3. Main Issues

Revised Clinical Offer

3.1. Since the consultation ended, the team has worked to develop an operating framework congruent with current evidence-based practice, governance, and recruitment of interim clinical staff to the vacant posts.

3.2. 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.

3.3. 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.

3.4. Our revised clinical offer includes an improved training offer to foster carers focusing on supporting children in their care who have attachment disorders and who are exhibiting challenging behaviour.

3.5. In addition, the clinical team will 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.

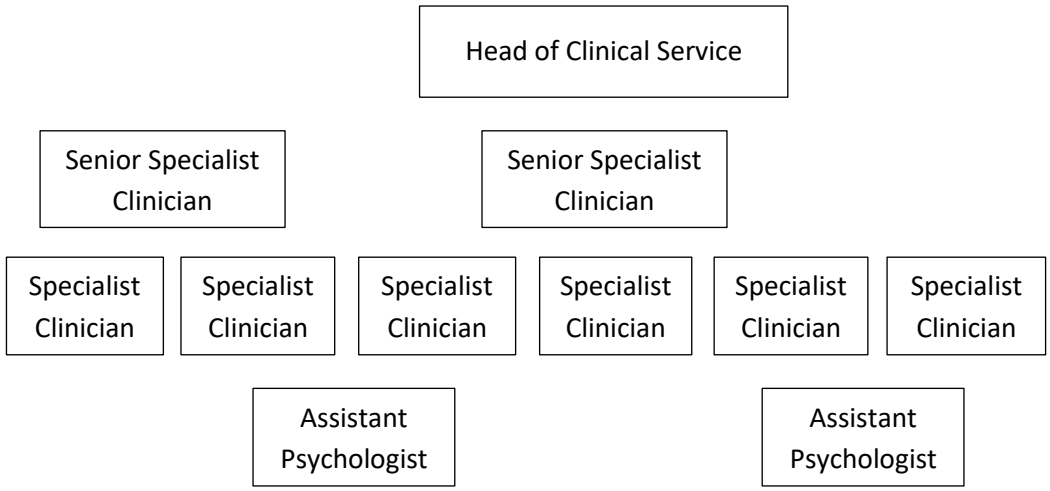
3.6. They will also contribute to the assessment of children's emotional health and wellbeing to inform care planning. This involvement may also include supporting decisions about contact with birth family, placement suitability, safety planning, reunification planning, sibling assessments and a strengths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

3.7. The revised clinical service will also build on existing relationships with other mental/ emotional health and wellbeing services to ensure that more complex needs of children and young people are met.

3.8. Children and young people will continue to be signposted to appropriate services as needed.

3.9. The overall aim of the revised service is to improve placement stability and so reduce the need for out of county placements, minimising unnecessary disruptions and improving the child's care and family experience.

Staffing



3.10. The new team structure consists of 9.6 full time equivalent (FTE) posts. The clinical lead is shared with Peterborough.

3.11. The new model of practice is different from the approach that the clinical service used to offer. We are very confident that this new approach will benefit children and young people in care and on the edge of care. The changes have, however, resulted in some resignations from the service. More positively, we have been able to recruit interim clinicians to support the service whilst we continue to recruit permanently. The current team have been able to work with all children and young people referred to the service, meaning that despite the move to the new model, no children or young people have experienced any delay in accessing the support they need.

3.12. The team will retain interim clinician support until the service is staffed permanently.

4. Inclusion Criteria

4.1. 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.

4.2. 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.

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

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

5. Exclusion Criteria

5.1. Any child with a moderate to severe mental health need that meets the threshold for secondary mental health services.

5.2. Any child with mild to profound autism, learning disabilities or behaviour that challenges.

5.3. 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.

6. Delivery

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

6.2. 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.

6.3. 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.)

6.4. 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.

7. 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 model of care will be multi-modal, to meet this complexity of need.

7.4. The team will therefore consist of specialist clinicians that will offer Systemic Family Therapy, Dyadic informed Developmental Therapy (DDP), Eye Movement Desensitization and 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 professional network around their care.

7.5. The team will 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.

7.6. 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.

8. Conclusion

8.1. We are confident that the revised clinical offer to foster carers, children and young people within Cambridgeshire will contribute to stability of placements and support the emotional and wellbeing of children. Our next steps are to continue to recruit to current vacant posts as well as those currently covered by interim clinicians. Our operating procedures/framework has been shared with the wider service has been received positively.

9. Significant Implications

None identified

9.1. Resource Implications; N/A

9.2. Procurement/Contractual/Council Contract Procedure Rules Implications: N/A

9.3. Statutory, Legal and Risk Implications; N/A

9.4. Equality and Diversity Implications; N/A

9.5. Engagement and Communications Implications; N/A

9.6. Localism and Local Member Involvement; N/A

9.7. Public Health Implications; N/A

10. Source documents

10.1. Source Documents – None.