

# UASC Clinical Network Vision and Strategy

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# Introduction

The purpose of the UASC Clinical Network is to develop an operational model which is Kent County wide that implements a national mental health objective which is that we will support UASC to manage their emotional health and wellbeing. In doing this we will deliver outcomes that are evaluated against High Value Health Care. Those being:

- Excellent clinical outcomes
- An outstanding patient experience
- Consistent and improving patient safety
- Highly efficient and cost-effective services

It is set in the context described in appendix 1 which underpins the requirement for such a Clinical Network to exist.

## Aspirations:

The aspirations adopted by the UASC Clinical Network are:

1. All UASC in Kent with compromised emotional health and well-being are identified.
2. All UASC are offered screening using a validated tool in respect of their emotional health and well-being as part of their holistic health assessment.
3. All UASC have an identified emotional health and well-being keyworker.
4. Measured improvements in a UASC's emotional health and well-being
5. Increase ability and confidence of professionals and communities to provide interventions in respect of emotional health and well-being.

This fits with the wider principles informing current health and social care delivery models and supports the principle of integrated care that:

- Deliver the best outcomes for UASC by providing evidence based health and social care
- Keeps UASC at the centre and is holistic in approach.
- Coordinate care around a UASC through early identification and identified pathways from which they can access an effective response.
- Deliver services that enable UASC to make informed and self-management decisions in respect of their emotional health and wellbeing.
- To identify support needs in respect of their emotional health and wellbeing and working with social services, border agencies, education, police, solicitors, foster carers and the voluntary sector to access support.
- Provide emotional health and wellbeing clinical formulations according to identified needs.
- Provide a response that is timely and appropriate for the UASC, flexibly meeting their needs, whether requiring advice, sign posting, assessment or an intervention
- Deliver a coordinated approach to emotional health and wellbeing that is efficient in its use of clinical resources



# The scope

All stakeholders supporting UASC in Kent.

## Provision:

The UASC clinical network will look to provide the following:

Screening of all UASC in respect of their emotional health and wellbeing, their physical health, educational, legal and looked after children requirements.
Known and agreed multi agency and professional clinician competency level in respect of interventions and formulations
Provide clinically supervision and consultation to staff according to their competency Level

It will also work with GP's, the voluntary sector, public health and other services which will:

1. Strengthen the relationship with GP practices as we will be working in partnership and will be working with them as members of the extended primary health and social care team
2. Develop strengthened pathways and integrated working with education, the policy, the boarder agency, reception centres, foster carers, the voluntary sector and community services
3. Work in partnership to develop an integrated service with all identified stakeholders at a time of intensity of need.

## Operational positioning:

Implementation of the UASC clinical network is monitored by the LAC commissioner, NHS England and the CCG.

The following work plan is being undertaken:

1. All UASC with compromised emotional health and well-being are identified.

1	Actions	Aspiration	Owner	Target Date
1.1	Identify a validated screening tool	1,2,4,5	GS/AD	Feb 2016
1.2	Pilot use of a screening tool in reception centres with	1,2,3,4	GS/AD	October 2016



	paediatricians.			
1.3	Develop referral pathway of screening tool and competency formulation	1,2,3,4	GS/AD	October 2016
1.4	Implement use of screening tool in variant contexts	1,2,3,4,5		January 2017
1.5	Develop/identify referral pathway in variant contexts	1,2,3,4,5		January 2017

- 2) All UASC are offered screening using a validated tool in respect of their emotional health and well-being.

2.0	Actions	Aspiration	Owner	Target Date
2.1	Training for staff in the use of screening tool	1,2,3,4,5		July 2016
2.2	Incorporating screening as part of all health assessments	1,2,4,		April 2016

2. All UASC referred have an identified emotional health and well-being clinician

3	Actions	Aspiration	Owner	Target Date
3.1	Develop a competency framework	3,5	AD/KCC	Dec 2017
3.2	Develop a pilot network of integrated agencies and clinicians	3,5	AD/multi-agency	Dec 2017
3.3	Embed identified competency framework into clinical network delivery	3,5		July 2017
3.4	Monitor and evaluate the competency framework and clinical network	3,5		On-going



4 Measured improvements in a UASC emotional health and well-being

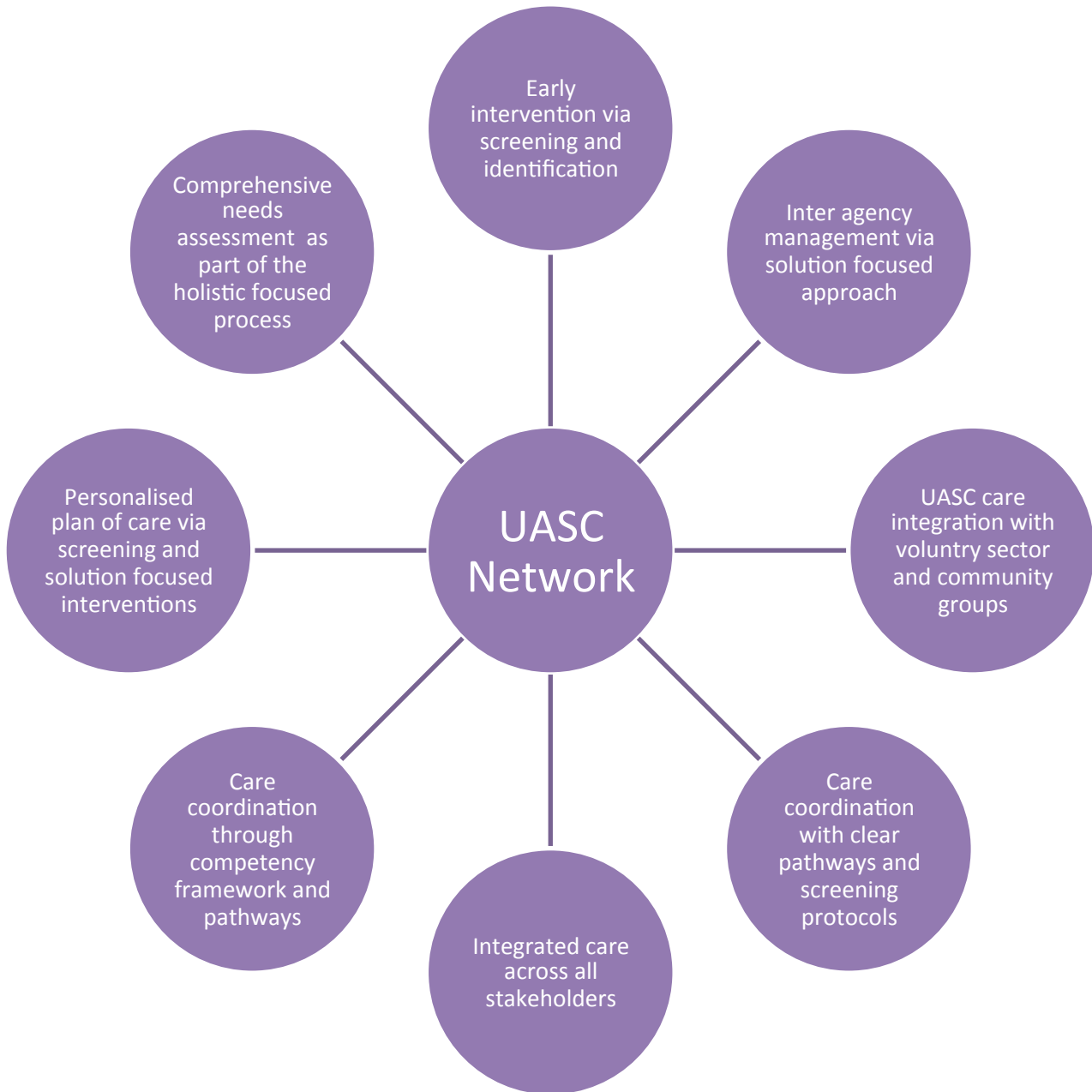
4	Actions	Aspiration	Owner	Target Date
4.1	Identify and agree Minimum Data Set (MDS).	1,2,4	AD/all agencies	June 2016
4.2	Collate MDS for all new UASC	3,4,5		June 2016
4.3	Audit MDS and set up audit templates and cycles using NICE quality measurers	1,2,4,	AD	Dec 2016
4.4	Annual report year on year to measure against the NICE quality measurers	1,2,3,4,5	AD	On-going

4 Increase ability and confidence of staff to provide interventions in respect of the emotional health and well-being of UASC.

5	Actions	Aspiration	Owner	Target Date
5.1	Network wide education according to competency measures	3,5	All agencies	On going
5.2	Network wide identified CPD via appraisal and clinical supervision/consultation	3,5	All agencies	On going
5.3	Mandatory clinical supervision in relation to competencies	2,3,4,5	All agencies	March 2017
5.4	Reflective supervision that supports a clinicians emotional health and well being	3,5	All agencies	March 2017



The work plan connects to an integrated delivery model in the following ways:



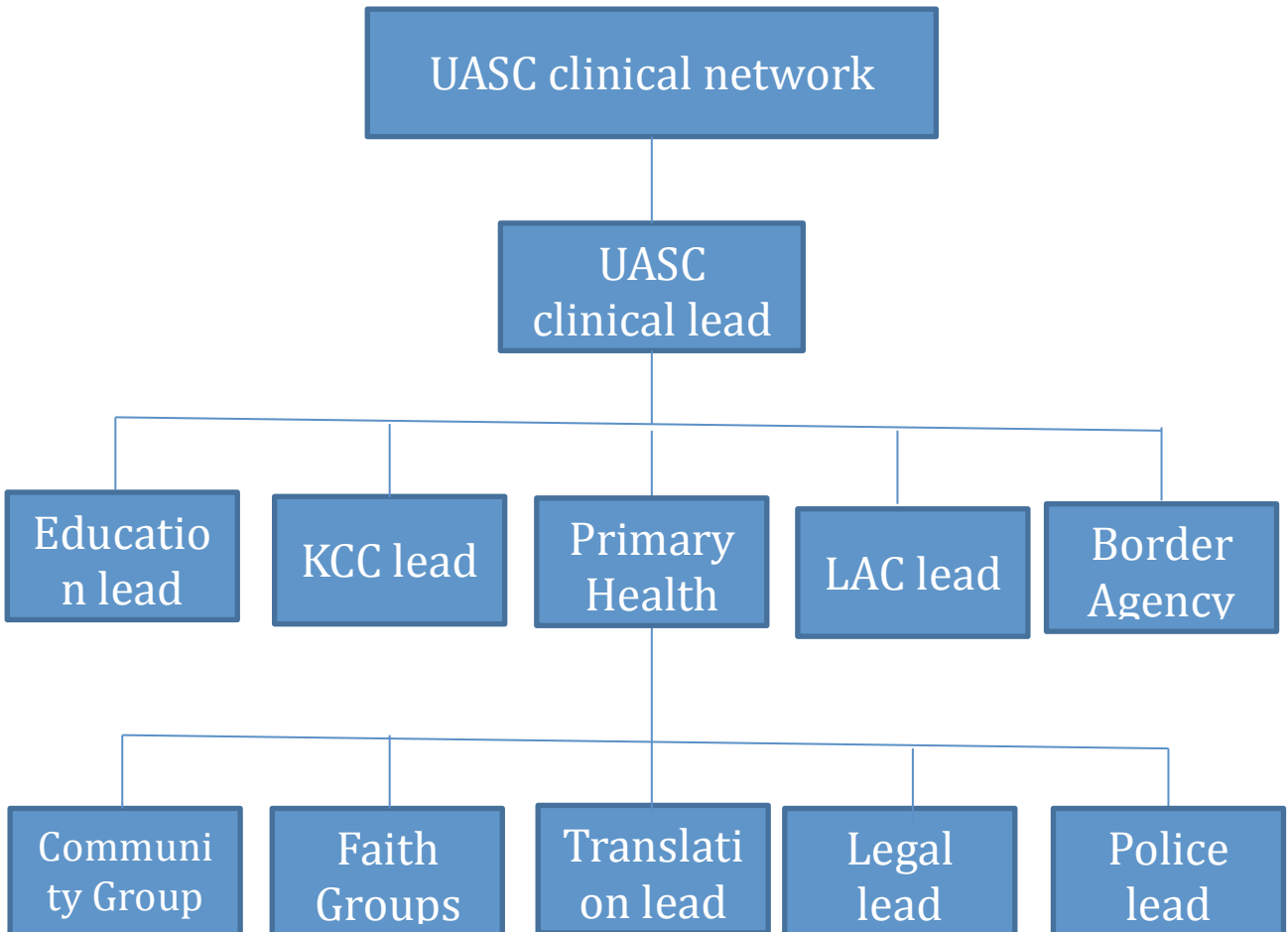
In making these connections and developing this strategy there is the potential of a fully integrated and systemic delivery of emotional health and wellbeing care for all UASC in Kent.



**Strategic positioning:**

To enable the UASC clinical network to be fully effective in its operational delivery there needs to be some organisation reform. The current structure and way of working is silo and agency based, with a primary focus on situated care requirements. This does not fit with the wider health and social care commissioning values or with evidence based clinical effectiveness.

The following network structure would enable agencies to fully link into the proposed delivery model.



Other stakeholders are likely to be identified and become partners in the UASC clinical network and would work via an agreed Terms of Reference, see appendix 2.





Work streams within the network would be the following:

	<b>Work stream</b>	<b>Clinician</b>	<b>Organisational leads</b>
•			
1. Establish the UASC clinical network	Delivery model	All agencies	Identified per project.
2. Organise UASC clinical network to deliver an integrated solution via MDS and agreed quality markers.	Delivery structures and processes	Clinical Lead	
3. Develop relationships with stakeholder agencies to deliver improved partnership and integrated working via Network	Integrated Programme board Commissioners KCC	Clinical Lead	
4. Enable clinicians to drive the delivery and quality of care	Integrated multi-agency teams	Clinical Lead	Agreed Governance Framework
5. Delivery of effective and efficiently provided services.	Transformation and CIP	Clinical Lead	
6. Competent and capable teams	Workforce development	All agencies.	Clinical Quality Leads for each agency

## What needs to happen?

There needs to be an identified clinical lead and consultant who also holds the role of chair for the UASC clinical network. See appendix 3 for a proposed JD and person specification.

Current work force are re-positioned to be clinical expert in their given role and yet have a therapeutic cross over to deliver emotional health and wellbeing interventions within an identified competency framework. The network will ensure the delivery of clinical supervision, developing clinical pathways and enhancing educational delivery.



# Briefing Paper on an Emotional Health and Well-being Governance Framework for Unaccompanied Minors Seeking Asylum

## The Situation

Due to the current refugee crisis and increase in the volume of unaccompanied children arriving in the UK and seeking asylum there is the need to develop a governance framework from which quality of care can be delivered. This work is pertinent to the whole of the UK due to the practice of dispersant of these children to other geographical localities. The project will look to disseminate the developed framework to other localities to support the efficient and effective delivery of emotional health and wellbeing support for this group of vulnerable children.

Unicef state that the refugee and migrant crisis in Europe – whether off its coasts, on its shores, or along its roadsides – is a crisis for children. One in every four asylum seekers in Europe so far this year has been a child. A total of 110,000 children sought asylum between January and July 2015 – an average of over 18,000 children every month in Europe.

The needs, protection and best interests of each one of these children should always come first. It is a matter that touches our deepest principles of humanity and responsibility. Children are victims of humanitarian crises – they are not the cause of them.

The displacement of minors is part of a Europe-wide crisis that provokes extreme political and emotive reactions, as is illustrated by the recent reversal of the German 'open door' policy and can be witnessed through monitoring the vocabulary of the British press. There is a widespread confusion of attitudes and knowledge of what is possible. This is compounded by a conflation of the notion of 'immigration' which is perhaps the most inflammatory topic in current British politics, with the terrible reality of what it means to be a refugee and an asylum seeker.

The political volatility of this crisis cannot be disregarded but there is a moral and humanitarian obligation to look urgently past the rhetoric and to the reality of a situation that is occurring right now. If the issues brought up in this briefing paper are not addressed with urgency, the human and economic cost will be high. In 2015 more than 3,000 unaccompanied minors seeking asylum arrived in the UK of which 900 are in Kent.



## The Cost

Asylum seekers have paid a huge personal cost; at the very least, by definition they have lost their homes and communities. Asylum seekers, and particularly children are at high risk of mental health disorders and must be seen as on the brink of having to bear a greater burden. This burden (of suffering mental health problems) becomes an economic burden on the country where these children now live. In July 2015, *The Guardian* reported that:

‘Kent county council has appealed to the Home Office and children’s services across the south of England for urgent help with a £5.5m funding shortfall and the “enormous strain” on social services, and for assistance in finding foster places for the children, who are on their own and as young as 12.’

It is clear that a great deal of money could be saved were measures in place to integrate children who arrive in the UK into their new communities and foster in them resilience to the risk factors that their situation brings with it.

All refugees are at high risk of mental health disorders which can be compounded by Post Traumatic Stress Disorder (PTSD). Not only is there the initial traumatic event that caused them to lose and leave their home, (war and destruction with concomitant loss and bereavement) but to this is added the trauma of the extreme and dangerous journey to the UK. To this, it has to be said, can be added the trauma of detention (which current British legislation allows to be indefinite) when they finally arrive. It should be pointed out that in many cases the ages of asylum seekers are unknown, and it is not uncommon for the authorities to estimate a child’s age as higher than it actually is because this allows them to be detained and deported more easily. (Immigration Detention Centres are officially called Immigration Removal Centres because their explicit aim is to remove the ‘problem’).

The unaccompanied children who arrive in the UK are likely to have experienced or witnessed physical and sexual violence, watched the death of family members and those who lived in their community and have been culturally displaced with no congruent sense of belonging. It cannot be said that the current policy or resources in the UK are targeted at aiding these children to survive this ordeal healthily and with a sense of hope for their future. Aside from there being a need to address the individual sufferings and traumas of the children who arrive in the UK, Amnesty International notes ‘a child refugee in the UK **cannot** sponsor any family members, even their parents, to join them’ (<https://www.amnesty.org.uk/actions/bring-refugee-families-back-together-asylum-uk-reunion>). This is a good example of how an already traumatic situation can be compounded with the added trauma of enforced separation (and this is in the relatively happy circumstance that the child’s parents are alive

The area of childhood bereavement is a field in which research has shown a link between incidents of delinquent and criminal behavior and a particular risk factors. Draper and Hancock point to such figures for persistent young offenders – 22% of whom had been bereaved; 39% had experienced family breakdown and 4% had lost contact with significant people in their lives (Nacro Research Briefing 2002). They also cite a study which contends ‘that a developmental trajectory towards psychological illness is likely to occur if bereavement is part of a “chain of adverse events” rather than an isolated incident’ (Harrington and Harrison).

It is not hard to see that asylum seeking minors are at extremely high risk – not only are they (again by definition) in the midst of a chain of adverse events, but it is highly likely that bereavement, often violent, forms part of that chain. They may also be in a state of anxiety, on the brink of bereavement when they have been separated from their families who are in war zones. Alison Penny and Di Stubbs (‘Bereavement in Childhood: What do we Know in 2015’) cite bereavement as part of a ‘cascade of events’ which lead to anxiety, stress and emotional and behavioural problems in children. It is hard to think of a group of people more caught up in a ‘cascade’ of negative events than those currently seeking asylum in the UK.

Penny and Stubbs also state that children who have suffered bereavement are:

- More likely to die themselves
- More likely to suffer accidents



- More likely to suffer serious illness
- More likely to drink/take drugs and have sex under the age of 15
- More likely to have learning difficulties
- More likely to attempt suicide
- More likely to become violently criminal
- More likely to become unemployed

It seems reasonable to group young asylum seekers in the same risk categories. All of these have the effect of making the child a 'burden on society' and to fulfill the negative stereotype that they are a drain of the nation's resources. However this need not be so, (and perhaps the Banksy's graffiti of Steve Jobs as a Syrian refugee most pertinently illustrates this) if appropriate and targeted interventions are put in place.

We would advocate the implementation of a 'dialogic' model of intervention which has been shown to be highly effective in the treatment of psychosis (and hugely reducing the cost of such treatment) over the last 25 years in Sweden and the principles of which are adaptable.

It is clear that the present state of affairs is unacceptable at a basic humanitarian level but also that it backfires as a policy (and economically) to eradicate a problem because failure to address trauma and mental health issues as close to their origins as possible leads to catastrophic outcomes for the individual and thereby the State that has to bear a later burden of imprisonment or medical care, much of which could be avoided with early intervention. This is true in cases where the upheaval and tragedy of life is not as obvious as it is in the lives of young asylum seekers who are among the most vulnerable members of our society.

## What is to be done?

Firstly these children need to be regarded as members of our society and not as pariahs or unwanted aliens. The UK needs to provide a welcome rather than present an attitude of passive hostility which in itself creates more problems. As such, as vulnerable members of society, unaccompanied children seeking asylum need to be provided with a mental health safety net.

The sheer numbers of vulnerable children arriving in this country mean that the current mental health services have little capacity to screen or assess their mental health needs. It is seen as financially prohibitive to set up a designated mental health service. There is evidence that on arrival in the UK these young people are interviewed by staff who are unaware of their mental health vulnerability. The children often don't have access to legal support in the asylum process and they are held in reception centers awaiting dispersal. They also experience socio vertigo with no links to familial food, routines, religious observance, differences in attitudes to animals, education, sexual and gender expression as well as dress code and the use of alcohol.

In the interaction with these agencies the child is likely to experience confusion as they encounter suspicion about their asylum claim, as well as disbelief in the story they tell and the age they report they are. These experiences are likely to exacerbate any previous trauma, to slow their development into adulthood and increase their vulnerability.

Sussex NHS Partnership Trust is currently commissioned to deliver child and adolescent mental health services for Kent and is looking to address the complex physical and mental health requirements of these children. NICE has stated that the assessment and provision of services for emotional and mental distress need to be provided by services and staff that fully understand the plight and circumstances of unaccompanied minors. Added to this

NHS England state in their values as guidance to commissioners which are:



- To give due regard to the need to eliminate discrimination, harassment and victimization, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- To give regard to the need to reduce inequalities between patients in access to, and outcome from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

To enable these values to be achieved there is a need to develop a clinical network from which professionals can cultivate multi-disciplinary ways of working that integrates a therapeutic formulation, work together to ensure that the care given is seamless, holistic and enhances the emotional health and wellbeing of each child.

The network would look to develop a governance framework from which screening, assessment and supervision takes place. It will also look to identify and train staff to use a screening tool that would recognize significant distress that requires further assessment and support, competencies that enable staff to be trained and skilled in managing the emotional health and wellbeing requirements or to escalate to someone who can.

Therefore the network will aim to identify a screening tool, to develop a competency framework for all professionals supporting these children and to deliver training and supervision that underpins the competencies required.

1. Children with emotional and mental health concerns will be identified at an early stage in the asylum process.
2. All professionals working with unaccompanied minors are competent in the emotional health and wellbeing care that they give.
3. A reduction in delinquent activity due to previous trauma and unsupported vulnerability.
4. Cross agency and professional discipline working to deliver better outcomes for this vulnerable group of children.

How we will measure the outcomes:

1. Audit
2. Action research
3. The child's experience
4. Improved professional competencies

The model for providing care for children that might prevent them developing serious and further mental health problems could be based upon the Systemic Psychotherapy techniques of 'open dialogue' as developed in Sweden by Jaakko Seikkula in cases of severe psychosis.

It is worth noting the success of this approach: The use of antipsychotics was halved and 84% returned to full employment. This is compared to 40% returning to full employment and 70% on antipsychotics. The key findings are also the reduction in schizophrenia over time. In 1985 they had 33 new referrals and in 1995 they had 3. This goes against current trends which have seen a rise in psychosis and diagnosis schizophrenia.

It would clearly be of great value if we enabled young asylum seekers to be employable human beings rather than in need of state funded intervention (in the shape of mental health services or prison). The dialogical approach has been shown to drastically reduce the number of days a person spends in hospital.



One of the foundational principles of dialogical thinking is that, rather than being a predominantly biomedical issue, mental health problems are intrinsically bound up in the situation of a person and their relationships with others. This is why there is such a correlation between significant bereavement (the loss of relationship) and mental health breakdown (and further to criminal behaviours). It is easy to see that unaccompanied minors seeking asylum are at risk on multiple levels – they are displaced from any familiar system of relationship, that may have provided the resilience to deal with trauma and they are placed in a new, possibly unfriendly system once they arrive in the UK. They are routinely destabilized (as the emphasis on ‘dispersal’ noted earlier suggests).

The first principle of effective systemic and dialogical intervention is the provision of **immediate support** when a crisis occurs. (Early intervention is consistently a top priority in relevant literature and studies – see, for example the NSPCC *What Works in Preventing and Treating Poor Mental health in Looked After Children*). Therefore it must be routinely recognized that each new child arriving in the UK is in a moment of crisis as they declare their refugee status. This crisis requires immediate multi-disciplinary screening, assessment and intervention, as well as therapeutic intensity to support the child to make sense of their lives in a different culture and with new relationships. Immediacy is essential for effective intervention and every professional interaction needs to be therapeutic.

Such an approach would also fit in with the NSPCC’s findings in relation to Looked After Children in Britain: ‘Structured programmes focusing directly on the child are more effective when they have core components with some flexibility to meet individual needs, and a ‘joined up’ approach from services with follow-up support’.

It is clearly necessary for current agencies to agree a way of working that is formulated to best support emotional health and wellbeing. Current resources should be mobilized to work within an integrated multi-disciplinary system. The child would come to know and build a relationship with the workers and the workers in turn will know the child’s unique story and help them to make sense of it and to move towards an improved future.

Indeed the NSPCC conclude the following, in the light of the complex and individual needs of ‘looked after children’, all of which support the model advocated for unaccompanied minors in this briefing paper:

- Approaches to behavioural and emotional issues are more likely to be effective when they include some focus on developing relationships and understanding.
- Consistent approaches that reflect fidelity to the programme are associated with better outcomes.
- High levels of commitment from both carers and young people enhance the efficacy of the interventions.

## Conclusion

The proposed network will aim to promote resilience and prevent escalation of mental health concerns via early interventions delivered by people known to the child. It will improve access to the right support at the right time. It will support clinicians to give appropriate care for this vulnerable group of children and it will develop a competent workforce. It will give account of what it achieves through a variety of measures.



# Appendix 2

## Uasc Clinical Network Terms Of Reference

DATE

### 1.0 TITLE & FORMATION

**UASC Clinical Network**

### 2.0 STATUS & DELEGATED AUTHORITY

- 2.1 The UASC Clinical Network is being constituted in 2016 and is operational within Kent. It reports to all member agencies and the CCG.
- 2.3 The UASC Clinical Network is authorised by NAME AGENCIES to carry out any activity within its terms of reference. It is authorised to seek clarification and further investigation of any clinical matters pertaining to the care of UASC.
- 2.4 The UASC Clinical Network is authorised by the above named agencies to obtain outside or other independent professional advice with relevant experience and expertise as required.
- 2.5 The Clinical Network may recommend actions which require financial expenditure, yet the Network itself does not have any delegated powers of expenditure as this rests with the relevant budget holder or otherwise in accordance with powers of authorisation as prescribed in the multiple Agencies Scheme of Reservation and Delegation. Should the Network be delegated a specific budget at any point, this will be subject to the standard financial regulations as determined by the budget provider. The allocation of any Network budget will be determined according to the standard joint decision making processes of its members.
- 2.6 The Clinical Network may establish forums or project teams as it considers appropriate to support its objectives and duties. Any forum or project team so established shall act under these terms of reference and report to the Network as required.





## VISION AND OBJECTIVES

- 
- 3.1 Network Vision:  
Improving present and future outcomes by raising the profile of and ensuring all UASC arriving in Kent receive services that are appropriate to their needs.

The UASC Clinical Network is operational to support the access and equity of service for all UASC who are at risk or have an identified concern within the community of Kent.

The availability, practice, quality and experience of delivery, quality improvements, and evaluating performance will be driven by the Clinical Network.

This is interlinked to the LAC Services Clinical Strategies, the Quality Strategy and CCGs Services Strategy.

- 3.2 The overall objectives of the UASC clinical network are to:
  - Be a resource for advice, consultation, sharing best practice - including service models, and sharing of areas of excellence.
  - Raise the profile of the needs of UASC within and external to Kent.
  - Develop a Clinical Network of Services which could include various elements comprising
    - Service description
    - Referral criteria
    - Who can refer and when and where.
    - Tiered Service Structures
    - Self-Management
  - Produce Visual Organogram of Services
  - Achieve representation on relevant internal and external groups and organisations via Clinical Network members
  - Tiered Guidance including (generalist, specialist, integrated, holistic):
    - Competencies
    - Super-ordinate Structure, including:
      - Supervision, Governance, Clinical Effectiveness, Interfaces upwards and downwards, and Continuous Professional Development
  - Developing and maintaining two-way feedback with multiple agencies.
  - Be all-inclusive for all Professionals and stakeholders.
  - Clarity of services delivery requirements
  - Developing and delivering a comprehensive Continuous Professional Development programme
  - Provide equitable high standards of emotional health and wellbeing interventions throughout a tiered approach for UASC who are known to be at risk or identified as having mental health concerns.
  - To develop and oversee a Care Work Plan which will support the identified targets and aims of the Clinical Network quality Strategy.

## 4.0 ACCOUNTABILITY

- 4.1 The UASC Clinical Network reports to and is accountable to the member agencies and CCG.





- 4.2 The Chair of the Network shall provide written and verbal reports to the member agencies and CCGin a format and at a frequency agreed by the Committee. Such reports shall highlight:
- Progress against the work plan
  - Perceived Risks
  - Quality concerns
  - Other matters as identified by the UASC Clinical Network Membership group, which require Attention.

## 5.0 MEMBERSHIP & ATTENDANCE

- 5.1 Full members (with voting rights):
- Nominated Chair
  - Nominated Deputy Chair
  - Individual Agency representatives
  - Commissioner
  - Public Health
- 5.2 In attendance
- UASC identified clinical staff
  - As invited by the Committee Chair
  - Co-opted members as agreed by the committee
  - Supporting administrative officer
- 5.3 The Clinical Network will be chaired by a UASC clinical lead.
- 5.4 Other stakeholders may be invited to attend at the invitation of the committee when there is discussion on issues relating to their area of responsibility.
- 5.5 The Clinical Network may co-opt members for a time limited period or as standing members at the discretion of the Network. Co-opted members shall have speaking rights but not voting rights.
- 5.6 Observers will be allowed to attend meetings as agreed by the Network. Observers will have speaking rights as invited by the Network but they do not have voting rights.
- 5.7 Members shall be assumed to be attending a meeting of the Clinical Network unless apologies are sent in advance to the Administrator.
- 5.8 A Network Administrator shall be allocated and will ensure arrangements are in place for the provision of administrative support to the Network.

## DUTIES

- 6.1 The duties of the Network are to:



- Identify agencies providing services and support to UASC.
- To develop a work plan which supports the vision to increase access to high quality services.
- To develop indicators/measures of success and oversee the audit of these measures to demonstrate the impact of the work plan. To oversee the delivery of the work plan.
- To guide achievement of clinical effectiveness of relevant services
- To identify workforce and organisational development requirements to support delivery of the plan, linking to the member agencies Workforce and Organisational Development Strategies.
- To interface with clinical governance and continuous improvement of clinical skills
- Delivery of high quality, safe and effective care for UASC
- Development and support for staff working with UASC at risk or have an identified mental health concern; as well as the promotion of therapeutic skills in the wider workforce
- Opportunity for clinical supervision, reflective practice and learning from experience for staff.
- To consider and amend the work plan in the context of further development of network strategies including:
  - o Clinical Services Strategy
  - o Quality Strategy
  - o Quality Account
  - o Quality Improvement Plan
  - o Quality Priorities
  - o Clinical Audit Plan.
  - o Clinical Effectiveness Plans
- To recommend to the agencies risks for inclusion on the High Level Risk Register or Board Assurance Framework and to support the review of relevant risks on the Register & Framework.
- Champion the pursuit of continuously improving service quality and promote the dissemination of identified good clinical practice across Kent.
- To make such recommendations to member agencies and the CCG as appropriate.
- To hold an annual away day to develop the thinking and strategy of service provision in Kent.

The Clinical Network will operate with the primary purpose of designing, delivering and evaluating the delivery of UASC services.

## 7.0 MEETINGS

7.1 The Clinical Network will aim to meet weekly. The focus for each meeting shall be to collate a minimum data set (see appendix 2), to cross check care activities, to discuss complex cases and to formulate across agency and discipline.

7.2 The committee may also convene:

- Special meetings, and / or
- Virtual meetings. (Which may be instead of, or additional to, programmed meetings).

7.3 Venues will be agreed and notified to members and as relevant co-opted members and observers.



## **8.0 QUORUM**

8.1 A quorum shall be 6 Full Members.

## **9.0 DECISION MAKING**

9.1 The Forum has joint and collective responsibility for agreeing decisions. Decisions shall be reached by consensus where possible, and where there is not unanimous agreement, a vote shall be taken and the result recorded.

9.2 In the event of an urgent decision being required between meetings on any matter within the Terms of Reference of the Committee, the Chair may seek input from committee members and make a decision as to a consensus of opinion. The action will be reported to the next meeting and recorded in the minutes/notes.

## **10.0 PAPERS**

10.1 The MDS for each meeting will be devised by the Chair in collaboration with other members of the clinical network.

10.2 The Deadline for MDS collation will be communicated prior to each meeting, with any urgent business beyond the deadline to be agreed with the Chair in advance of the meeting.

10.3 The agenda and associated papers/documents for each meeting will be distributed in advance of the meeting to all members and co-opted members.

10.4 Members have responsibility to manage the papers/documents in accordance with each member agencies records management policies.

10.5 At the discretion of the committee, matters of a confidential or sensitive nature concerning information may be excluded from the minutes.

## **11.0 REPORTING**

11.1 The MDS of the committee meetings shall be formally recorded and maintained by the clinical network administrator.

11.2 The clinical Network shall receive updates and reports from its project teams.



## 12.0 TERMS OF REFERENCE – RATIFICATION AND REVIEW

- 12.1 The Terms of Reference will be agreed by the member agencies and ratified by the CCG.
- 12.2 The Terms of Reference will be reviewed after 6 months and thereafter annually or earlier at the committees discretion. The Clinical Network may only be dissolved with the agreement of the CCG and member groups.
- 12.3 Amendments to the Terms of Reference as agreed by the members will not be required to be reported back to the CCG or member agencies unless they are deemed by the clinical network to constitute a significant change



# Appendix 3

## Job Description

**Job title:** Lead Consultant Therapist

**Band:** 8D

**Location / Work Base:** Various locations in Kent.

**Business Unit / Department:** LAC.

**Reporting to:** Operational Director and General Manager

### JOB PURPOSE SUMMARY:

To provide overall professional leadership for all clinicians delivering psychological care for UASC in Kent. To be responsible, in collaboration with other senior leaders, for the provision and development of psychologically competent services for the care group, ensuring the delivery of high quality psychological care and to hold a consultant case load.

### MAIN DUTIES and RESPONSIBILITIES:

- To be accountable as part of the UASC clinical network and stakeholders for the management of business development.
- To represent the needs of UASC across Kent wide services in developing new initiatives, formulating evidence based solutions and negotiating contracts with commissioners of services.
- To provide professional leadership for agencies and psychological therapy for the care group across Kent wide services, leading on appraisal, professional development and supervision systems, as well as standards of professional behaviour for all clinician delivering psychological interventions in order to affect a high quality psychological practice for UASC across Kent wide services.
- To work autonomously within professional guidelines and to provide professional leadership exercising responsibility for the systematic governance of psychological practice with the UASC across Kent wide services. To ensure that suitable systems are in place for the clinical and professional supervision and support of all clinicians delivering psychological interventions, to enable them to maintain safe, effective, compassionate care according to the requirements of their professional registration.



- To propose and implement policy and service development changes in relation to psychology and psychological interventions for UASC's.
- To ensure that systems for effective recruitment, professional appraisal and identification of CPD are in place and working effectively across the clinical network.
- To be responsible for the development of applied psychology services within agencies, including clear systems that support recruitment, and workforce planning in line with the business plan and the care group service model.
- To initiate and carry out, audit, research and training programmes and to propose and implement policy and service development changes within the UASC clinical network.
- To hold a consultant case load.

### **Operational Delivery**

1. To lead in design, planning and implementation of evaluation, monitoring and development of psychological care and holistic interventions within core services and the UASC clinical network, through the deployment of professional skills in research, service evaluation and audit, ensuring incorporation of psychological framework for understanding and provision of high quality care.
2. To utilise psychological theory, evidence-based literature and research to support evidence-based practice in psychological work, and to inform work with other network members and across core agencies.
3. To take a lead role in coordinating and to undertake appropriate research and provide research advice to other staff undertaking research within the clinical network.
4. To initiate and implement project management for programmes of research and development, including complex audit and network evaluation, with colleagues within and across the network to help develop and improve services to UASC and their foster families.



## Patient / Customer Care

Overall: to be responsible for the delivery of high quality, effective and safe psychological interventions within Core Agencies in order to meet Kent wide strategic aims and objectives.

1. To provide highly developed specialist psychological assessments of clients based upon the appropriate use, interpretation and integration of complex data from a variety of sources including psychological tests, self-report measures, rating scales direct and indirect structured observation and semi-structured interviews with UASC, their foster families and others involved in the UASCs care.
2. To provide assessment and case management advice for complex cases especially those requiring specialist input and external admission.
3. To formulate plans for the formal psychological treatment and/or management of a UASCs presenting problems based upon an appropriate conceptual framework of the UASCs problems, and employing methods based upon evidence of efficacy, across the full range of agencies.
4. To be responsible for the implementation of a range of psychological interventions for individuals, carers, foster families and groups, within and across teams employed individually and in synthesis, adjusting and refining psychological formulations drawing upon different explanatory models and maintaining a number of provisional hypothesis.
5. To make highly skilled evaluations and decisions about treatment options taking into account both theoretical and therapeutic models and highly complex factors concerning historical and development processes that have shaped the individual, foster family or group.
6. To exercise full responsibility and autonomy for the treatment of and discharge of UASCs whose problems are managed as a psychologically based standard care plan, ensuring appropriate assessment, formulation and interventions, communicating with the referral agent and other involved with the care on a regular basis.
7. To provide expertise and specialist psychological advice, guidance and consultation to other professionals contributing directly to UASC's formulation, diagnosis and treatment plan.
8. To ensure that all members of the clinical team have access to a psychologically based framework for the understanding and care of UASCs of the service, through the provision of advice, consultation and the dissemination of psychological knowledge, research and theory.
9. To undertake risk assessment and risk management for relevant individual UASCs and to provide both general and specialist advice for clinicians in aspects of risk assessment and management.
10. To ensure where appropriate, the provision of a care package appropriate for the UASCs needs, co-ordinating the work of others involved with the care, arranging UASC care reviews as required and communicate effectively with the UASC, his/her foster family and all others involved in care; and to monitor progress during the course of multi-disciplinary care.
11. To communicate in a highly skilled and sensitive manner, information concerning the assessment, formulation and treatment plans of UASCs under their care and to monitor and evaluate progress during the course of both uni- and multi-disciplinary care.
12. To provide expertise and advice to facilitate the effective and appropriate provision of psychological care by other professionals in the network.
13. To provide consultation about the psychological care of the client group to staff and agencies outside the UASC clinical network.

## Strategic Management

1. To participate actively in professional and managerial supervision, ensuring arrangements are maintained, including where necessary, specialist therapeutic supervision appropriate

for the specialist area of UASC care and undertake relevant training aligned with the post holder's personal development plan and other professional bodies' guidelines regarding continuing professional development.

2. To be responsible for and ensure appropriate systems for the clinical and professional supervision of qualified and unqualified clinicians working in core agencies within the UASC clinical network.
3. To be responsible for the provision of clinical and professional supervision to staff employed by the UASC clinical network.
4. To be responsible for the provision of specialist clinical placements for trainee therapists, ensuring that they acquire the necessary clinical and research skills to doctoral level where appropriate, and competencies and experience to contribute effectively to good psychological practice, and contributing to the assessment and evaluation of those competencies.
5. To provide specialist advice, consultation and training in the management of clinical risk and within core services, clinical supervision to other members of the team for their provision of psychologically based interventions to help improve UASCs functioning.
6. To provide pre and post qualification teaching of clinical therapeutic interventions in the specialism of UASC and systemic psychotherapy.
7. To continue to develop expertise in the area of professional pre and post-graduate training and clinical supervision.
8. To be responsible for psychology advice and consultation in setting up and strengthening staff support systems for coping with high stress areas of work, and processes such as debriefing, team review, critical incident reviews including suicide reviews and providing direct psychological interventions where required.
9. To directly contribute to the UASC clinical network strategic aims and objectives

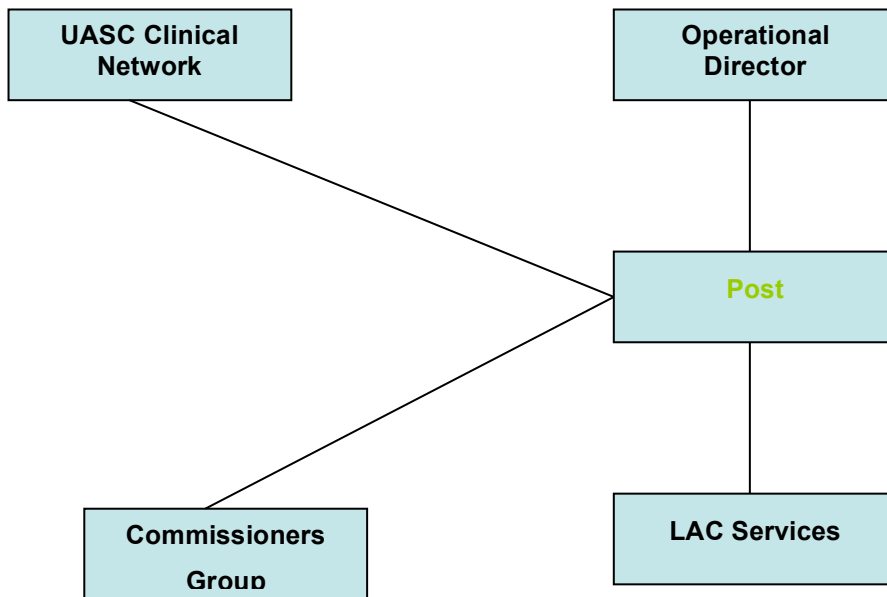
### **Service Development and Improvement**

1. To participate as a senior member of the UASC clinical network and member agencies in the design and development of a high quality, responsive and accessible service for UASCs, their carers and foster families within the locality/agency including leading in collaboration with agency management on those aspects of the service where psychological and/or organisational matters need addressing.
2. To provide leadership and exercise responsibility in collaboration with member agency management for developing and delivering plans for management of cost or generation of income on behalf of the clinical network
3. To provide leadership and exercise responsibility in collaboration with service management for managing relationships with commissioners of services and other financial stakeholders in order to safeguard the business viability of the Trust.
4. To lead on the systematic governance of psychological practice within core agencies and stakeholders, including maintaining systematic records of appraisals, clinical record keeping standards and the transcribing of minutes and records of appropriate professional meetings.
5. To propose, design and implement service development in the locality/service, based on national policy, liaison with stakeholders, and/or as required.
6. To lead, in collaboration with service manager(s), appropriate recruitment from a psychological perspective.
7. To provide effective leadership and management to professionals that promotes high performance standards both individually and as a team, in the achievement of the UASC's clinical network priorities and objectives.

### **Management and Leadership**

Position in the organisation and other key relationships are shown in the organogram.





### Communication and Relationship Building

1. To ensure that all clinicians within member agencies maintain up to date knowledge of legislation, national and local policies and issues in relation to both the specific client group and mental health.
2. To contribute to other lead consultant psychologist and the professional lead to development and articulation of best practice in psychological therapies across agencies working with UASC.
3. Maintain an individual professional profile with member agencies as direct evidence of clinical practice at an advanced level. Disseminate good practice through national and international conferences presentations and preparing relevant material for publication in appropriate professional journals.
4. To contribute to the development of an open learning culture within the network, which supports clinical governance, innovation, and the provision of safe and effective services, in line with broad government and Department of Health Policies to tackle inequalities, improve public services and promote social inclusion, which involves users and staff and values learning.
5. To ensure the development and articulation of best practice in psychological therapy within UASC clinical network and contribute across the network by exercising the skills of a reflexive and reflective scientist practitioner, taking part in regular professional supervision and appraisal and maintaining an active engagement with current developments in the field of systemic psychotherapy and related disciplines.
6. To ensure the development, maintenance and dissemination for the highest professional standards of practice, through active participation in internal and external CPD training and development programmes.

### Finance and Resource Management

1. To exercise responsibility in collaboration with member agencies for the deployment of psychological resources available to services both in terms of clinical staff and psychological materials employed in the assessment and treatment of OASCs.

2. To exercise responsibility for the appropriate and safe use of specialist psychological equipment within the clinical network including appropriate systems of stock control and purchasing of equipment.
3. To provide leadership and exercise responsibility in collaboration with member agency management for developing and delivering plans for management of cost or generation of income on behalf of the UASC clinical Network
4. To exercise responsibility for selection and allocation of resources for training

### **Information Management**

1. To be responsible for data entry and utilising computer data entry systems.
2. To be responsible for using computer software to create reports and documents.
3. To ensure the highest standard of clinical record keeping including electronic data entry and recording, report writing and the responsible exercise of professional self-governance in accordance with professional codes of practice of the relevant professional bodies related to their practice, the health professionals council and Trust policies and procedures.

### **General**

- 1 To ensure professional accreditation/registration is maintained, complying with Continuing Professional Development requirements to maintain registration.
- 2 To participate fully in the trust's performance review and personal development planning process on an annual basis.



**EFFORT, PHYSICAL SKILLS and WORKING CONDITIONS:**

<b>Physical skills</b>	On a daily basis takes the lead, in planning and implementing systems for evaluation, monitoring and development of psychological interventions; through the deployment of professional skills in research, service evaluation and audit, incorporating psychological frameworks for providing and identifying high quality care.
<b>Physical effort</b>	On a daily basis develop, implement and manage a specialist assessment clinical network and high level and complex programmes of psychological therapies for OASCs with highly complex psychological needs within the clinical network. Also carry out high level and complex psychological treatment and other interventions within the specialist area that necessitate the interpretation and communication of highly complex and sensitive medical, psychological and social information, the application of empathy and the ability to manage hostility, aggression, potential violence or manipulation from the patient. To arrive at a formulation and treatment plan where there is likely to be a range of options available.
<b>Mental effort</b>	<i>On a daily basis</i> provide highly developed specialist psychological assessments of OASCs based upon the appropriate use, interpretation and integration of complex data from a variety of sources including psychological tests, self-report measures, rating scales direct and indirect structured observation and semi-structured interviews with OASCs, foster families and other agencies involved in the clients care.
<b>Emotional effort</b>	On a daily basis will convey unwelcome information to OASCs that may be rejected or where there are significant barriers to acceptance. Also the need to overcome cultural, knowledge-based or cognitive barriers to understanding, while managing highly complex physical and psychological dilemmas.
<b>Working conditions</b>	The post holder will work across a variety of settings in Kent, which will include working in unpleasant working environments (such as reception centres with exposure to infection) and with clients who may present a risk to the post-holder (such as violent or distressed individuals). The post holder will work with frail and vulnerable OASCs with significant physical complication. The post holder will work with clients at significant risk of self-harm and suicide.

**Supplementary Information:****Equality and Diversity**

The Trust is committed to eliminate racism, sexism and forms of discrimination. The Trust will not discriminate on grounds of age, colour, disability, ethnic origin, gender, gender reassignment, culture, health status, marital status, social or economic status, nationality or national origins, race, religious beliefs, or non beliefs, responsibility for dependants, sexuality, trade union membership or hours of work.

It is required of all employees to uphold this policy in the course of their employment with the Trust and whilst undertaking their duties.

### **Mobility / Flexibility**

The normal place of work for the post is as stated above, but as a term of employment post holders may be required to work from any of the Trust's establishments.

### **Health and Safety at Work**

In accordance with the Management of Health and Safety at Work Regulations 1992 (as amended) and other relevant Health and Safety legislation, staff have a duty to take responsible care to avoid injury to themselves and others by their work activities and to co-operate in meeting statutory requirements.

### **Infection Control**

Employees must be aware that preventing healthcare acquired infections and infection control is the responsibility of all staff. Clinical procedures should be carried out in a safe manner by following best practice and infection control policies.

### **Data Protection and Confidentiality**

Employees must maintain confidentiality when dealing with sensitive material and information and be aware of the Caldicott principles, the Data Protection Act 1998 and the Human Rights Act 1998. The protection of data about individuals is a requirement of the law and if any employee is found to have permitted unauthorised disclosure, the Trust and individual may be prosecuted. Disciplinary action will be taken for any breach.

### **No Smoking Policy**

The Trust operates a smoke free policy which means that smoking is not allowed anywhere on Trust sites including buildings, car parks and entrances.

### **Safeguarding**

Post holders have a general responsibility for safeguarding children and vulnerable adults in the course of their daily duties and for ensuring that they are aware of the specific duties relating to their role. The expectation is that the post holder is familiar with the relevant procedures and guidelines, all of which can be found on the Trust's intranet.

The above duties and responsibilities are intended to represent current priorities and are not meant to be an exhaustive list. The post holder may from time to time be asked to undertake other duties and responsibilities commensurate with the grade. Any changes to this job description to take account of changing service needs will be made in discussion with the post holder.



## PERSON SPECIFICATION

**Job title: Lead Consultant Systemic Psychotherapist**

<p><b>Qualifications and Training</b></p>	<ul style="list-style-type: none"> <li>• First professional qualification and experience</li> <li>• Masters Level Degree in Systemic Psychotherapy</li> <li>• Eligibility for UKCP accreditation</li> <li>• Training for and/or experience of clinical supervision of clinicians</li> <li>• Post –Graduate doctorate in Systemic Psychotherapy and AFT accreditation</li> <li>• Other specialist further training in psychology of vulnerable children</li> <li>• Training in management skills</li> <li>• Specialist NHS training in management skills (e.g. recruitment &amp; selection)</li> <li>• Training in research methodology and experience of staff training in the use of clinical interventions</li> </ul>
<p><b>Experience and Knowledge</b></p>	<ul style="list-style-type: none"> <li>• Extensive experience of working as a qualified systemic psychotherapist with vulnerable clients.</li> <li>• Highly developed knowledge of the theory and practice of highly specialised psychological practice.</li> <li>• Experience of the application of applied psychology in different cultural contexts and experience of working within a multicultural framework.</li> <li>• Experience of successfully representing the profession and/or network in local or regional policy forums, across services or at an equivalent level.</li> <li>• Experience of successful professional management of qualified and unqualified clinicians.</li> <li>• Extensive experience of providing successful clinical leadership within a multi-disciplinary provider service.</li> <li>• Experience of multi-professional management of teams or services with highly vulnerable clients.</li> <li>• Experience of exercising full clinical responsibility for client's psychological care and treatment, both as a professional clinician and also within the context of a multi-disciplinary care plan.</li> <li>• Experience of successful partnership with partner providers and other stakeholders.</li> <li>• Evidence of significant expertise in clinical risk management.</li> <li>• Experience of teaching training and/or professional and clinical supervision at postgraduate/professional registrant and post registration level.</li> <li>• Extensive experience of providing successful clinical leadership within a multidisciplinary health care context.</li> <li>• Substantial experience or training in more than one therapeutic</li> </ul>

	<p>intervention specialty</p> <ul style="list-style-type: none"> <li>• Training and/or substantial experience of trauma and bereavement</li> <li>• Post-qualification experience in a family therapy team</li> <li>• Extensive experience of NHS management tasks (e.g. supervising clinical staff; recruitment &amp; selection)</li> </ul>
<p><b>Skills and Abilities</b></p> <p><i>Include any of the following skills: technical, communication, analytical or judgemental, planning and organisational</i></p>	<ul style="list-style-type: none"> <li>• Doctoral level knowledge of psychological therapy practice.</li> <li>• Doctoral level of research design and methodology.</li> <li>• Highly developed knowledge of the theory and practice of specialised psychological practice.</li> <li>• Demonstrate knowledge of the theory and practice of leadership and management in mental health delivery.</li> <li>• Evidence of continued professional development</li> <li>• Formal training in supervision.</li> <li>• Knowledge of any National Service Framework guidelines, NICE guidelines and other regional and National policies for the area of specialty, and their implications for clinical practice &amp; professional management in relation to OASC and LAC.</li> <li>• Ability to design &amp; implement policy for the clinical network &amp; to propose service changes that impact beyond that area of activity</li> <li>• Skills in the use of complex methods of psychological assessment, intervention and management frequently requiring sustained and intense concentration levels.</li> <li>• High level proven ability in translating national policy and evidence regarding psychological practice into effective local action to improve services.</li> <li>• Ability to identify and prioritise appropriate areas for service improvement, and to design, plan and deliver these improvements.</li> <li>• A high level ability to communicate effectively at both a written and spoken level, complex, highly technical, clinically sensitive and contentious information to service users, their foster families and a wide range of lay professional individuals within and outside of the NHS and social care.</li> <li>• Skills in providing specialist consultation to other professional and non-professional groups.</li> <li>• Ability to develop, implement, manage, evaluate &amp; carry out high level &amp; complex psychological treatment &amp; other interventions within the specialist area that necessitate the application of empathy and the ability to interpret &amp; communicate highly complex &amp; sensitive information.</li> <li>• The ability to manage hostility, aggression, potential violence or manipulation from the patient</li> <li>• Ability to manage the rejection of unwelcome information where there are significant barriers to acceptance and the ability to overcome cultural, knowledge-based or cognitive barriers to understanding</li> <li>• Ability to carry out or take responsibility for R &amp; D programmes including design &amp; use of databases, spreadsheets &amp; specialist research methodologies</li> <li>• Ability to contain and work with organisational stress and to contribute to staff wellbeing.</li> <li>• Ability to identify, and employ, as appropriate, clinical governance</li> </ul>

	<p>mechanisms for the support and maintenance of clinical practice in the face of regular exposure to highly emotive material and challenging behaviour.</p> <ul style="list-style-type: none"> <li>• Awareness of significance of ethnic &amp; cultural issues in delivery of psychological services</li> <li>• Ability to identify, provide and promote, as appropriate, means of support to carers and staff exposed to highly distressing situations and severely challenging behaviours.</li> <li>• Ability to develop and use complex multi-media materials for presentation in public, professional and academic settings.</li> <li>• Record of having published in either peer reviewed or academic or professional journals and/or books</li> </ul>
<p><b>Personal qualities</b></p> <p><i>Link to Trust values where possible – please see examples given on Behaviours against Values</i></p>	<ul style="list-style-type: none"> <li>• Ability to contain &amp; work with organisational stress</li> <li>• Ability to hold the stress of colleagues &amp; other relevant persons</li> <li>• Ability to cope with continual exposure to distressing &amp; highly emotional clinical material</li> <li>• Ability to cope with physical requirements of job (work in dept, at reception centres, in homes, at hospitals)</li> <li>• Ability to sit in one position for lengthy periods during therapeutic interventions</li> <li>• Ability to operate within irregular working hours</li> <li>• Current full driving licence &amp; use of a car</li> </ul>
<p><b>Other requirements</b></p> <p><i>Add to the pre-populated list if necessary and remove the 'Car Driver' statement if not essential to the job</i></p>	<ul style="list-style-type: none"> <li>• Ability &amp; preparedness to work to professional guidelines</li> <li>• Ability to interpret general clinical, professional &amp; organisational policies &amp; to use own independent initiative to establish how they should be applied within the area of specialty</li> <li>• Willingness to uphold the Trust's values</li> <li>• Eligible to live and work in the UK</li> <li>• Hold a full, valid, UK driving licence and have access to a car to use for business purposes (unless you have a disability as defined by the Equality Act 2010)</li> </ul>



# Appendix 4

## Potential Minimum Data Set

The UASC clinical network would ensure that a Minimum Data Set is collated for each child to enable Kent to evidence against agreed quality measurers and to gain an understanding of what is required.

The following are a starting point from which the UASC clinical network could start a process of agreeing and developing a MDS that enables all member agencies to gain evidence base for the services they are providing.

Age

Gender

Location

Placement type

Learning disability status

Physical disability

Language(s) spoken

Ethnicity

Religion

Key worker identification and status

Current concerns(s)

Main reason(s) for seeking asylum

Any kin in the UK

GP details

Allocated NHS No

Care Assessment

Health Assessment to include EH&WB screening.

Educational Assessment

Legal Assessment and representation

Level of intervention required

GP letter re care plan (as recommended keyworker)

Missing without authorisation

Client attended/DNA (initial appointment)





Therapist cancelled (Initial appointment)

Interventions made

Indirect consultation i.e. other clinicians, agencies and MDT

Discharge intelligence to dispersal area.

On-going discussion due to complexity

Telephone support episodes

Assimilation orientation



# Appendix 5

## Referral Pathway for Mental Health Support:

