Improving Emotional Health and Wellbeing for Children Looked After and Young People Leaving Care

Recommendations from a Multi-Agency Task & Finish Group

Context and Purpose

Cambridgeshire Corporate Parenting Sub-Committee requested a Task and Finish group be established to consider what improvements could be made in services going forward. The group focused on working within existing resources using a "Transforming Care" model. This was informed by national guidance which clearly states that improving the emotional health and wellbeing of children and young people who are looked after, requires a multi-agency response. This responsibility cannot be split off into any one service or organisation. The purpose of this group was for members to effect changes within their own services where possible, and then summarise recommendations for the Joint Commissioning Unit and Corporate Parenting Sub-Committee to inform wider strategic developments.

Participating Agencies

This was a multi-agency venture between the following Cambridgeshire services:

- Cambridgeshire Virtual School (CVS)
- CPFT Adult Mental Health Primary Care (AMH)
- Clinical Commissioning Group (CCG)
- CPFT Child and Adolescent Mental Health Service (CAMH)
- Emotional Health and Wellbeing Service (EHWB)
- Cambridgeshire Clinical Team (CCT)
- Cambridgeshire Social Care (CSC)
- Special Education Needs and Disability (SEND)

- Centre 33 contributed to discussions about services for young people leaving care.

Tasks and activities

To achieve the above aims, the following work was undertaken:

- Shared review of recent relevant national guidance, legislation, research and policy

- Case studies were shared and discussed to develop a greater understanding of what is currently available from key partners and where the gaps in services are most problematic

- Consultation was undertaken with young people from the Corporate Parenting sub-committee and Cambridgeshire Foster Care Association.

This resulted in five key themes for consideration:

1. Oversight of universal and specialist services
2. Use of data to inform county wide service developments and assess impact
3. Clarity about service pathways and accessible, reliable, information for foster carers
4. Shared models of practice across services and application of evidence based practice
5. Children and Young People's experience of services

1. Oversight of universal and specialist services

Areas for development	**Recommendations**
It was unclear to the group whether a single agency or position within Cambridgeshire keeps oversight of all services within county working to address the emotional wellbeing and mental health needs of care experienced children and young people.	National Guidance has recommended a Virtual Mental Health Lead post to sit within commissioning to ensure robust clinical governance of both specialist and generic services who work with our children and young people. This could help to ensure that we only commission and use services that work from an evidence base, using an approach that is coherent with relevant NICE guidelines. It would allow corporate parents to set clear expectations about assessment, consent and confidentiality, **prior** to any therapeutic work taking place. It would be reasonable to ask services to report to a Virtual Mental Health Lead (or equivalent) using the same routine outcome measures and specific markers (e.g. placement stability and time in education) which would then allow us to make an assessment of impact in a much more coherent way.
There is an issue currently with children in care who have experienced developmental trauma being offered individual play therapy, often in school, without a full clinical assessment. This is well intentioned but potentially very unhelpful for children and not a good use of resource. It is also not in any way	It would be most efficient to address this broadly rather than continuing to work on a case by case basis.

coherent with what the evidence base indicates.	

2. Use of data to inform service developments

Areas for development	Recommendations
There was no coherent approach across agencies regarding data collection. Some services use routine outcome measures but different agencies take different approaches and the data is not shared in an effective way.	It would be helpful to use the SDQ/IHA and RHA information as a prompt for further clinical assessment and/or intervention in a proactive way. At present the wider data set is shared annually between CCS and CCC but changes in scores or trends in the data are not tracked. There may be opportunities to address this in the re-structure of a clinical team for corporate parenting in CCC and as part of reviewing the joint protocol with ChiC Health. ChiC health are currently looking at incorporating more detailed measures such as RCADS to support their assessment process.
At present children and young people who are on the CPFT Child and Adolescent Mental Health (CAMH) waiting list are not easily identified as being looked after or “edge of care”. They are prioritised at the Single Point of Access by being rated “moderate risk” or higher. However, once they are in services it is not always apparent to the staff, when they are reviewing the waiting list, whether a child is in care (or on a Child Protection plan).	CAMH representatives were interested in finding ways to address this so that they can meet the needs of those children who are most vulnerable. They also suggested trialling a fast track system for children and young people who are looked after, as part of plans to address health inequalities. Further discussions about this between CCC and CPFT are planned for the New Year. It may be possible to track costs avoided if this contributes to stabilising some local foster placements or preventing escalation of need. When foster carers were consulted as part of this work they felt strongly that reduced waiting times and more contact during the waiting period, would be very helpful for them.

3. Clarity of Available Services

Areas for development	Recommendations
Professionals and carers consistently reported that they were unclear about what services are available, how to make referrals, what to expect from services, who is responsible for monitoring these, who can give consent for treatment, and how to know which of the available options are most appropriate. This is even more complex for young people placed out of county.	It would be extremely helpful to have an online resource specifically for children and young people who are looked after, that sets out detailed information about service criteria, pathways, referral processes, what children and young people can expect, and who to contact in a crisis. The local offer website contains some of this currently but there is much scope to develop this into a really rich resource. For example, it could include webinar trainings for carers, host online support groups facilitated by a clinician, and helpful video and written resources about some of the every-day challenges foster carers experience. This could be co-constructed with carers and young people and updated every three months. The clinical lead in CCC might be well placed to develop this in partnership with CCG, health and third sector colleagues. Foster carers requested a “decision tree” guide to services that would help social workers and professionals more quickly determine which support route they should be trying to access. This could potentially be built into the online resource or could form part of practice guidance that is shared within CCC if it can be updated regularly enough. In relation to Children and Young People living outside of Cambridgeshire, the Standard Operating Procedure for out of County Therapies has worked well to improve governance, communication and partnership working. It would be helpful to review this as part of developing the new clinical team structure for corporate parenting and joint working protocol with health.

4. Shared Models of Practice and Partnership Working

Areas for development	Recommendations
Overall there seemed few opportunities to build shared models of practice and exchange knowledge across agencies. This creates delay for children and unnecessary tensions between services. However, there were many good examples of partnership working across agencies and services when individual clinicians had particular knowledge and experience of working with children and young people who are looked after. When people had worked across local services for many years helpful relationships had often developed that meant conversations could happen in flexible and less fraught ways, resulting in better partnership working. Network Plus has been helpful in some of the case examples that were discussed.	Corporate Parenting Social Work practitioners and CAMH staff to have shared learning events to provide key information about their services and practice developments. CAMH staff could then more helpfully contribute to care planning, placement stability, review meetings, if they had a better understanding of these processes, were supported to prioritise them and invited in to consult actively by social care. There is a great deal of knowledge within systems that could be shared more effectively. For example, VS asked for a clinical contribution to designated teacher training to support looked after children in schools. This has been agreed, is easy to provide and has broad impact. Build greater links between third sector providers (e.g. Blue Smile, Acorn Project and Centre 33) so that communication between services is improved. Bi-annual community of practice events could be run to support this and promote evidence informed practice across agencies. Foster carers were keen to work in partnership with services to enhance the current offer and build on the existing skills and capacity within the service. They expressed an interest in co-facilitating evidence based groups (Nurturing Attachments) and delivering training alongside other professionals to increase impact and engagement. A review of the clinical contribution to training is currently being led by Lynne Milton (CCC clinical team). This will report to CCC HoS and AD in Feb 2020. This review has included stakeholders and partner agencies to ensure the approach is coherent between services (e.g. drawing on Trauma Informed Models in a way that is aligned with VS developments).

	Develop greater coherence between plans that should be supporting children and young people such as PEP, Reviews, EHC plans and Health care plans. At present these processes can be disjointed and would be much richer if they were joined up. This can be particularly problematic if “therapy” is provided through a PEP process in the absence of a broader formulation or knowledge about input from other clinical services. VS educational psychologist is working on an audit to inform next steps regarding this. CCC clinical team and VS have developed closer links to ensure consultation is available to education staff regarding therapeutic interventions.

5. Experience of Services

All of the recommendations should improve young people’s experience of accessing services and their effectiveness. National Guidance and feedback from young people locally highlighted repeatedly the importance of meaningful consultation to guide services. Young people said they have found themselves repeatedly explaining to health professionals important details such as what a CiC review is, or why their carer has a separate social worker to their own. They spoke about the importance of the language that is used and why it matters that people don’t use the terms “LAC” or “contact” for example when speaking about them/with them.

It was not clear to members of the T&F group how the voices of young people currently shape services that are commissioned to address mental health/emotional health and wellbeing. We noted examples of good practice in other local authorities such as children in care councils being able to develop “quick guides” for the professionals working with them addressing use of language and overall approach (for example, sensitivity to trust in relationships and genuine care). If this work is not already underway in Cambridgeshire there is scope to develop it in a way that could really have impact.

Conclusion

We would welcome feedback from the Joint Commissioning Unit as to whether these recommendations are in line with broader strategic and operational plans.

It seems timely to share the recommendations of the T&F group as the clinical team in corporate parenting is being re-structured, with a revised service specification and increased resource. If these recommendations are supported within CCC and partner agencies the Corporate Parenting Sub Committee could potentially oversee an action plan, owned by the members of the existing multi-agency group, to put these into action and assess impact.

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