5. Team working

5.1. Ability to contribute to team working

- Ability to draw on knowledge that a well-functioning inpatient team:
  - can maintain a capacity to be self-reflective in the face of the challenges and intensity of inpatient work
  - can maintain a focus on the various tasks associated with inpatient work
  - will not be drawn into unhelpful behaviours or attitudes that could adversely impact children/young people or their families/carers
  - can respond constructively to negative feedback from children/young people, families/carers and other parts of the statutory system (e.g. other agencies, referrers or commissioners)
  - can raise concerns about poor or harmful practice clearly, confidently and responsively
  - works to mitigate the impact of discrimination and systemic inequalities for team members and children/young people and their families/carers
  - comprises team members who work to support their own and each other's wellbeing (and therefore capacity to help) by setting limits, holding boundaries and fostering compassion to self and others

- An ability to sustain a therapeutic culture by ensuring that there is:
  - clarity over the team's organisational structure
  - clarity over (and agreement on) the leadership of the team
  - clarity over roles (and role diversity)
  - mutual communication that is open, respectful and reflective
  - mutual valuing of team members

- An ability to recognise signs that team working is becoming dysfunctional, e.g. teams that:
  - maintain consistency by applying the same inflexible procedures to all, at the cost of being unable to adapt them to individual need
  - have difficulty working together and arriving at a coherent formulation focused on the child/young person, rather than on what can be offered by each professional/viewpoint (and so, the professional organisation taking priority over the child/young person)
  - become preoccupied with internal team conflicts that they are unwilling to acknowledge and resolve
  - fail to implement a coherent team-based plan, with the result that individual members or subgroups of the team work independently of each other

- avoid coming together to arrive at coherent plans because this reduces the likelihood of exposing team conflict
- denigrate the input/efficacy of other agencies/systems and become an embattled and isolated unit (along with an uncritical and idealised view of their own success)
- become divided within themselves (e.g. different members of the team taking sides with either the child/young person or their parents/carers, or becoming preoccupied with advancing their own ideas)
- become focused on professional hierarchies, with separate agendas and chains of management

- An ability to reflect (individually and as part of a team) on the functioning of the whole team, and individual practice within it
- An ability to reflect on challenges to team communication and functioning (usually through discussion with a supervisor or peer) to consider how these can be best managed, e.g. by:
  - identifying when (and when not) to challenge problematic team behaviours
  - presenting a case calmly and objectively
  - focusing on the challenges (rather than on personal issues)
  - focusing on the present and future rather than the past
  - listening to the point of view of other team members
  - contributing to problem solving (identifying potential strategies for resolving the issues)

- An ability to actively contribute to meetings on planning, coordinating, maintaining and evaluating a child/young person's care or care plan
- An ability to value the contribution of others but also to assert differences of view and to resolve issues or concerns through open dialogue

5.2. Ability to contribute to maintaining a therapeutic social environment (therapeutic milieu)

- An ability to draw on knowledge that a therapeutic milieu is one where the overall environment aims to make a positive contribution to improving wellbeing and functioning
- An ability to draw on knowledge that (alongside interventions included in a care plan) a therapeutic milieu aims to help children/young people practice new ways of coping through interactions with others (including peers and staff), with a sense of safety and support, and is characterised by:
  - the ward as a social community
  - a clear structure with routines (e.g. daily activities, mealtimes, and free time), as well as staff-led input (both individual and group)
  - expectations of behaviour that are not too restrictive, and that are clearly explained, including limits that are consistently maintained (but balanced with individual need)
  - helping children/young people understand what will be expected of them and what they can expect from others
  - helping children/young people cooperate and support each other in making day-to-day decisions about ward functioning, and:
    - staff developing a sense of shared responsibility and mutual respect with the children/young people
    - regular opportunities for staff and children/young people to spend positive, developmentally appropriate, playful time together, and engage in normal activities and conversations
    - consistent interpersonal boundaries, in which staff behave predictably and reliably, and role-model positive behaviours
    - staff who can move flexibly between positions of 'professional helper' and 'being human' in response to children/young people's needs
    - helping children/young people attend to their daily living needs (washing, personal care, and physical health and wellbeing)
- An ability to draw on knowledge that an effective therapeutic milieu depends on a well-functioning and confident staff team

- An ability to draw on knowledge that the therapeutic milieu is influenced by people who are not present (including family/carers) and to find ways to recognise their roles, and to respond to their needs and contributions at different stages of an admission

5.3. Ability to coordinate with other agencies and/or people

General principles

- An ability to draw on knowledge that the welfare of the child/young person should be the overarching focus of all interagency work
- An ability to ensure that communication across agencies is effective by making sure:
  - that practitioners' perspectives and concerns are listened to
  - that there is explicit acknowledgement of any areas where perspectives and concerns are held in common, and where there are differences
  - where there are differences in perspective or concern, an ability to identify and act on any implications for effective intervention delivery
- When working with other agencies, an ability to ensure that the perspectives and concerns of the person coordinating care are listened to

Case management

Involving the child/young person and their family/carers

- An ability to ensure that (when appropriate) the child/young person and/or family/carers are informed of any interagency discussions and the associated outcomes
- When appropriate, an ability to include the child/young person and/or family/carers in any interagency meetings
- An ability to support the child/young person and their family/carers in making choices about how they use or engage with partner agencies
- An ability to discuss issues of consent and confidentiality when sharing of information across agencies with the child/young person and their family/carers,
- An ability to record whether there is consent to share information (and if relevant, why the information is being shared when consent has been withheld)

Receiving referrals from other practitioners/agencies

- An ability to recognise when the referral contains sufficient information to make an informed decision about how to proceed
  - where there is insufficient information to make decisions, an ability to identify the information required and to request this from the referrer and/or partner agencies
- An ability to draw on knowledge of local policy and procedure to select the appropriate pathway to ensure the case is allocated at an appropriate risk/response level

Identifying and working with other agencies involved in the child/young person's care
An ability to establish which agencies are/have been involved with the child/young person and their family/carers
An ability to establish/clarify the roles/responsibilities of other agencies in relation to the various domains of the child/young person's life
An ability to gather relevant information from involved agencies and add it to the child/young person's record
An ability to share relevant information with the appropriate agencies (on a 'need to know' basis), and:
▪ an ability to assess when sharing of information is not necessary and/or when requests for sharing information should be refused

Sharing information across agencies
An ability to share assessment information in a manner which supports partner agencies in:
▪ understanding and recognising areas of risk
▪ sharing the risk plan
▪ understanding the implications of information held by the referrer's service and the work in which they are engaged
▪ understanding the potential impact of current interventions on the child/young person's functioning, and the ways in which this may manifest in other settings
Where there are indications that agencies may employ different language, definitions and assumptions from those employed by the team, an ability to clarify this
An ability to draw on knowledge of custom and practise in each agency, to ensure that there is a clear understanding of the ways in which each agency will respond to events (e.g. their procedures for following-up concerns, or for escalating their response in response to evidence of risk)
An ability to co-ordinate with other agencies using both verbal and written communication, and to agree with them:
▪ the tasks assigned to each agency
▪ the specific areas of responsibility for care and support assumed by each agency, and by individuals within each agency
An ability for individuals within the referring service to recognise when they are at risk of working beyond the boundaries of their clinical expertise and/or professional reach
Where a common assessment framework is used across agencies, an ability to:
▪ record relevant information in the shared record
▪ make active use of the shared record (to reduce redundancy in the assessment process)
▪ maintain a shared record of current plans, goals and functioning

Referring the child/young person for parallel work	
■	An ability to draw on knowledge of local referral pathways (i.e. the people to approach, and the protocols and procedures to follow)
■	In relation to any agency to whom the child/young person is referred, an ability to draw on knowledge:
	■ of the agency's reach and responsibilities
	■ of the agency's culture and practice
	■ of the extent to which the agency shares a common language and definitions to those applied in the referrer's services
■	An ability to communicate the current intervention plan, and update other agencies with any changes as the intervention proceeds (including any implications of these changes for their work)
■	An ability to communicate a current understanding of the child/young person's difficulties, and to update that understanding when new information emerges
■	An ability to maintain a proactive approach to monitoring the activity of other agencies, and to challenge them if they do not meet agreed responsibilities
■	Where appropriate, an ability to act as a conduit for information exchange between agencies

■	An ability to recognise when effective interagency working is compromised and identify the reasons, e.g.:
	■ institutional/systemic factors (e.g. power differentials, or struggles for dominance of one agency over another)
	■ conflicts of interest
	■ lack of trust between professionals (e.g. where a legacy from previous contacts is being reflected)
■	An ability to detect and to manage any problems that arise because of differing custom and practice across agencies, particularly where these differences have implications for the child/young person's management, and:
	■ an ability to identify potential barriers to effective communications, and, where possible, to develop strategies to overcome them
■	An ability to identify transitions that have implications for any of the agencies involved (e.g. transition to adult services, moving out of area, change of school) and to plan how these can be managed, to ensure:
	■ continuity of care
	■ the identification of and management of any risks
	■ the identification and engagement of relevant services

Discharging the child/young person to a partner agency
■ An ability to inform all agencies of the intention to discharge the child/ young person from the service
■ An ability to ensure all partner agencies are aware of current risk levels and have appropriate safety plans and monitoring in place, and: ▪ an ability to ensure that partner agencies receive updated safety plans (e.g. if plans are revised in response to new episodes of self-harm or suicidal behaviour)
■ An ability to inform partner agencies of the circumstances under which links with the service should be reinstated
■ An ability to take a proactive stance in monitoring the functioning of the child/young person and their family/carers following discharge (directly, or via the services they are in contact with), and to reconnect with them if functioning deteriorates
■ An ability to ensure the partner agencies have plans for monitoring the wellbeing of the child/young person

5.4. Ability to manage endings

Working with planned endings

- An ability to work collaboratively with children/young people to manage the process of discharge from inpatient care, identify and mitigate any risks, and put in place any future support

- An ability to prepare children/young people for endings by explicitly referring to the likely time limits of an admission or the intervention as soon as it is known
- An ability to assess any risks to children/young people that may arise during or after discharge (or transfer from) the service
- An ability to help the child/young person express feelings about discharge, including both positive and negative feelings (e.g. disappointment with the limitations of the intervention)
- An ability to help children/young people make connections between their feelings about discharge and about other losses/separations
- An ability to help children/young people explore any feelings of anxiety about managing without the service
- An ability to help children/young people reflect on the process of the admission and what they have learnt and gained from it
- An ability to say goodbye in a shared, mutual and genuine way
- Where there is a planned transition to another service, an ability to prepare children/young people appropriately (e.g. by giving them information about what the new service offers and its style of working, or arranging joint appointments with practitioners from the new service)

Working with premature or unplanned terminations

Knowledge

- An ability to draw on knowledge of national and local guidance on the assessment of risk relating to children/young people ending contact with a service, including policies, procedures and standards in relation to:
  - risk assessment and management
  - consent, confidentiality and information sharing
- An ability to draw on knowledge of local organisations to which the child/young person may be referred at the end of unplanned contact with the service

Working with unplanned endings initiated by the child/young person

- Where possible, an ability to explore with children/young people why they wish to terminate contact with the service earlier than originally planned
- An ability to explore with children/young people whether their concerns about the service can be addressed
- An ability to assess any risk arising from early termination with the service
- An ability to contact relevant agencies regarding early termination

- An ability to review contact with the child/young person verbally or through a discharge letter

- Where working with families/carers, an ability to establish who wishes to terminate contact early (i.e. the extent to which it is something they all wish for, or if it is a view held by some and not all)

Working with unplanned endings initiated by the team

- Where an unplanned ending is initiated by the team (e.g., because of a failure to engage or to make progress), an ability to discuss with the child/young person:
  - the reasons for discharge, in a compassionate (non-blaming) manner
  - their own sense of what has not worked for them (especially if it can help identify treatment regimens that may be more helpful)
  - any negative feelings associated with the discharge (e.g. a sense of failure)
  - the options for treatment that are open to them

5.5. Managing transitions in care within and across services

Transitions take place when the child/young person reaches an age cut-off for a service, when they move from one service pathway to another or when an episode of care ends. A poorly managed transfer of care can lead to their losing contact with the services or support they need. This means it is critical to make sure that transitions are organised appropriately.

Competences in this document overlap with those in the sections 'Ability to coordinate with other agencies and individuals' (5.3) and 'Ability to work with issues of confidentiality and consent' (3.3).

Knowledge

- An ability to draw on knowledge that transitions in care (within and across services) can be potentially destabilising, and:
  - an ability to draw on knowledge that anticipating the ending of treatment, services or relationships, and transitions from one service to another, can provoke strong feelings in the child/young person that should be acknowledged and discussed

Identifying transitions in care within and across organisations

- An ability to identify transfers of care that may represent points of greater risk, e.g.:
  - transfers within an organisation (e.g. from one practitioner to another)
  - transfers across organisations (e.g. from inpatient care to the community)
  - transfers to adult services
  - transfers from the health and social care system to the forensic or criminal justice system
  - unplanned transitions (e.g. because of the departure of a key worker)
  - planned transitions (e.g. a worker taking annual leave)

Knowledge about the transfer

- An ability to draw on up-to-date knowledge of the services or professionals that the child/young person is being transferred to, using this information to ensure that the proposed transfer is:
  - appropriate to the child/young person's needs
  - is offered in an appropriate timescale

Helping the child/young person prepare for a transfer of care

- An ability to advise the child/young person of the proposed transfer, ensuring that they:
  - are given as much notice as possible
  - understand why the transfer is happening
  - are informed about the services that will be on offer and the professionals they will be linked to
  - are informed about the timescale
  - know what information will and will not be communicated to the new professional and/or service, and can discuss any concerns, and:
    - an ability to balance considerations of confidentiality against the risk of harm to the person, and to judge when it is their best interest to share information
- An ability to discuss the child/young person's feelings about the transfer, and to work with them to:
  - identify barriers that make it less likely that they will maintain contact with the new service (e.g. anxiety or anger about starting afresh, upset over loss of contact with valued professionals)
  - discuss their concerns and feelings
  - identify issues that will make a transfer of care problematic (and so signal a potential increase in risk)

- Where family/carers have been providing significant support, an ability to consider what information is appropriate to share with them about the transfer

- An ability to draw on knowledge that children/young people may require significant support and preparation to successfully navigate transfers of care, e.g.:
  - ensuring that the service to which they are referred is suited to their developmental stage and capacities
  - maintaining involvement with their family/carers (if this is something that the child/young person sees as helpful)
  - where possible, a joint handover appointment
- An ability to draw on knowledge of the increased vulnerability of children/young people who are already experiencing multiple transitions (e.g. from school to college, plus changes in living arrangements and transfer across clinical services)

- Where there are indications that transfers of care will present significant challenges to the child/young person, an ability to implement appropriate strategies, e.g.:
  - identifying a named individual who can maintain continuity of support during the transition
  - where appropriate helping the child/young person to develop skills in independence, assertiveness and self-advocacy

- An ability to draw on knowledge that family/carers may find transfer of care a challenge, e.g.:
  - by feeling excluded as the child/young person takes more ownership of their care
  - by feeling excluded where adult services do not routinely involve family and carers

Communication within and between services to whom the child/young person is being transferred

- An ability to assure effective communication with professionals within and between services by providing written communication that identifies:
  - the relevant clinical issues, the current care plan and the reasons for any concerns about risk
  - the rationale for the transfer (i.e. the areas for which help is sought and the services which it is hoped the service or other professionals will offer)
  - expectations regarding feedback from the new service (e.g. confirming receipt of information and advising on the actions taken)

Recognising and managing challenges to transfers of care

- An ability to monitor the progress of a transfer
- An ability to identify when a transfer has been compromised and to identify the reasons, e.g.:
  - institutional/systemic factors (e.g. long waiting lists or organisational change)
  - lack of cooperation or trust between professionals (especially where it reflects the 'legacy' of previous contacts, or a lack of understanding of what has been requested)
  - lack of clarity about who is responsible for acting on a transfer request (leading to a failure to act)
- An ability to address concerns about a compromised transfer, for example through further verbal and/or written communication

- Where possible and appropriate, an ability to offer bridging support and contact if this will help the person to connect with the new service

Transitions in and out of care for looked-after children

- An ability to draw on knowledge that there is a significant impact on children/young people's emotional wellbeing and mental health when they move repeatedly in and out of care, and/or experience repeated placement breakdowns, and that this will impact on their reactions to transitions in and out of an inpatient ward

- An ability to draw on knowledge that while returning home from care is often the best outcome, for some this can result in further abuse/neglect and a cycle of moving in and out of care, and the ability to assess:
  - the risks the family could pose to their child
  - how much they are able to change
  - their ability to protect their child from harm, taking into account their history and current situation

- Where a return to home is possible, an ability to work with the child and their family to help strengthen their relationship
- An ability to agree with the parents what needs to happen before and after their child returns home

- An ability to liaise with relevant agencies and services, to:
  - share understanding and information
  - put in place support for the child and their family before and after the return home
  - return the child home gradually, and plan for what will happen if the return is not going well
  - monitor how the child and their family are managing

5.6. Leadership

Different problems can require different types of leadership, so there is no single leadership style that is effective for all situations. Nonetheless, this section identifies the competences associated with compassionate leadership, which can sustain stronger connections between people, improve collaboration, raise levels of trust, and enhance loyalty.

Qualities associated with leadership can be displayed by all members of a team, not just by individuals who have formal management roles.

- An ability to draw on knowledge that effective team leaders articulate and represent the values and aims of a unit, and the culture required to achieve these

- An ability to draw on knowledge that effective leaders build trust with staff by:
  - demonstrating that they understand and value their motivations
  - encouraging participation in decision-making
  - encouraging them to express their ideas and opinions, and showing respect for these
  - explicitly acknowledging and giving credit to staff contributions
  - listening to their concerns and interests and responding by acting on them

- An ability to draw on knowledge that effective leaders:
  - help staff to understand their roles and how they can contribute to the unit's overall success
  - instil staff with a sense of value and purpose and foster their engagement with the aims of the unit
  - develop a shared vision with the team, embracing their ideas in the context of the needs of the population served by the service
  - encourage innovation (but can challenge ideas and behaviours respectfully if they are contrary to accepted professional practice/the evidence base)
  - encourage an appropriately self-critical stance among staff (being open to evaluating the efficacy and functioning of the unit and identifying ways in which it can be improved)
  - are committed to open communication and the identification and resolution of team conflicts where they arise

- An ability to draw on knowledge that effective leaders maintain an ethical and supportive environment that helps staff feel safe in their work (e.g. knowing that their managers will advocate for them and treat them fairly)

- An ability to draw on knowledge that effective leaders:
  - identify, and endeavour to secure, the resources needed for the unit to operate effectively
  - make strategic decisions based on a 'big-picture' view, balancing emerging opportunities with long-term goals and objectives and a vision for the service
  - are able to make and implement decisions (but also revise them if there are compelling reasons to do so)
  - take responsibility for their decisions, and learn from their mistakes
  - demonstrate resilience when there are setbacks and maintaining the ability to show others the way forward
  - help staff cope with organisational change and address issues promptly, so that problems do not become entrenched or escalate