STANDARD OPERATING PROCEDURE
CPWP EARLY INTERVENTION

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*April 2024*	*New SOP. Approved at Children's Services Divisional Governance Meeting (11 April 2024).*

Contents

1. INTRODUCTION

Background to the Team
Children and young people's mental health remains a priority area as half of all mental health conditions are established before the age of fourteen. Early intervention and support could help children and young people learn to better manage their mental health needs, enable access to timely support and interventions at the earliest opportunity and prevent more severe needs developing in adulthood.

In 2011 The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) was initiated as a service transformation programme delivered by Health Education England partners. The programme aims to improve the wider CYP emotional and mental health support within the community to enable system-wide change to be achieved through embedding key principles into routine practice.

Why is the service important?
According to Young Minds one in six children will have a probable mental health problem between the ages of five to sixteen, that is one in five children in every class in the UK. They will require support ranging from low level support through to getting risk support. Mental Health Statistics UK | Young People | YoungMinds

Any child or young person who experiences mental ill health, whether mild or severe may experience lower school attendance and educational attainment.

The principles of The Children and Young People's Improving Access to Psychological Therapies programme focus on improving access to services, raising aware of mental health issues, increasing service user participation, and improving quality of care through evidence-based practice.

The CPWP offer works with CYPs experiencing mild to moderate social emotional and mental health needs and operates across schools and the communities for easy access to the right support at the right time using principles of I-Thrive. National i-THRIVE Programme | i-THRIVE (implementingthrive.org)

Overview of The CPWP programme
We have a team of dedicated Practitioners that deliver interventions within community-based settings across Hull to increase accessibility to mental health support.
The practitioners provide early intervention mental health support for children and young people aged 5 – 18 across education settings, health, and community-based settings.

The Children's Psychological Wellbeing Practitioner (CPWP) sit within Early intervention CAMHS. These practitioners have completed training as part of the CYP IAPT programme.

The leadership across Early Intervention oversee the clinical and operational delivery of the team and come from multiple backgrounds including Nursing, Psychology, I-APT, Psychotherapy etc. The team offers interventions, support, advice as part of the wider emotional and mental system across Hull to complement the already well-established provisions as part of Thrive.

The team has an interface with all parts of the system, including Early Help, Hull Thrive, Social Care and Specialist CAMHS to ensure all children, young people and families are fully supported to meet their needs.

The CPWPs main functions are:

- To deliver evidence-based interventions for mild to moderate mental health issues to children, young people, and families.
- To work in partnership with education settings and external agencies.
- Offer advice, support, and signposting.

The Children's Psychological Wellbeing Team deliver low-intensity evidence-based approaches for:

- Generalised anxiety disorders
- Social anxiety disorder (social phobia)
- Obsessive Compulsive Disorder
- Depression / Low Mood
- Phobias
- Confidence and self esteem
- Relationship difficulties
- Self-harm
- Separation anxiety

The CPWP offer delivers therapeutic interventions to children and young people on a 1:1 basis age 10-18 and/or in groups either weekly or fortnightly. We also deliver Parent-Led CBT work for CYP's from the ages of 5 – 17 however, this work is purely with the parents.

The sessions are for children and young people/families of children and young people who are experiencing mild to moderate mental health difficulties.

The CPWP will help children and young people within the community settings who present with more severe problems to access more specialist services.

The CPWPs will provide support via:

- 1:1 intervention (Face-to-face and via Microsoft Teams)
- Group interventions
- Parent led CBT for anxious children
- Co-ordinated response to other services to support emotional wellbeing

The CPWP offer is part of HTFT Early Intervention CYPMHS service within the Children and Young People's Learning Disabilities Division.

2. SCOPE

These Standard Operating Procedures are aimed at Clinical Staff; consultants, junior doctors, unit managers/Team Leaders, nursing staff, support staff, therapists, psychologists, family therapists, students, and agency staff where appropriate.

These are clinical staff from all service areas across the Trust; Community Services, Mental Health Services, Learning Disability Services, Forensic Services, Specialist Services, Children's Services, Therapy Services and Acute Services.

The document is aimed at these staffing groups to ensure that clinicians understand how the service operates from accepting a request for support right through to discharge from service.

This document should be referred to when making a request for support, identifying need through to being discharged.

This document should also be referred to by practitioners delivering the CPWP Programme.

3. DUTIES AND RESPONSIBILITIES

Service Manager is responsible for the operational and strategic oversight of the service, building and maintaining relationships with schools, early intervention and early help service leads and managers to ensure good collaboration with the ICB and wider partners. The Service Manager will directly manage the band 7 Team lead. The Service Manager will be the direct link into the Children's and Learning Disabilities division at a senior level.

The Team Lead is responsible for the clinical and operational oversight of the team, direct management of the senior practitioners and management of the practitioners. Offering consultation to Education and other professionals. Occasionally holding a small caseload if required. The Team Lead will work both in an identified trust base and out in the Education and communities at identified times.

Senior Practitioners are responsible for delivering clinical supervision to the Practitioners when in training and when qualified. Senior practitioners may hold a small caseload when required. They will also offer consultation to Education settings, other professional and lead on duty within the service and conduct triages when needed. This requires flexibility both in a trust base and out in education and community settings. Senior practitioners will also be required to be working towards or qualified as a low intensity CBT supervisor.

Practitioners (Qualified) will hold a maximum of 20 CYPs on caseload delivering low intensity CBT interventions such as therapeutic group, 1:1 and parent led CBT. Practitioners will also support duty at identified points and contribute to triages when needed.

Trainees will attend university one day a week and hold a caseload of up to 10 whilst in their training year.

Practitioners will have access one day a week with their team in an identified trust base. To access face to face support, reflective practice, admin support and reconnect as a team seeking both clinical and managerial supervision and support when required.

If practitioners conduct home visits, this is risk assessed prior to the visit taking place and lone working is followed using policy and practice within the team and underpinned by Trust policy.

Admin Support are responsible for receiving and creating referrals on Clinical system, creating and monitoring duty tasks and communicating these to the duty staff, answering telephone and emails enquiries and carrying out all associated administration tasks. Admin also support staff as required with administrative queries.

4. PROCEDURES

4.1. Access

Request for support (referral)

Referrals from Contact Point – These referrals will be triaged by Contact Point and reviewed by the Senior Practitioner or Team Lead on duty on receipt of referral. The referral will be screened, and a welcome letter will be sent out. Additionally contact will be made with the family and young persons over the telephone when risk is identified and or needs require further clarifications record appropriately on Clinical system.

Referrals from other Camhs service

Referrals from Humber CAMHS/Neuro services will be actioned on Clinical system. Ideally the referring Team should have had a discussion with duty prior to making the internal referral.

4.2. Accepting a request for support (referral)

The referral is reviewed by duty and actioned using the following:

The weekly MDT will be used to review referrals suitability when needed and documented.

Admin will send out to the CYP and family a welcome letter, with information on the CPWP offer, useful websites and other contact numbers such as the Crisis Team. Copies are sent to GP, school nurses and school if they made the initial referral.

The welcome letter also informs families that they can contact the early intervention service on 01482 205205 if changes are noticed with regards to presentation or risk or approach their educational setting for support if needed.

The CPWP Team works on a process of assessment and intervention once allocated to a practitioner. We do not assess and then place on a waiting list for treatment as this is not consistent with the CPWP approach. Cases will remain on an access plan under waiting list management until allocated to a practitioner.

However, if we do identify an increased need for the CYP, their assessment is prioritised, and we will assess. However, they may still wait for intervention.

The Senior practitioner will usually facilitate this and/or the Team Lead. Once this has happened an agreed plan will be put in place to ensure the YP and family are supported whilst they wait for intervention. This plan will be recorded on the system within the clinical record. These plans will be updated on the clinical system and managed via the duty system which is overseen by the Team Lead.

4.3. CYPs and Families multiple requests for support

If we receive requests for support for CYPs who have had previous requests into the service, then we will take these referrals directly to the MDT. Following on from this we will look at how best to support the CYP and family using the AMBIT framework and using tools such as the disintegration grid, to ensure we do not keep repeating interventions that may not be best placed to meet the young person's needs.

CYPs and families will be supported to access the most effective support to meet their needs. This will be through a number of approaches including, but not exhaustive of, signposting, holding a Team around the family meeting, making onwards referrals if needed.

4.4. Access Plan Management

The CPWP offer is early intervention therefore we anticipate that most young people should receive their assessment and intervention within an access time of 6-8 weeks. Although it is the aim of the service to allocate referrals in a timely manner for assessment there may be times of high demand where it is not always possible. In these instances, Team Leaders and or senior practitioner (duty) will ensure that families are contacted by telephone to continue to triage on-going risk, need and ensure that those whose needs are escalating are expedited and supported accordingly. The frequency of this triage is based on clinical judgement and shared decision making. This should be clearly documented in the clinical record and reviewed at every contact.

Consideration should be given as to whether these cases would benefit from CAMHS Crisis or Intensive Home Treatment (CCIHT) in the short term to support the young person or to social care and other early intervention/early help services.

We will also continue to action the below steps as part of a waiting list management plan:

- Waiting list access plan is managed using 3.4 within the SOP and this list is reviewed weekly. Practitioners' active caseloads are reviewed weekly by Team Lead to manage capacity and wait times in service.
- Access plan waiting list clinically reviewed in the weekly MDT.
- Duty calls to the families/CYPs once every half term (6 weeks) whilst on the access plan
- Advise families of ways to contact the team directly if needs change and other services who can respond to social care and mental health crisis.
- Call to families/CYP every half term to advise of wait times wherever possible and review need and risk.

If families/CYP are unable to be contacted whilst conducting the 6-week check in calls, contact should be attempted up to 3 times within a week period. If still no response a contact us letter should be sent requesting the family / CYP to contact the service reasons given. Further attempts should then be made to contact the family/CYP as per waiting list process and using safeguarding at the centre of all decision making. Following this it will be discussed at the MDT and a decision will be made around if an unplanned home visit is required.

The case will continually be discussed at the weekly MDT and documented, and Practitioners will access additional clinical supervision when needed to consider the contextual needs of the CYP and family. If there is still no contact, then using Was Not Brought and No Engagement Policy N-072.pdf (humber.nhs.uk) and considering and following safeguarding steps and procedures. Safeguarding Children Policy N-045.pdf (humber.nhs.uk) (No case should be discharged whilst on the waiting list for non-engagement and should continue to wait to be allocated, unless family/ young person states they no longer require/want support)

4.5. Responding to and supporting Children and young people who are referred with multifaceted and complex social, emotional and mental health needs

When children and young people are referred into the service and the referral form indicates that there is possible complex, multifaceted and or long term needs and presentation these referrals will be expedited and allocated for an assessment. Following the assessment, the CYP may present with needs that an early intervention service can respond to, or we may identify that another service is required alongside Early Intervention such as Social Care, Early Help or a referral to specialist CAMHS (e.g., core, crisis, Home based treatment, eating disorders).

4.6. Allocating a referral to a practitioner.

Referrals will be allocated once the designated Practitioner has capacity for identified support. Once allocated the individual young person will then be closed from the access plan. The practitioner will then lead and coordinate all interventions and care as a lead worker.

It is important to note that the whole team have access to each practitioner's caseload to cover annual leave and sickness.

On allocation Practitioner will

- Make an initial phone call to the family and young person to introduce themselves and explain a little about the role and service.
- They will then arrange an appropriate time/date for an assessment (face to face or online) to take place in convenient location.
- Assessment can be done with parent and CYP if identified as more suitable for the young person.
- If families have been put forward for Parent-led CBT, then a shorter brief assessment will be done purely with the parent.

The CPWP Team uses nationally recognised outcome measures, such as RCADS, ORS and CORS.

4.7. Following on from assessment:

If appropriate the CPWP offer will consist of one of, or a combination of, the following

- Group
- 1:1
- Parent led CBT

If we identify with the young person and the family that the CPWP team isn't best placed to meet their needs following an assessment, then this will be clinically discussed with the Senior CPWP Practitioner and Team Lead (if required). The discussions will work via a shared decision making, process to understand risk and need, ensuring the young person receives the most appropriate intervention and support to meet their needs.

This may well then trigger the Senior CPWP Practitioner to gather additional information. For more complex needs, a joint assessment maybe undertaken between the Practitioner and the Senior practitioner within early intervention or alongside other parts of the CAMHS service if required.

Following on from this, it may be deemed appropriate for the Senior practitioner to co-deliver the work and additional discussions may be required at MDT, or escalation through to one of the specialists CYP services such as Core CAMHS or partners such as safeguarding.

4.8. Assessment and risk tools

The CPWP Team uses a Low intensity Cognitive behavioural therapy assessment using the 5 areas model and problem statement and incorporating risk and safeguarding. The key principles of cognitive behavioural therapy - Kristina Fenn, Majella Byrne, 2013 (sagepub.com)

The assessment is completed with every young person in a one-to-one setting, usually within the young person's school. Additional information is gathered as a standard from the child/young person's and their family. Other information from significant others connected to the CYP and family can contribute to the assessment on a case-by-case perspective and should be clearly documented.

The assessment can be completed with the family and young person together if identified as appropriate.

Practitioners complete their associated paperwork which is held in the clinical system to enable practitioners to input information contemporaneously and directly into clinical system. The assessment is completed and all paperwork and gather all information from the CYP, and family. Ensuring the documentation is clear in relation to who has contributed which parts to the assessment.

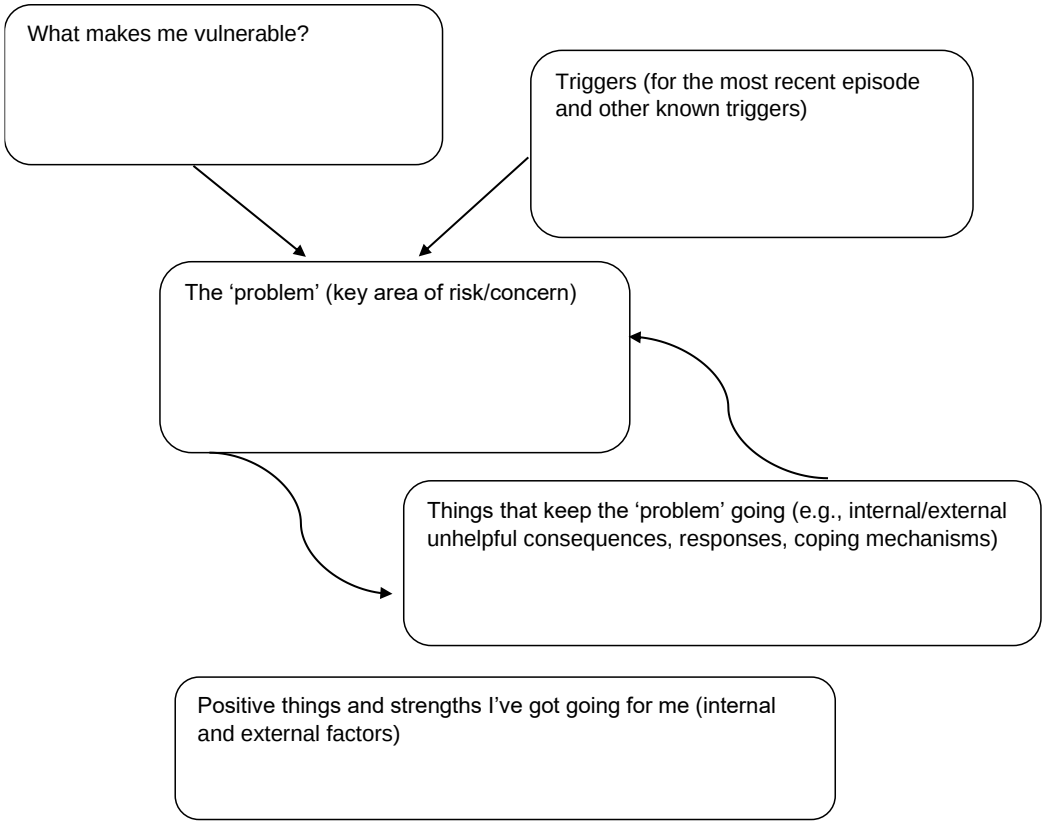
The assessment outcome section at the bottom of the document should include a clear formulation and outcome of assessment, including a clear plan and actions around identified risk or safeguarding.

Additional Risk Assessment

If clinical, contextual safeguarding risk is disclosed at any point during the assessment or during an intervention, then Practitioners will undertake a formal risk assessment and safety planning session. This aim is to help the Practitioner to understand the level of risk, and support families and other professionals in supporting the CYP to reduce or mitigate risk factors. Risk assessments also provide an insight as to whether the CYP's overall presentation is appropriate for a low-intensity CBT intervention. This risk assessment is not for risk from others as this is supported through safeguarding and other stator measures or for non-attendance educationally unless there are other clinical risks alongside of the non-attendance.

The Early Intervention service utilises a contextual safeguarding risk assessment using the 5 P's formulation. This is to establish the context, identify the risks, analyse the risks, evaluate the risks, and respond to and support the risk in collaboration with the Child/Young person and the system around them.

5 P's Formulation of risk and safety



NICE guidance ([NG225] Published: 07 September 2022) recommends regarding risk assessments tools and scales that:

- *we do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.*
- *we do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.*
- *risk assessments should focus (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.*
- *Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.*

Therefore, in early intervention we use a contextualised approach and risk documentation support and empower CYPs to understand their own needs, what they can do for themselves, what others can do to help them and what do they need to stay safe and well. Early intervention requires a systemic approach to understand and respond to risk and safety whilst working as a system with and around the CYP through principles of Thrive.

The risk assessment incorporating the 5 P's can be utilised for all risk including clinical and social risks such as absconding, risk of harm to self and others and CSE etc.

The risk assessment as a standard is completed with Child/young person and Family and if applicable the education setting and any significant others.

If risk is identified at point of referral, then a risk assessment will be automatically completed with the child/young person and family.

4.9. Engagement and commitment

Engagement and commitment are essential to the successful completion of evidenced based interventions. This will be discussed in detail and contracted with the CYP, family and education setting at point of referral and during the assessment. The contract can be re-visited throughout the duration of the support and intervention if needs and circumstances change. Non engagement and commitment could result in the intervention not being deemed the most appropriate, this would be explored with the CYP and family and may result in being offered an alternative support plan, a referral on to another service to meet need or intervention ending. Steps will be followed prior to the final shared decision being made to ensure CYP's and family's needs and voice are central within the process. This may include utilising MDT's, clinical supervision, safeguarding, referrals process within the SOP.

4.10. Due to non-attendance

If a CYP or family does not attend their session, intervention, or consultation then the lead practitioner will contact the family/CYP directly by phone and text. This will be to arrange an alternative appointment and to revisit the contracting as part of the offer to meet their needs.

If a CYP or family continues to not engage, then the Lead Practitioner and admin will work in partnership to attempt to make contact. To ensure we are working as a collaborative we will be working with Education and the system to support with ascertaining contact. Three phone calls will be delivered in the space of two-week period, alongside two contact us texts and a contact us letter. Following this it will be discussed at the MDT and a decision will be made around if an unplanned home visit is required.

The case will continually be discussed at the weekly MDT and documented, and Practitioners will access additional clinical supervision when needed to consider the

contextual needs of the CYP and family. If there is still no contact, then using Was Not Brought and No Engagement Policy N-072.pdf (humber.nhs.uk) and considering and following safeguarding steps and procedures. Safeguarding Children Policy N-045.pdf (humber.nhs.uk)

4.11. Discharge process

CYPs will access their exit assessment and outcomes measures within an exit interview. As part of the discharge from the service CYPs and families will be supported to increase their own tool kit and awareness of self and others to create sustainable change.

4.12. No longer requiring intervention and support.

If a CYP or family inform us that they no longer require a service from us then the practitioner or duty will work through with the CYP and family what current needs they have now, are they accessing support from elsewhere or have things improved. This will then inform the agreed plan as part of discharge. This information will be documented and then detailed in a letter to the CYP and family with a copy to the GP, school nurse and information shared with the education setting.

4.13. End of intervention and support

The end of intervention will always be discussed in advance and an action plan for further support will be created with the CYP and family if required. Exit interviews enable opportunity for appropriate endings from a therapeutic perspective and time to agree any moving on plans collaboratively. Letters will be sent to GP, school nurse and education settings confirming end of support and agreed plan.

5. ADDITIONAL ASPECTS

5.1. Record Keeping

Contacts/care events should be recorded at every contact with CYP, family, school, professionals etc, and adhere to Trust policy with regards to record keeping.

The CPWP Team utilises an approach that ensure there is a clear, defensible communication record for each young person they have supported at the end of their working day. This will include attendance, risk, safeguarding and any mitigation needed. Risk assessment and safety plans and or safeguarding referrals and clinical notes will be completed and on the system within 24hrs.

The assessment is in the clinical record keeping system and is updated as information is gathered contemporaneously. On occasion it may be necessary for a Practitioner to assess a young person over multiple sessions, for example where there are high levels of anxiety, and a therapeutic relationship is required to be established prior to completing the assessment fully. In these circumstances Practitioners will complete the assessment after each contact within the clinical system and within 24 hours. Where this is the case there should be recorded evidence of reasons why the assessment has taken longer to complete, including communication notes, MDT case discussions as standard and clinical supervision if necessary. It is the Practitioner's responsibility to update these records.

5.2. Duty Support

The Early Intervention Service has a direct phoneline 01482 205205, this line will be open between 8.30am to 4.30pm to coincide with education settings. The phoneline will always have both admin and Mental Health practitioners available to respond to calls and offer advice and support. If support is needed outside of these times, then families and young people can access contact point up until 5pm then crisis team from 5pm if required.

Senior practitioners and Team Lead during term time will provide duty support via an operational rota. Outside of term time practitioners will also provide duty support on a rota agreed in advanced.

Internally if a duty call is required for an open case or indeed to discuss a potential request for support then this can be tasked to the team on the clinical system and on email to hnf-tr.earlyinterventions@nhs.net. Allocated duty practitioner and Team Lead will have oversight and is managed via the duty rota.

Practitioners will also use duty to seek effective timely support for clinical, operational and safeguarding needs.

Practitioners are advised to call into the 01482 205205 number between 8:30am and 4:30pm stating their request and a duty practitioner will either call back or immediate requests will be transferred to a practitioner or Team Lead on duty from across the Early Intervention service.

The CPWP Team run a duty rota Monday to Friday (excluding bank holidays) to ensure we have the correct support available within working hours. This is supported by the wider Early Intervention service.

5.3. Safeguarding

CPWP will work in partnership with educational settings and wider partners in relation to safeguarding and child protection. CPWP complements systems and processes that are already established within the education and the community, by working in partnership to keep children and young people safe from harm.

CPWP follow the Hull Safeguarding Partnership Policies and Procedures and ensure that they work within the guidelines of the Humber Teaching NHS Foundation Trust's policies and practices.

CPWP follow the safeguarding duty process within the Early Intervention service which includes seeking support from Humber safeguarding when required.

A practitioner will lead on all child protection and safeguarding that is disclosed to or identified by them, following the Trust's policies and procedures, however they will also adhere to individual educational setting's procedures for logging and reporting any child protection issues through the setting's Designated Child Protection Coordinator and Safeguarding Leads. This is to ensure a joined-up approach is facilitated and prevent duplication or additional distress for the child or young person. This approach will be changed if clearly identified the above would create additional distress or place a CYP at further risk of harm. The situation would then be managed in the most appropriate and safe way following advice given and supported by duty within Early Intervention and Humber safeguarding.

Safeguarding supervision will be logged on Clinical system within the safeguarding tab and using the SCT9 form, along with any referral documentation into Hull or East Riding EHASH. A Datix should also be completed for Safeguarding/Child protection/ early help referrals.

Practitioners will liaise with the Team Lead and senior practitioner to ensure they are supported with their decision making and escalation. When required the practitioner will access Humber Teaching safeguarding team for advice and guidance.

5.4. Non-English speaking / English as additional language

When we are working with children, young people, and families where English is an additional language or with non-English speaking families, we should approach this from a needs-led perspective utilising the translation service when needed, translating within text messaging, and creating letters using the family's first language.

5.5. Navigating the system based on the CYP and family's needs.

If a CYP or family presents with needs that require support from the wider system, the lead practitioner will work with the CYP and family to identify their needs and create a plan.

When the plan incorporates additional request for help and referrals, the lead practitioner will support the CYP and family to identify the correct intervention, support and or actively complete the request for help forms, source details and then monitor the progress.

The lead practitioner will ensure the CYP/family are supported with their needs in a planned way whilst additional support is accessed.

5.6. Escalation process to Specialist services including Core CAMHS

If a CYP presents with needs that require a more specialist response, then CPWP will follow a robust process to ensure that CYPs and families have a good experience of the service whilst being supported to navigate the system.

At each point of the process CYPs and families will be communicated in a relational way ensuring needs are met and shared decision making is experienced (risk and safeguarding will be considered at all parts).

Identified practitioner will clinically discuss case and access supervision directly with their Team Lead or senior practitioners.

All information, communications and assessments are on the system, up to date, and defensible.
Family and CYP fully informed and consented to discussing the case with supervisors and case discussion to core CAMHS.

- Clinical case discussion recorded on clinical system, including main presenting need, risk and support required, detailing supervisor or Team Lead
- Practitioner completes a transfer and allocation form detailing the reasons for escalating the case and confirming that consent has been gained for the case to be discussed by core CAMHS
- Practitioner adds a Task on Clinical system for the admin team to open a referral to Core CAMHS for their consideration.
- Core CAMHS discuss case in weekly MDT and agree an outcome (accept/decline)
- The family and young person will be contacted again to share the outcome and clarify next steps.
- If the referral is declined by Core CAMHS then practitioner will take advice from Core and discuss and plan with senior practitioner and/or Team Lead
- With urgent transfer and allocation, the Practitioner will be supported by the Senior practitioners or Team Lead when required to continue to support the CYP and family whilst waiting for assessment.
- With a routine referral into Core the Practitioner supported by the Senior practitioner/Team Lead when needed will offer support, advice and guidance and agree a fixed term plan to end appropriately whilst offering self-help and some psycho education support.

5.7. Escalation Process to Eating Disorders Team

Identified Practitioner will clinically discuss case and access supervision directly with a senior practitioner / Team Lead. All information, communications and assessments are on the system up to date and defensible. Family and CYP fully informed and consented to the referral into the ED service.

- Clinical case discussion recorded on system including main presenting need, risk and support required detailing senior practitioner or Team Lead
- Request duty call with member of Eating Disorder Team to discuss case.
- If agreed a referral to the Eating Disorder Team is appropriate identify an agreed plan to end early intervention support with CYP and family appropriately and safely
- If following clinical discussion with eating disorders team, it is agreed CYP needs are best met within the practitioner advice and guidance will be taken from eating disorders team and practitioners will seek further support from a senior practitioner or Team Lead. Family and CYP will be kept updated with all discussions.
- All discussions and actions will be recorded on clinical systems.

5.8. Escalation to Crisis Team / Home Intensive Intervention Team

- The Practitioner will contact the crisis team/home intensive intervention team directly to request support by following the below.
- Practitioner will seek support from the Crisis team directly. Then share with senior practitioner /Team to lead of process to support if needed. Or Practitioners if appropriate can seek support and supervision from a Senior practitioner and or Team Lead to clinically discuss the case prior to contacting the team.
- The practitioner will support the CYP and family, safety plan and safeguard and gain consent.

- If agreed Crisis/ Home based treatment is required a referral will be created by Early Intervention admin. Ensuring the clinical record is updated accordingly with the updated correct documentation including an updated risk assessment.
- The crisis/home-based intervention team will lead on this and advise the Practitioner and senior practitioner / Team Lead of out comes to co-work the case with the Practitioner until identified who can best meet the CYP's needs.

5.9. Supervision:

Practitioners are clinically supervised at least once every half term and ad hoc by an identified registered Senior practitioner. This will incorporate safeguarding supervision also using the SCT9 form accordingly. Following supervision actions will be recorded on Clinical system. As above in Safeguarding 4.3 additional and ad hoc safeguarding supervision can be sought from Humber safeguarding.

It is important that all Practitioners have access to group supervision to support their own development professionally. This can be set up with a senior practitioner or Team Lead across services or the Practitioners can facilitate their own peer supervision that can be overseen by a senior clinician within the service. This will help ensure that experiences of working within a busy Early Intervention service can be shared, explored and supported in an empowered way using reflective practice within a high-challenge/high-support environment.

5.10. Compliments

These will be recorded within the CYP's record and recorded through internal systems, shared with and celebrated within the teams.

With consent these compliments will also be used within newsletters, engagement events and other service promotions and within the wider trust.

5.11. Complaints

Wherever possible initial complaints should be responded to via the allocated practitioner to ensure we are working relationally. If the issues cannot be resolved and CYPs/families still feel they have not received the service they require or are unhappy with their experience then we will support the families to have access to the Team Leader and/or Service Manager to respond directly to the family, identify solutions, offer an additional space to be heard and to create a positive outcome for the family and a learning opportunity for the service.

Wherever possible we aim for complaints to be resolved within the service, however if this is not successful, we will advise and support the CYPs and families to make a formal complaint via the Trust.

Within service all stages of complaints will be used as a reflective learning and development opportunity and recorded in service for the Early Intervention SLT to review as a collective

At all stages of the above we will work in line with the appropriate policies and guidance within the Trust. Complaints and Feedback (humber.nhs.uk)

6. TRAINING

Training Matrix (this is not an infinitive list and will evolve as the service does)

Training Need	Practitioner	Senior Practitioner	Team Lead	Notes
Specific Training Needs e.g., elements of CBT CPWP Training	X	x	x	
Supervision Training		X	X	
Mandatory & Statutory Training	X	X	X	
Restorative practice	X	X	X	
Introduction to Education Systems and working systemically.	X	X	X	
AMBIT	X	X	X	
Arc training		X	X	
Arc light touch	X	X	X	
Systemic Practice		X	X	
My Star training.	X	X	X	
Risk assessment	X	X	X	

7. REFERENCES

Safeguarding Children & Adults Team (humber.nhs.uk)

Complaints and Feedback Policy.pdf (humber.nhs.uk)

Record a Compliment (humber.nhs.uk)

Activity Recording Glossary.pdf (humber.nhs.uk)

Shared Decision Making, Collaborative Decision Making | On My Mind | Anna Freud Centre

THRIVE Framework for system change | i-THRIVE (implementingthrive.org)

AMBIT — Core shared content for a manual of developing practice Teams, get your own version, start with this content, add, attune, improve it, & share learning. (annafreud.org)

What is ARC? - ARC Framework

CASCADE Framework (annafreud.org)

CBT & Motivational Interviewing: Supporting children & young people to engage in CBT | Training | Anna Freud Centre

NHS England » New mental health support in schools and colleges and faster access to NHS care

Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Appendix 1 – Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name:** CPWP Early Intervention
2. **EIA Reviewer (name, job title, base and contact details):** Emma Train-Sullivan, Early Intervention Service Lead
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** SOP

Main Aims of the Document, Process or Service
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Medium	The service is commissioned for Children and young people aged 5- 18.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	For all children and young people between the age of 5-18 using policy and guidance to deliver an inclusive and equitable service. The team will adapt to meet the needs of Children and young people and will use accessible venues and resources.
Sex	Men/Male Women/Female	Low	For all children and young people between the age of 5-18 using policy and guidance to deliver an inclusive and equitable service.
Marriage/Civil Partnership		NA	
Pregnancy/ Maternity		NA	

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Race	Colour Nationality Ethnic/national origins	Low	For all children and young people between the age of 5-18 using policy and guidance to deliver an inclusive and equitable service.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	For all children and young people between the age of 5-18 using policy and guidance to deliver an inclusive and equitable service.
Sexual Orientation	Lesbian Gay men Bisexual	Low	For all children and young people between the age of 5-18 using policy and guidance to deliver an inclusive and equitable service.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	Working with the wider system to ensure we are an inclusive offer for all children and young people using Trust policy and national guidance.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. This has been reviewed based on a strong working knowledge/ evidence and experience of delivery in this service area.	
EIA Reviewer: Emma Train-Sullivan	
Date completed: 16th April 2024	Signature: