Looked After Children (CLA) Annual Report 2017/18

CONTENTS
Section
1 Executive Summary
2 New National Guidance on CLA/ National changes/guidance
3 Local Information
  3.1 Demographic Information
  3.2 Benchmark with National Data
  3.3 Local Statistics (age/gender/ethnicity)
4 Service Summary
  4.1 Staffing & Supervision
  4.2 Governance & Reporting Arrangements
5 Performance Indicators
  5.1 National Targets
  5.2 Local Improvement Requirements
6 CLA Team Clinical Activity
  6.1 Health Assessments
  6.2 Immunisations
  6.3 Dental Checks
  6.4 Local Requirements
7 Other Clinical Activity
  7.1 Sexual Health
  7.2 Teenage Pregnancies
  7.3 Substance Misuse
  7.4 Emotional Health & Wellbeing
  7.5 Training
  7.6 Other (e.g. Complex Case Work)
8 Adoption & Fostering
9 Service Improvements
  9.1 Specific Improvements / Team Achievements
  9.2 Audits (and research if applicable)
  9.3 Partnership working
  9.4 User surveys
  9.5 Inspection Updates
  9.6 Professional development (and publications if applicable)
  9.7 Other
10 Areas for development 2018-2019
1. Executive summary

This Annual Report has been produced for CNWL Camden Community Health Services within Central and North West London NHS Foundation Trust, Camden Clinical Commissioning Group and the London Borough of Camden Corporate Parenting Board. The report outlines the delivery of health services to children looked after (LAC) by the London Borough of Camden (LBC) during the period from 1 April 2018 to 31 March 2019, in line with national statutory guidance. It reviews performance indicators, clinical work undertaken by the LAC health team, service improvements and plans for further development.

The aim of the LAC health service is to ensure that children looked-after by the borough of Camden have their health needs addressed. This includes the provision of a detailed, high quality assessment of children’s health needs (statutory initial health assessment) when received into care and a statutory review health assessment, annually for children over five years of age and 6 monthly for those under five years of age. The team works in partnership with the London Borough of Camden and local health providers to ensure that appropriate services are developed to meet the health needs of Camden LAC.

The term 'Looked After Children' (LAC), Children Looked After’ (CLA) and ‘Children in Care’ (CIC) are all used to refer to children who are placed in the care system. The term 'Looked After Children' is currently used within statutory and government documents and is used widely to refer to teams working with this group of children. However, some Local Authorities prefer the term 'Children Looked After' and teams are thus named to reflect this. In the past the use of 'Children in Care' became popular, so may also be a preferred term within some organisations.

The terms are therefore interchangeable, however, in Camden this group of children is referred to as 'Looked After Children'.

The key points below provide a short summary of areas covered within the main report.

1. Statutory performance indicators continue to show strong performance by the LAC Health Team. During 1 April 2017- 31 March 2018, of those LAC who had been looked after for at least one year:
   - 97% had had their statutory health assessment in the previous year
   - 90%-100% had had their statutory health assessment in the quarter in which it was due
   - 83% are recorded as having had a dental assessment in the previous year
   - 75.5 % were up to date with all immunisations
   - 100% of under 5’s up to date with developmental checks

2. 47% of the 104 new entrants to care were 16+ years, and 52% of these were unaccompanied asylum seeking children. 36% were 10-15 years and 17% 0-9 years of age. 68% of LAC were male and 32% female. 68% were from an ethnic minority.

3. There has been excellent overall attendance for statutory initial health assessment and a huge improvement in meeting statutory timescales to Initial Health Assessment (IHA). 14% of IHA were achieved within the statutory 20 working days during Q1, rising to 86% uptake in Q4.

4. On-going outreach work to attempt engagement with young people who refuse health assessments, a system for review of their health needs and liaison with other involved professionals ensures that health needs of individual ‘hard to reach’ looked after young people are kept in mind and addressed in a holistic manner, even when they have refused to be seen by the LAC nurse or doctor.

5. The team has a system for recording and monitoring health recommendations which require action for individual LAC. The follow-up of recommendations has been below target during Q3 and Q4, which is mainly due to delayed or missed appointments by unaccompanied minors for infectious diseases screening and immunisations. This is being addressed by the Health Improvement Practitioner who actively follows up health care plans after initial health assessments. The LAC team are currently looking at the feasibility of introducing a “Health Passport” for each LAC, which will help carers, keyworkers and young people to track health appointments.
6. Immunisation uptake for children looked after for less than 1 year is lower than in previous years and is mainly accounted for by a number of young people not attending for their Meningitis ACWY vaccine. A number of unaccompanied minors also need to complete the schedule. The LAC specialist nurse will attend immunisation training so that immunisations can be given opportunistically.

7. The LAC health professionals identify children with weight management problems and arrange interventions. Across Q1 to Q4 in 2017-2018, between 7.8 and 12.6% of looked after children and young people were identified as overweight or obese, significantly lower than the figure for non-LAC Camden children.

8. The LAC health team offers a range of other clinical input to individual LAC. This includes health improvement sessions, for example, on healthy eating, lifestyles and sleep hygiene. Assessments are undertaken for developmental delay and for complex developmental disorders. Emotional health is assessed in liaison with CAMHS. Sexual health advice is given and there is regular liaison with sexual health services. There were 6 known pregnancies in 2017-2018. The LAC specialist nurse liaises closely with the Youth Offending Service regarding LAC known to this team. The LAC health improvement practitioner offers health workshops for young people in supported accommodation units.

9. The North Central London integrated care pathway for unaccompanied asylum seeking children, led by the Camden team, was finalised during 2016 and is running well. One third of Camden LAC are currently unaccompanied minors. A psychotherapist attends the initial health assessment with the paediatrician and there are clear lines of referral for infectious disease and sexual health screening. There is a significant pick-up rate of infectious diseases amongst UASC, including TB.

10. There is improved support for young people in residential and supported accommodation units. LAC health staff provide 1 to 1 tailored health advice and group health promotion work with young people on a range of health issues. There is improved information and support for care leavers who are offered leaving care health assessments and are each provided with a personalised health summary when they reach 18 years of age.

11. There is on-going close liaison with the Camden & Islington Sexual Health Network to ensure that looked after young people receive the services they need, through individual and group work. This includes identification and monitoring of LAC who are vulnerable to child sexual exploitation and ensuring that appropriate interventions are put in place. It also includes advice sessions for carers and individual work with teenagers who have learning needs.

12. There is routine screening for emotional and behavioural disorders at the initial health assessment using the Strengths and Difficulties Questionnaire and close liaison with the social worker and CAMHS team for children requiring interventions. Strategies to enhance resilience are incorporated into health care plans.

13. The LAC health team shares relevant health concerns about LAC with social work and health colleagues to ensure holistic care, while maintaining confidentiality where appropriate. In addition to routine liaison work, this is done via attendance at social care LAC review and strategy meetings and through regular forums including the Health & Development panel and meetings with the Disabled Children’s team manager.

14. There is improved liaison with Leaving Care Pathways and residential units. The LAC health team offers practical support and training for staff to understand the health needs of LAC, provide health advice on specific issues and engage staff in ensuring health recommendations are carried out for young people.

15. The LAC health nurses contribute to foster carer support groups with health sessions on a variety of topics tailored to the needs of carers and the children currently placed with them. The LAC nurses also offer direct support to individual foster carers on health issues such as behaviour management, therapeutic parenting, sleep promotion, sexual health etc.
16. The LAC health service provides training for prospective adopters and a range of professional health colleagues including health visitors, school nurses and paediatricians.

17. The designated doctor provides an advisory service to Camden Adoption and Fostering Team with regards to the health of adult fostering and adoption applicants and provides assessments for children placed for adoption. The designated doctor and nurse attend the adoption and fostering panels.

18. Feedback from foster carers and young people on an anonymised user survey was overwhelmingly positive. Feedback from a survey of Independent Reviewing Officers showed that they value the work of the LAC health team very highly, in terms of quality of health assessments and availability of the team for health support and advice.

19. This report summarises the partnership working with other disciplines and agencies which is essential to providing holistic care for LAC. The report also summarises professional development and peer review activities which ensure LAC team members are up to date with knowledge and training.

20. The report concludes with an outline of areas for development for 2018-2019. These include:
   - improving the follow through of health recommendations,
   - developing a ‘Health Passport’ for looked-after children,
   - immunisation training for LAC nurses to improve immunisation uptake,
   - develop a health questionnaire for young people who refuse health assessments,
   - continue to improve liaison and support to Leaving Care pathways, document and ensure all care leavers receive their personalised health summary,
   - monitor the pregnancy rate in LAC and undertake further pregnancy preventive work finalise the guidance for adoption records when NHSE have finalised their recommendations.

2.0 New/recent National Guidance on Children Looked After

The following guidance has been published in relation to Looked After Children.

1. Caring for Better Health: An investigation into the health needs of care leavers. The Care Leavers’ Association DoH 2001. This report provides a comprehensive overview of the needs of care leavers. The project team worked with ten CCGs and sought the views of care leavers and professionals. The report focuses beyond the age of 25 years to look at the long term health consequences for this group of young people.

2. Children speak out on living in care. Children’s Rights Alliance for England 2017. This briefing paper is a forum for the voices of LAC who describe their issues around entering and leaving care and the inadequate support that they receive.

3. Transforming children and young people’s mental health provision: a green paper. DoH & DfE 2017. This document promotes access to high quality mental health and wellbeing support. It states that some young people who need additional or specialised support should be assessed and referred quickly.


6. Applying corporate parenting principles to looked-after children and care leavers. Statutory guidance for local authorities; DfE 2018. This guidance provides information on the role of local authorities and how they should meet the corporate parenting principles as in section 1 of the Children and Social Work Act 2017. This guidance is designed to help local authorities and partners consider the kinds of services that may be offered to LAC.
7. National Transfer Scheme Protocol for Unaccompanied Asylum Seeking Children, DfE 2018. The National Transfer Scheme (NTS) protocol for unaccompanied asylum seeking children (UASC) has been created to enable the safe transfer of children from one local authority to another. The protocol is intended to ensure that these children access the services and support they need. The scheme is based on the principle that no local authority should be asked to look after more UASC than 0.07% of its total child population.

8. Measuring the wellbeing of children in care: Views from the frontline and opportunities for change, National Children’s Bureau 2018. This research paper explores how wellbeing is measured, and is based on the views of children in care councils and professionals working with LAC. The report looks at the use of Strengths and Difficulties Questionnaire (SDQ) as a measuring tool, however, due to mixed views on its use, many professionals use their own tools. The research raises particular issues around the access to specialist mental health services.

9. Foster Care in England, DfE 2018. This document reviews foster care and the needs of young people within these placements.

3. Local information

3.1 Local demographic information

Local demographics: 1

- Camden had an estimated resident population of 225,140 people in 2013 (Greater London Authority Round 2012 ‘Camden Development v2’. Interim 2011 Census based).
- The age and sex profile of Camden is very similar to that of London but relatively younger than England, with significantly greater proportions of younger adults aged between 25 and 40 years.
- 52,100 children and young people aged 0-19 years are estimated to live in Camden, accounting for approximately 21.6% of Camden’s population (2015). This includes approximately 14,400 children aged 0-4 (2015).
- 77% of school children are from a minority ethnic group (2016).
- The health and wellbeing of children in Camden is mixed compared with the England average.
- The level of child poverty is worse than the England average with 30.86% of children aged under 16 years living in poverty (2014).

3.2 National data: children looked after in England (including adoption and care leavers) year ending 31 March 2017 (2017-2018 data will be available September 2018).

Numbers: Nationally, the number of looked after children continues to rise. There were 72,670 looked after children at 31 March 2017, a rate of 62 children per 10,000 population. This is an increase of 3% compared to 31 March 2016 and an increase of 5% compared to 31 March 2012.

Age profile: There has been a change in the age profile with a steady rise in the number of older children starting to be looked after and a particular increase in the proportion of 16+ year olds; this is likely to reflect the increase in asylum seeking children. 62% of children looked after in 2016 were over 10 years, compared with 56% in 2012. There has been a reduction in the number and proportion of looked after children aged 1-4 years.

Gender: At 31st March 2017, 56% of looked after children were male and 44% female. These proportions have varied little over recent years.
Reasons for rise: The rise over time reflects the higher number of children starting to be looked after than ceasing to be looked after. It is largely accounted for by the rise in the number of unaccompanied asylum-seeking children (UASC), which increased by 54% between 2015 and 2016 and by a further 6% in 2017. There were 4560 UASC in March 2017, 4300 in March 2016, 2740 in March 2015 and 1950 in 2013. 6% of children looked after at 31st March 2017 were UASC. This partly accounts for the changing age and ethnicity profiles.

Ethnicity: UK wide, looked after children are predominantly white. At 31 March 2017, 75% were white, 9% were of mixed ethnicity, 7% were black or black British, 5% were Asian or Asian British and 3% were other ethnic groups. Children of mixed and black ethnicity appear to be slightly over-represented in the looked after children population, while children of Asian ethnicity are slightly under represented. Over the last five years there has been a small increase in the proportion of looked after children of non-white ethnicity, likely to reflect the increase in the number of unaccompanied asylum seeking children.

Placement type: 74% of looked after children in 2017 were cared for in a foster placement, 6% were placed with their parents and 1% were in an adoptive placement. The remainder were in a secure unit, children’s home or hostel.

Adoption: 1
4,350 looked after children were adopted in 2017, down 8% on 2016 and down 19% of the peak of 5,360 in 2015. This fall follows a period of increasing numbers of looked after children being adopted since 2011.

3.3 Camden LAC demographic information:
3.4
This information is provided by the London Borough of Camden Children’s Safeguarding and Social Care Quality Assurance Unit.

3.3.1 LAC numbers
- There were 199 LAC children on 31.03.2018. The number of LAC at any one time has stabilised at around 200 since June 2014.
- The total number of LAC over the course of the year will be higher due to turnover (children entering and leaving care). 302 children were looked after at any time during 1st April 2017 - 31st March 2018 (295 in 2016-2017)
- There were 104 new admissions to care during this period
  Of these 104 children, 49 (47%) were aged 16+ years (34.3% in 2016-2017), 34 (33%) aged 10-15 years (34.3% in 2016-2017) and 21 (20%) aged under 10 years (31.4% in 2016-2017).
- Between 01.04.2017 and 31.03.2018, there were 54 new unaccompanied asylum seeking minors who became looked after (compared with 36 in 2016-2017 and 25 in 2015-2016).
- 104 children left care during this period.

3.3.2 Age distribution of Camden LAC at 31.03.2018, compared with 31.03.2013
There was a shift upwards in the age of LAC during 2014-2016. There are fewer 0-9 year olds and a significant increase in the 16+ age range. The proportions have stabilised in 2017-2018

The following charts reflect the difference in caseload ages between 2012/13 and 2017/8:

3.3.3 Gender of Camden LAC at 31.03.2018, compared with 31.03.2016

There has been an increase in the proportion of male LAC compared with previous years, related to the increase in unaccompanied minors, the majority of whom are male.

The following charts illustrate the changes in gender for Camden LAC between March 2016 and March 2018.

3.3.4 Camden LAC duration of care at 31.03.2018

The following charts illustrate the changes in duration of care between 2014 and 2018.
Figure 3.3.4 demonstrates that an increasing number of children and young people are looked after for less than 1 year. This probably reflects the higher number of young people who are over age 17 years at care entry.

3.3.5 Ethnicity of Camden LAC at 31.03.2018

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or British</td>
<td>10%</td>
</tr>
<tr>
<td>Black or British</td>
<td>33%</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Groups</td>
<td>11%</td>
</tr>
<tr>
<td>Mixed</td>
<td>13%</td>
</tr>
<tr>
<td>White</td>
<td>34%</td>
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</table>

3.3.6 Reasons for entering care

Abuse or neglect has been the primary reason for accommodation in recent years, demonstrated in nearly 48% of looked after children in 2015-2016. Family dysfunction, parental mental ill health and families in acute stress have been other significant factors. A number of children become looked after because of severe disability necessitating accommodation in specialist placements including residential schools.

However, the recent change has been the significant increase in unaccompanied minors, representing over 50% of new entrants to care during 2017-2018 and accounting for approximately one third of the current Camden LAC population (coded as ‘absent parenting’). This explains the increase in the proportion of Camden LAC who are 16+ years and the increase in the proportion of males.
3.3.7 Camden LAC placement type at 31.03.2018

49% of Camden looked after children are in foster placements, 16% are in children’s homes (usually children >14 years of age) and 21% (16+ years) are in semi-independent units. 7% are fostered within their family/friends network. The remainder are in a variety of other placements as seen in this graph below.

3.3.8 Comparison of Camden data (3.3) with national demographics (3.2)

The number of Camden LAC has remained stable compared with national figures. The age has increased in line with national findings, although the main increase in Camden occurred during 2014-2016. Camden has a far higher proportion of 16+ year old LAC (45% in 2017 and 47% in 2018) than the national average (24% of LAC at March 2017).

Camden has a higher proportion of male LAC and a significantly higher proportion of LAC from ethnic minorities, reflecting the local population and the high proportion of unaccompanied asylum seeking children (UASC). Approximately 30% of current Camden LAC are UASC, compared with 6% of LAC nationally in March 2017.

Far fewer Camden LAC are in foster placements (49%), compared with 75% nationally in 2017, probably a reflection of their higher age.
4. Service Summary:

4.1 Staffing and supervision for service in 2017/2018

4.1.1 Staffing
The designated doctor and nurse fulfil a strategic role in service planning and advising CCGs in meeting their responsibilities as commissioner of services to improve the health of looked after children. The CCG Designated roles in Camden are commissioned from and hosted by the provider services for LAC.

The LAC Health Team is based at Crowndale Health Centre in Camden.

All members of the Provider LAC health team are experienced, suitably trained within their area of expertise and fully up to date with safeguarding training. They undertake on-going training in relevant subjects in order to maintain their competencies. The doctors and nurses within the team are registered with the General Medical Council / Nursing and Midwifery Council and have undertaken additional training working with children in the community. They fulfil the requirements of the Competency Framework (RCGP/RCN/RCPCH 2013 and 2015). They undertake regular appraisals and are subject to revalidation as required.

The team comprises of

- **Designated Nurse LAC (Band 8a)** 1 wte: Manager of nursing staff, clinical leadership, advises other clinical services, leads service planning.
- **Specialist Nurse LAC (Band 7)** 1.8 wte: Completes health assessments, plans care to meet complex needs, liaises with clinical network.
- **Health Improvement Practitioner (Band 5)** 1 wte: Follows up clinical support to LACs; works with groups and individual YP on key health targets such as sexual health, smoking, imms, weight management.
Designated doctor for LAC 0.4 wte  Clinical lead for LAC Health Team, undertakes Initial Health Assessments, adviser to CCG, medical adviser for adoption and fostering.

Named Paediatrician for LAC 0.2 wte  Undertakes Initial Health Assessments, supports and supervises trainee paediatricians, provides clinical follow up for LAC’s with complex medical issues.

Administrative support is supplied for the LAC clinicians by the Safeguarding Children’s Service².

4.2 Supervision and peer review
Camden LAC health team has the following supervision arrangements in place:

4.2.1 The LAC nurses are managed and supervised by the Designated Nurse for LAC on a 1:1 basis and meet regularly for discussion of issues within the service, including any individual LAC cases. The team is co-located with the Camden Health Safeguarding Children Team and with easy access to discuss any safeguarding issues.

4.2.2 The LAC designated nurse has 4-6 weekly supervision with the Designated Nurse for Safeguarding.

4.2.3 The LAC health nurses, medical staff and health improvement practitioner have a weekly team meeting for case allocation, review of care plans and case discussions. There is an established monthly business meeting attended by the Children’s Services manager for review of operational issues and service developments.

4.2.4 The LAC designated doctor attends bi-monthly peer review with designated doctors from North Central and North East London to discuss difficult cases (particularly around adult adoption and fostering medicals), to share ideas with regards to service developments and ensure uniform high clinical standards.

4.2.5 Clinical staff also attend a range of regional and national meetings such as the London LAC nursing group, London CoramBAAF health group, the Royal College of Nursing LAC forum and the CoramBAAF annual health conference as outlined in the section on professional development (para 9.6)

4.2.6 The Designated Dr was elected to sit on the Health Group Advisory Committee for CoramBAAF in 2011 and completed 2 terms by June 2017.

4.3 Governance & Reporting Arrangements

4.3.1 For CNWL, the designated nurse attends the provider meeting covering the Goodall Division (i.e. community services in Hillingdon and Camden). In addition, the designated nurse produces a bi-monthly governance report for the Clinical Governance team, which provides information on KPIs, audits, incidents, compliments and complaints, policies and guidance, risks and compliance with CQC.

4.3.2 The LAC health and safeguarding teams attend commissioner-provider meetings with Camden CCG, frequency 2-4 times per year as determined by the strategic commissioning manager. This meeting reviews the LAC work plan, performance, Camden LAC commissioned targets and any other areas for commissioning to consider. In addition the designated doctor provides an annual report to the CCG.

4.3.3 The designated nurse attends the Camden Children’s Management meeting with Universal Children’s Services to provide service updates and information on projects undertaken.

² CNWL Provider Service
4.3.4 The designated doctor is a member of Camden Corporate Parenting Board and participates in its quarterly meetings. The LAC annual health report is presented alongside other service developments as they arise.

4.3.5 The designated doctor or designated nurse attends the bi-monthly health subgroup meeting of Camden Children Safeguarding Board to represent issues relating to Looked After Children.

4.3.6 The clinical team are located in a building adjacent to the London Borough of Camden (LBC) LAC team which greatly facilitates interagency working. The LAC nurses are co-located with the LBC fostering and Looked After Children’s team on 2 days per week. The health team are available via email and telephone within working hours for consultation with all social work teams. A formal meeting takes place monthly (Health & Development Panel, para 7.6.3).

4.3.7 CNWL has a programme of peer review to ensure providers are able to evidence meeting CQC standards. The 5 key lines of enquiry (KLOEs) include: being safe, effective, caring, responsive and well-led. The peer reviews are undertaken by managers in the organisation who are independent of the service being reviewed. The feedback from Goodall Division CQC peer reviews of the Camden LAC health team has been consistently positive, with all criteria being met in each of the 5 domains.

4.3.8 The clinical team undertakes quarterly essential audits in record keeping and infection control. Any gaps in standards are promptly rectified and an action plan sent to the Quality Governance team.

5. Performance indicators

5.1 National health performance indicators
Local authorities are required to report on eleven performance indicators (the National Indicator Set, NIS), which refer to looked-after children or care leavers (903 return).
These include the following health statistics:
In children looked after at 31 March who had been looked after for at least 12 months:
- Number of children whose immunisations were up to date
- Number of children who had their teeth checked by a dentist
- Number of children who had their annual health assessment
- Number of children aged 5 or younger whose development assessments were up to date
- Number of children identified as having a substance misuse problem during the year
- Number of children for whom an SDQ score was received.

5.2 Statutory health requirements:
- An Initial Health Assessment (IHA) should be undertaken within 4 weeks of a child entering care and statutory guidance states that this assessment should be completed by a doctor.
- A review health assessment (RHA) should be completed annually for over 5 year olds and every 6 months for children under 5 years. These assessments can be completed by a suitably trained health professional.
- Health recommendations are completed by the health professional undertaking the health assessment and the social worker should use these to complete the child’s health action plan.
- All LAC are required to be registered with a GP and, if over 2 years of age, with a dentist.
- LAC should be fully immunised in line with the national immunisation schedule.
5.2.1 Local performance against national targets: statutory reporting by LB Camden to Department of Health

Statutory reporting by local authorities to the Dept. of Health for health and dental checks comprises the % of children who have been looked after for under 1 year who have had a statutory health assessment within the year and the percentage of children looked after for >1 year who have had a dental check within the year. The most recent available data for England and the inner London average is given for comparison. This data is provided by the Children’s Safeguarding and Social Care Quality Assurance Unit.

Table 1: Statutory reporting by LB Camden to Department of Health - comparison of performance over last 3 years:

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</thead>
<tbody>
<tr>
<td>Of those LAC for at least a year, % of those who had an annual health assessment in the previous year</td>
<td>96%</td>
<td>98%</td>
<td>97%</td>
<td>90%</td>
<td>93%</td>
<td>Camden data provisional. All those without dental check are older LAC and UASC who are refusing dental assessments.</td>
</tr>
<tr>
<td>Of those LAC for at least a year, % of those whose teeth have been checked by a dentist in the previous year</td>
<td>94%</td>
<td>93%</td>
<td>83%</td>
<td>84%</td>
<td>86%</td>
<td>Due to low uptake of catch-up meningitis ACWY vaccine among 16-17 year olds</td>
</tr>
<tr>
<td>Of those LAC for at least a year, % of those whose immunisations are up to date</td>
<td>97%</td>
<td>94%</td>
<td>75.5%</td>
<td>87%</td>
<td>81%</td>
<td>LAC team data records this figure as 100%</td>
</tr>
<tr>
<td>% of LAC aged under 5 years whose development checks are up to date</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>83%</td>
<td>88%</td>
<td>LAC team data records this figure as 100%</td>
</tr>
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</table>
### 5.2.2 Additional local targets set by Camden CCG for Camden LAC Health Service

- % of LAC receiving a Review Health Assessment (RHA) where this is due in the quarter
- Number and % of clinical outcomes from care plan met or exceeded at review
- % of children in care who are overweight or obese
- Teenage pregnancy rate
- % of LAC who have been in care for >12 months whose immunisations are up to date

#### Table 2: Performance against Camden LAC commissioned targets 2017-2018

<table>
<thead>
<tr>
<th>CCG agreed target</th>
<th>Q1 April-June 2017</th>
<th>Q2 July-Sept 2017</th>
<th>Q3 Oct-Dec 2017</th>
<th>Q4 Jan-March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>% LAC receiving annual health assessment where this is due in the quarter</td>
<td>&gt;90%</td>
<td>97.8% 45 due 1 deferred due to emergency placement in therapeutic secure unit 44 seen</td>
<td>95% (2 refused)</td>
<td>90.5% 42/50 3 refused/did not attend 3 In hospital 1 placement breakdown - new appointment offered 1 deferred</td>
</tr>
<tr>
<td>Number and % clinical outcomes from care plan met/exceeded at review</td>
<td>&gt;77% 34/44 care plans completed (mostly UASC hospital clinic infectious disease screening and specialist referrals)</td>
<td>82% 23/28 5 care plans carried forward to Q3</td>
<td>36.3% 20/55 35 carried forward to Q4 as they had been only part completed due to complexity of UASC needs</td>
<td>63.4% 52/82 30 part completed carried forward to Q1</td>
</tr>
<tr>
<td>% children in care for &gt;1 year aged 2-18 years who are overweight or obese</td>
<td>N/A Not available</td>
<td>12.6% 13/106</td>
<td>7.8% 10/128</td>
<td>10.2% 13/127</td>
</tr>
<tr>
<td>Teenage pregnancy rate</td>
<td>N/A 6 LAC were recorded on Framework i as being pregnant during the period 01.04.2017 – 31.03.2018. On 31.03.2018 there were 47 female LAC aged 13 years or older. There were also 6 care leavers recorded as pregnant in 2017/18.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of those LAC for &gt; 1 year, % immunisations up to date</td>
<td>&gt;90%</td>
<td>93%</td>
<td>91% 114/130</td>
<td>76% 96/127</td>
</tr>
</tbody>
</table>
6. LAC Health Team Core Clinical Activity and Targets

6.1 Health assessment data

The LAC health team are required by statutory guidance to ensure that all children looked after by the London Borough of Camden have a statutory health assessment within 28 days of becoming looked after, and thereafter every 6 months (under 5 years) or annually (over 5 years). The following data refers to all Camden LAC (both those placed within Camden and out of borough) who have had health assessments completed April 2017 – March 2018.

6.1.1 Number and type of health appointments

Table 3: Total health assessments undertaken or supervised by LAC Health Team and comparison over 4 years, 2014-2018:

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Initial health assessments (doctor)</td>
<td>92</td>
<td>74</td>
<td>83</td>
<td>56</td>
</tr>
<tr>
<td>Review health assessments</td>
<td>168</td>
<td>184</td>
<td>136</td>
<td>214</td>
</tr>
<tr>
<td>Nurse –led IHA</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Statutory health assessments undertaken by out of borough specialist nurse, paediatrician or GP</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Pre- and post-adoption medical assessments and counseling</td>
<td>14</td>
<td>15</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Interim reviews (face to face contacts)</td>
<td>Paediatric clinic=8 Specialist nurses: ongoing work with several children and YP</td>
<td>Paediatric clinic=16 Nurse-led= 17</td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

In 2017-2018, 104 children entered care of whom 92 received an IHA in the LAC Paediatric Clinic. 5 young people had an outreach Initial Health Assessment undertaken by the specialist LAC nurse because of failure to attend 3 appointments in the clinic.

The remaining 7 new care entrants were looked after by Camden for a short time only:

- 2 were persistent non-attenders for IHA and are no longer LAC,
- 4 were transferred out under the UASC national transfer scheme before their IHA could be done
- 1 was not referred to the LAC health team and is no longer LAC
6.1.2 Unattended appointments for initial health assessment (IHA)

22 first appointments for initial health assessment (IHA) did not take place, including 20 which were cancelled and 2 missed 1st appointments with no explanation.

Several were cancelled because there was no interpreter booked.

There were 7 cancelled or missed 2nd and 3rd appointments.

An outreach nurse-led IHA is offered to young people after the 3rd missed appointment.

The non-attendance rate has shown significant improvement since 2016-2017, achieved by:

- The interpreter bookings issue has been resolved.
- Social workers are now expected to attend the IHA with the child or young person which has improved the attendance rate

6.1.3 Timescale to statutory initial health assessment

Statutory guidance states that an Initial Health Assessment (IHA) should be undertaken for all new LAC within 28 days (20 working days) of a child entering care and that this assessment should be completed by a doctor.

There were persistent problems in Camden with achieving this target. An audit found that of the IHA which took place between Jan- March 2017, only 14% were completed within 28 days.

Reasons identified included delays in referral by social worker, delay in receiving consent forms, non-attendance or cancellation of 1st appointment and problems with interpreting services and (at times) insufficient capacity in the health clinic.

Action plans were put in place to address the various issues causing delays and the designated doctor and nurse have worked closely with the local authority LAC team managers, LAC health team clinicians and LAC health admin staff to successfully improve timescales to IHA.

There has been a significant month by month improvement: 29% completed within 28 days in June-Sept 2017, 50% in Oct-Dec 2017 and 86% in Jan-March 2018 (see chart below).

The LAC designated doctor is working with the local authority LAC team managers to actively track all new notifications, ensure referrals are made to the health team in a timely manner and that clinic bookings for the IHA are made promptly. The LAC designated doctor is auditing timescales prospectively in 2018.
6.1.4 Nurse–led initial health assessments
Statutory guidance states that the IHA should be completed by a doctor; however, many services across the UK enable LAC nurses to perform IHA, particularly where young people persistently refuse to attend a Paediatric Clinic. The Camden LAC nurses will undertake outreach IHA where the young person has refused to attend for 2 or 3 booked appointments with the paediatrician at the clinic. These are discussed with the LAC paediatrician who also obtains the past medical history from available GP records. Any concerns will be raised with the GP and the social worker/keyworker contacted to facilitate a GP appointment.

6.1.5 Action for LAC who are persistent non-attenders at health appointments:
- An outreach nurse-led initial health assessment is offered at the young person’s placement where a young person has missed 2-3 appointments at the LAC clinic.
- If the young person continues to refuse, a LAC health care plan is drawn up based on existing health information from GP, hospital services, assessments by CAMHS, LAC education team, sexual health services, Missing Children practitioner, substance misuse team etc. Areas of health concern which require action and involvement by the LAC health team are thus identified and the LAC nurses work with the social worker to ensure that the health needs of the non-attenders, often the most vulnerable LAC, are considered.
- All LAC about whom there is concern about engagement with health services are discussed in the monthly health and social care panel meeting.
- A self-administered health questionnaire is being developed for young people who do not wish to attend.
- Ongoing attempts are made to engage non-attenders. 4 LAC did not have their annual review statutory health assessment completed in the year to 31/03/2018

6.1.6 Out of borough health assessments and outreach work
Approximately one half of Camden LAC live within the borough, however, Camden local authority retains responsibility for their care, including overview of health care.

The arrangements for statutory review health assessments vary across the UK: in some areas they are undertaken by local LAC health teams and charged to the placing health authority according to the national tariff. In Camden (and most London boroughs), LAC health nurses are commissioned to undertake statutory health assessments on an outreach basis for all LAC within reasonable travel distance.

The benefits of Camden LAC nurse outreach work are:
- quality of health assessments is ensured
- timeliness; not dependent on capacity of other health services
- ensures continuity of care for vulnerable looked after children who may move through several foster and residential placements, both in and out of London
- anecdotal feedback from carers is that they value the outreach service highly
- some young people who live within travelling distance but refuse to attend the clinic are willing to have their health assessment at their placement.
- enables a more holistic health assessment for pre-school children and an opportunity for the LAC specialist nurse to observe the child in his or her home environment where tailored advice to carers on health, developmental, behavioural and safety issues can be given.

Camden LAC nurses completed 97% of statutory review health assessments. This entailed regular visits outside London within the South East and some further afield.

2 looked after young people were remanded in custody and had their review health assessment completed by health staff on site.
The remainder are children who have severe physical and learning disabilities and are placed in residential homes or specialist foster placements outside London; their health assessments were completed by their paediatrician or special school nurse.

6.2 Immunisations
The percentage of Camden LAC looked after for under 1 year olds who are up to date with immunisations has been very high in previous years, 94% at end March 2017 and 97% at end March 2016. During 2017-2018, 93% were recorded as up to date in Q1, 91% in Q2 and 88% in Q3. However, at 31st March 2018 only 76% are recorded as fully up to date.

The LAC Health Improvement Practitioner (HIP) maintains responsibility for identification and recording of immunisations and tracking children and young people with missing immunisations. Rigorous follow up to ensure these are given includes regular telephone reminders to foster carers and key workers, liaison with GP practices and health promotion work with young people.

Some of the current dip in uptake is due to the high number of unaccompanied minors who require the full course of vaccinations as per the UK schedule and World Health Organisation protocol for vaccination of individuals with unknown previous immunisation status. This necessitates several appointments to complete the schedule. Refusals, non-attendance and insufficient key-working staff at residential units to accompany the UASC to their appointments all contribute to poor uptake.

However, the Health Improvement Practitioner (HIP) has also identified many older LAC who were missing the meningitis ACWY vaccine, recently introduced for all 15-16 year olds as part of the school leaving booster but with a catch up programme for older teenagers. Despite reminders to the social workers, foster carers and keyworkers, a number of these have not yet been done due to refusal by the young people.

The following actions are addressing this:

- The HIP and specialist LAC nurse are in the process of arranging training so they can also offer immunisations at LAC health clinic appointments. This will be of most use for UK born YP who are missing a single immunisation which could be given at the RHA.
- The HIP will continue to contact keyworkers, social workers, foster carers and GP practices to encourage attendance for vaccination.

Comparative data
Recent up to date comparative data for looked after children are not yet available. In 2015-2016, immunisation uptake for looked after children stood at an average of 81% for Inner London boroughs and at 87% nationally (England)3.

In the non-LAC Camden population, in 2015-2016, 85.6% of children had received the 1st dose of MMR by age 2 and 87.7% had received the 2 required doses of MMR vaccine by age 5.

92.7% of non-LAC children had received the other required vaccines (Dtap/IPV/Hib) by age 2 years4.

6.3 Dental Checks
All looked after children over 3 years of age are required to be registered with a General Dental Practitioner (GDP) and all LAC should have a dental check at least annually (oral check for those under 3 years). In practice, the Camden LAC health team encourage foster carers to register children with a dentist by age 2 years.

Responsibility for ensuring looked-after children are registered with a dentist and access dental care remains with the child’s foster carer or keyworker, supervised by their social worker. There is ongoing dental health promotion work with young people by the LAC health team. Camden community dental services are available for young people in local residential and semi-independent accommodation.

3 Children’s Safeguarding and Social Care Quality Assurance Unit
The recorded uptake of dental care for children and young people looked-after for > 1 year stood at **83%** for 2017-2018 as reported to the Dept. of Health (5.2.1 table 1). This is a significant drop from 93% in 2016-2017. Dental checks are recorded by the individual child’s social worker and these data are provisional.

Ensuring a high uptake of dental care entails joint work with the LAC social work teams by:

- Identification and tracking for all children & young people with outstanding dental checks
- Assisting carers who have difficulty registering with a dental practice
- An agreement for LAC to access the Camden community dental service, where they are among the priority eligible groups. In practice this is rarely required.

The majority of looked after children with outstanding dental checks are all young people over 14 years who are currently refusing dental care. Many are unaccompanied asylum seeking children who have never visited a dentist before and cannot be persuaded of the importance of dental care.

### 6.4 Local requirements

#### 6.4.1 Developmental assessments

A developmental assessment is carried out as standard on all looked after children under age 5 years, as part of every initial and 6 monthly review health assessment by the Camden LAC paediatrician or specialist nurse. 100% of LAC under age 5 therefore have a development assessment completed at least every 6 months and at more frequent intervals if there is concern.

#### 6.4.2 Optician checks

Foster carers and keyworkers are required by the local authority to ensure that all looked after children and young people have their eyes checked by an optician soon after care entry and then annually. This is checked at each health assessment and the requirement reiterated if not necessary, but data on compliance is not currently collected.

#### 6.4.3 Interim reviews

Many children and YP are seen for review at times other than for their scheduled statutory health assessment.

An increasing number of children and young people are looked after for less than 1 year, likely to be a reflection of the higher age at entering care. Many will therefore leave care (reaching the age of 18 years) during the months after their initial statutory health assessment by the LAC paediatrician and before they are due for their annual statutory review assessment by the looked after children’s nurse. This reiterates the importance of follow-up health interventions and health promotion work by the LAC nursing team and Health Improvement Practitioner (HIP) from the very beginning of a young person’s care period, as well as ensuring access to health advice for care-leavers.

The LAC specialist nurses and HIP follow up on a variety of health needs in older LAC. These include, for example, puberty and personal hygiene, sexual health needs, sleep related issues, emotional needs, diet and weight. This mostly takes place in liaison with other local health services such as CAMHS and sexual health services, facilitating referrals and offering support to young people, their keyworkers and foster carers. (see also para 7.6)

Young children are followed up by the specialist LAC nurse for developmental or weight/feeding concerns. Infants with drug withdrawal symptoms are followed up by the LAC paediatrician. Young children are seen by the LAC paediatrician for formal developmental assessment when clinically indicated or requested by court. Post adoption follow up is offered for adopted children by the paediatrician.
A number of older LAC are seen in the LAC paediatric clinic for assessment and follow up of medical problems, psychosomatic issues and psychological support, jointly with a CAMHS professional where needed.

6.4.4 Health Care Plan outcomes

It is a statutory requirement for each looked after child to have a Health Care Plan in place, which is renewed after each statutory health assessment. An excel spreadsheet is used by the LAC health team to track recommendations and actions arising out of individual health care plans. The % of actions detailed within the health care plan that have been completed within the set timescale is reported quarterly and ranged from 36.3% to 82% across Q1 to Q4 in 2017—2018 (Section 5.2.2, table 2).

This data is disappointing and has occurred despite the health improvement practitioner making significant efforts to chase up recommendations. It should be noted that all recommendations are followed through and actioned appropriately though may take longer than anticipated.

An audit of unmet health needs has been completed and identified a number of reasons contributing to poor implementation of health recommendations (see paragraph 9.2.1).

6.4.5 Overweight/obesity

An audit of the prevalence of obesity undertaken in Camden looked after children published in 2011 identified that 25% of LAC aged 2yrs – 17.9yrs were either overweight (12% of total; BMI > 91st – 98th centile) or obese (13% of total; BMI>98th centile for age). This was therefore included as an area for monitoring and action by Camden Clinical Commissioning Group.

Growth is measured at all health assessments. Children and young people aged 2–18 years who fall into the overweight or obese category are monitored (including those placed out of borough), with referrals and interventions made as described below.

These children’s weight is tracked via the LAC health team weight management database.

The percentage of children looked after for more than 1 year identified as overweight or obese averaged 10.2% across the year 2017-2018 (paragraph 5.2.2, table 2).

Only 4 LAC are currently recorded as having a weight in the obese range (BMI 98th centile or above). This is likely to be a reflection of the changing demographic of the Camden LAC population, of whom 31% are unaccompanied asylum seeking minors and none of whom are overweight.

Comparative data

Direct comparison with Camden and national data is not possible because the LAC data refers to children aged 2-18 years, whereas public health data is collected at primary school entry and in school year 6 (10-11 year olds) only. The most recent available data refer to 2016–2017, when 21% of Camden children aged 4-5 years and 34.2% of Camden children aged 10-11 years were classified as overweight or obese. Figures for England are 22.6% and 34.2% respectively. The available data confirms that the rate of obesity in the Camden LAC population is comparatively low.5

Interventions for overweight and obese LAC:

- Individual health promotion work, offering detailed consultations on healthy eating and regular weight review, is provided by the LAC health team.
- A referral to the Camden Healthy Lifestyles Outreach Practitioner is offered.
- For looked after children who are very obese (with a body mass index >99.6th BMI centile), a referral is made to University College Hospital Child and Adolescent Weight Management Clinic for further investigation.
- Liaison with local health services takes place for children who live too far from Camden. Those in residential school placements are monitored at their placement.

5 Public Health England Public Health Profile https://fingertips.phe.org.uk
Promotion of healthy eating for all LAC:
Advice on healthy diet and exercise is included on every child’s LAC health care plan.
Training on healthy eating is delivered to foster carers and LAC in residential / supported accommodation.
Foster carers identified on their own fostering medical assessment as significantly overweight are sent an information leaflet outlining the health risks to the carer and potential health risk to the child (in terms of healthy diet and lifestyle promotion).

7. Other Clinical Activity

7.1 Sexual health and children at risk of sexual exploitation

7.1.1 Sexual health
The LAC Health Team has established ongoing collaborative work with Camden & Islington Young People’s Sexual Health Network and care givers to ensure that vulnerable looked after young people receive the services they need. This includes provision of up to date information on services available to the young people and ongoing sex education and relationships work.

Clinical services
- LAC health professionals discuss concerns about sexual health and relationship issues with individual young people at annual health assessment appointments and at periodic health reviews.
- Young people are given information on local sexual health services, including clinics at Brook Euston, The Brandon Centre, Pulse and Camden Archway, where additional information is tailored to the unaccompanied minors (UASC) population on law and age of consent in the UK.
- Where sexual health needs are identified at the initial health assessment, the LAC Health Improvement Practitioner (HIP) contacts the sexual health team and facilitates attendance for individual work.
- Liaison with sexual health outreach workers in other boroughs where Camden children are placed.
- Information is shared with the sexual health team on LAC known to be at risk of sexual exploitation and on LAC about whom there are concerns such as non-compliance with contraceptive use or where sexual exploitation is suspected.

Health promotion and education:
In addition to routine health promotion and discussion about sex and relationships at each health assessment, the LAC nurse and HIP also undertake the following:
- The LAC nurse offers individual sessions for looked after children attending mainstream school who have learning needs, with use of training materials to help them understand how the body works as well as sexual health and relationships education.
- As identified at the review health assessment, particular attention is paid to preventive interventions at critical periods of risk for LAC, such as those transitioning to secondary school, moving into semi-independent placements or leaving care.
- The LAC Health Improvement Practitioner facilitates sexual health promotion at young people’s accommodation, on an individual basis where needed or in small group sessions. Topics covered during the last year have included personal hygiene issues, puberty awareness, contraception choices, pregnancy support, negative/positive relationships, sexual orientation, risky behaviour and sexual exploitation.
The LAC specialist nurse and Health Improvement Practitioner support health outreach “Clinic in a Box” sessions with the sexual health outreach nurse in supported accommodation and residential unit settings, providing a confidential health service for young people under 25 in Camden. This includes
  - C card scheme which encourages young people to have access to condoms when they need them. This helps to normalise the use of condoms and enables staff to discuss sexual health in a positive and supportive manner.
  - Offering pregnancy testing and advice
  - Access to contraceptive pills and patches including emergency contraception
  - Sexual health and relationship advice
  - Signposting to other services as needed.

### 7.1.2 Work with children missing from care and children at risk of sexual exploitation (CSE)

All LAC health staff have had training on Child Sexual Exploitation (CSE). Improved recognition of LAC who are vulnerable to CSE is ensured by completing a CSE risk assessment for LAC of secondary school age at their health assessment. Children and young people about whom there are concerns are discussed with their social worker and at the monthly Health & Development Panel meeting so that a CSE plan can be drawn up if indicated.

Children missing from care are especially vulnerable to CSE. Information on missing children is shared with the team by the social worker or the named nurse for safeguarding. LAC health staff liaise with carers and keyworkers to contact and engage missing young people, assess risks, provide support to the young person and/or carer and follow up on progress. Health follow-up is provided as appropriate, including sexual health, emotional support and referral to other services where required.

### 7.2 Teenage Pregnancy

Teenage pregnancy is both a cause and consequence of education and health inequality for young parents and their children. Babies born to teenage mothers in England and Wales have a significantly higher than average rate of stillbirth, infant mortality and low birth weight. Teenage mothers have a 30% higher risk of poor mental health, affecting their ability to form a secure attachments with their baby. Teenage mothers are more likely than other young people to not be in education, employment or training and children born to teenage mothers have a 63% higher risk of living in poverty. Despite significant progress over the last 18 years, with a reduction of almost 60% in the under-18 conception rate, a continued focus is needed.

Following the introduction of the Teenage Pregnancy Strategy in 1999, England achieved a 59.7% reduction in the under-18 conception rate by 2016.

By 2013 the rate had fallen to 24.3/1000, down 40% from 47.7/1000 in 1998, and by 2016 it had fallen further to 18.8 / 1000, though remains higher than that in comparable Western Europe countries (ONS 2016). In Camden, the under 18 conception rate is significantly lower than the national average, falling to 13.5 per 1000 by 2015 (most recent data).

There were 6 reported pregnancies in Camden LAC in the year April 2017-March 2018, an increase on previous years and significantly higher than the overall Camden figure. This is in the context of a population of 47 female LAC aged 13+ years on 31.03.2018. However, the total number of female LAC over the age of 13 over the course of the year is not known, so it is not possible to calculate the % pregnancy rate. 2 of the pregnancies resulted in live births, 1 is currently in the third trimester and 2 had a termination at the early stage of pregnancy.

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6 Public Health England, Teenage pregnancy and young parents report for Camden, January 2018
   www.gov.uk/phe
7 Public Health England, Teenage pregnancy and young parents report for Camden, January 2018
   www.gov.uk/phe
There were also 6 recorded pregnancies in care leavers now aged between 18 and 22 years. The LAC health team works with social workers and sexual health services to prevent unwanted pregnancies as outlined above and identify those at particular risk (para 7.1). The team does not offer specific pregnancy related or postnatal care, but facilitates referral to the Family Nurse Partnership service which ensures access to local maternity services. However, pregnant looked-after girls are supported through their pregnancies by the specialist nurse by individual contact and through regular liaison with their social worker and maternity services.

### 7.3 Substance misuse

National data for looked-after children is available to March 2016. Of the 48,490 children looked after for at least 12 months in the year ending 31 March 2016, 4% were identified as having a substance misuse problem. Half of these (50%) received an intervention for their substance misuse problem. A further 40% were offered an intervention but refused it. Comparable rates for non-looked after children are not available.

2017-2018 Camden LAC data: of the children who had been in care for at least 12 months in Camden, 20 (15.9%) were identified as having a substance misuse problem during the previous 12 months, compared with 21.3% in 2015-2016 and 16.2% in 2014/2015. Of these children, 100% received an intervention with none refusing (information from Children’s Quality Assurance Unit).

In Camden, screening is undertaken by the social worker using the DUST (Drug Use Screening Tool) on all looked after children as part of the core assessment and is coordinated by the LAC teams in partnership with FWD (Forward), the drug and alcohol service responsible for implementing Camden’s substance misuse strategy for children and young people. The highest numbers of referrals to FWD are for cannabis use with alcohol being the second highest reason for referral.

Substance use is discussed routinely as part of a looked after young person’s health assessment and individual advice given where indicated. Where substance use is identified and there is no intervention already in place, the social worker is informed and advised to make the referral to FWD or other local services.

### 7.4 Emotional Wellbeing

#### 7.4.1 Screening and referral for emotional difficulties

- Discussion on emotional health is an integral part of all statutory health assessments.
- The Strengths and Difficulties Questionnaire (SDQ) is completed at each *initial* health assessment for early identification of children and carers who need timely support. The SDQ is sent for scoring to the LAC CAMHS team, along with a copy of the health report and request for CAMHS assessment where needed.
- Children about whom there are concerns are discussed at the monthly LAC Health and Developmental panel (see para 7.6.3)
- There is regular phone and email liaison between CAMHS and LAC health staff regarding individual children, and attendance by the LAC health team at case discussions as necessary.
- A psychotherapist from the Tavistock refugee team attends the initial health assessments for unaccompanied minors to improve the service’s ability to provide early support to these young people. (see 7.6.1)

#### 7.4.2 Promoting resilience

- Promoting interventions to help build long term resilience of looked after children is a core aim for the LAC health team.
• Practical application includes detailed routine enquiry and discussion at health assessments of enjoyable activities and other interventions that can help build self-esteem, self-efficacy and a secure base for the individual child.
• Strategies to enhance resilience along with emotional and behavioural goals are incorporated into the child’s health care plan
• The designated nurse has developed a handbook on promoting positive outcomes (resilience enhancing strategies) as a training and reference tool for LAC clinicians as well as a support pack for carers which outlines strategies to strengthen the care of vulnerable traumatised LAC.

7.4.3 **CAMHS services for LAC Mental health services**

For Camden looked-after children are provided by the LAC CAMHS team in liaison with the Tavistock Clinic and other Camden CAMHS providers. Referrals to this team can be made directly by LAC health professionals where there is no existing therapy input. For children child placed out of London who require a psychological service, the CAMHS team and the child’s social worker liaise with local services to ensure access to appropriate assessment and interventions.

7.4.4 **Strengths and Difficulties (SDQ) questionnaire outcomes**

The Strengths and Difficulties Questionnaire (SDQ) is a good screening tool for emotional well-being in looked children (Goodman & Goodman, 2012)\(^8\). Since 2009, local authorities have been required to administer SDQs to LAC aged 4-16 years who have been in care for at least one year, and the mean value of the total difficulties score is included in statutory reporting. Screening at care entry is completed at the initial health assessment and subsequent annual statutory screening is arranged via the social worker and LAC education team.

Of the 85 children aged 4 to 16 years (inclusive) who had been in care for at least 12 months at the end of March 2018, carers returned 77 fully completed questionnaires (90.6%). The mean value of the total difficulties score was 13.7. This is almost unchanged from 2016/17 when the average score was 13.8 and has varied little in recent years.

7.5 **Training**

7.5.1 **Training for carers**

Regular training is delivered by the LAC specialist nurses and Health Improvement Practitioner (HIP) for foster carers and staff at residential and supported accommodation units.

Health training sessions for foster carers take place within a support group setting, as this format has been found to achieve the best uptake and engagement by carers. The LAC nurse is invited to participate in sessions by the fostering team as dictated by needs of the current cohort of carers. The sessions last about 2 hours and are facilitated by a social worker and LAC health worker, with time for informal discussion and sharing of problems and ideas.

Other health training is delivered at supported accommodation units and sometimes in school or home settings.

Health training for foster carers and residential unit staff includes:

• Health awareness for foster carers: accessing health services for looked after children, where to find information on common health conditions, understanding of their complex health needs.
• Foster carer’s role in promoting healthy lifestyle choices, nutrition and healthy eating.

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\(^8\) https://researchonline.lshtm.ac.uk/1845810/1/sa2012Goodman_SDQfostercare.pdf
- Child development workshops, including developmental milestones, promotion of learning through play, language development
- Management of common behavioural and sleep issues in young children
- Sexual health and access to services for looked after young people.
- How foster carers can support teenagers through puberty, how to talk to young people about sex and relationships. Some sessions will involve a specialist trainer.
- Supporting carers in managing transition of children starting secondary school
- Health and safety; first aid; accident prevention.
- Immunisations promotion

Specific additional training covered during 2017-2018 included:
- Meeting the health needs of UASC – training delivered to sexual health team
- Baby massage at foster carer workshops
- Puberty and hygiene session for children and foster carers.

Frequency: this is an integral part of the work delivered by the team and occurs as dictated by service needs and feedback from foster carers, social worker managers and supported accommodation unit staff.

7.5.2 Social workers:
Training is provided for social workers on the role of LAC health professionals and on procedures for arranging statutory health assessments. This is done as required when new staff are employed, on a 1 to 1 or small group basis at the LAC health clinic. Social workers are also invited to attend the training for foster carers and prospective adopters.

Frequency: as dictated by service needs and feedback from the local authority.

7.5.3 Health visitors and school nurses:
The designated nurse has redesigned the training programme for health care professionals to take into account the impact of trauma and attachment disruption on a child’s development. The training includes the basics of the neuro-scientific evidence for long term adverse effects of abuse and trauma on the brain, attachment theories, child development, loss and separation, therapeutic parenting, and resilience building. The aim is to heighten professional understanding of the complex and diverse needs of these vulnerable groups of children and young people.

Frequency: approx. annually. Last session delivered on 20.06.2017 and next planned for September 2018.

7.5.4 Prospective adopters
Preparation Group for prospective adopters is delivered twice per year by Camden’s adoption team and includes a session by the LAC designated paediatrician on potential medical and developmental issues facing adopted children. These include the impact of antenatal drug and alcohol exposure, postnatal abuse and neglect, medical and genetic problems and mental health diagnoses.

Frequency: usually twice yearly, as requested by the adoption and permanency team.

7.5.5 Medical staff:
- Formal teaching on the health needs of Looked After children is provided as requested 3 to 4 times annually by the LAC paediatricians for trainee paediatricians. This includes an annual half-day teaching session on the MSc in Paediatrics at the Institute of Child Health and regular teaching incorporated into the regional postgraduate training programme. In addition, there is weekly clinic based teaching for community paediatric trainees.
• GP forum: the LAC designated doctor and nurse attend the GP Safeguarding Forum annually to update GPs on service developments and provide information about specific health related issues relating to looked-after children and adoption. The most recent session concentrated on health needs of UASC, use of the UASC integrated care pathway and management of adoption records. Relevant information (UASC pathway and information on immunisation of unaccompanied minors) has recently been uploaded to the GP website.

7.6 DETAILS OF OTHER CAMDEN LAC TEAM WORK

7.6.1 Unaccompanied minors and asylum seeking children (UASC)

Since June 2015, there has been an increase in the number of UASC referred to the LAC health clinic for assessment. There were 54 newly arrived unaccompanied minors who became looked -after in Camden during the period April 2017- March 2018 (compared with 36 in 2016-2017 and 25 in 2015-2016). Approximately one-third of current Camden looked-after children are unaccompanied minors, resulting in a shift in focus of the type of work undertaken by the health team. This population has high health needs which are often complex, necessitating longer appointments for health assessments and extensive follow up of health issues.

An integrated care pathway for UASC was developed across North Central London, led by the Camden LAC paediatrician in liaison with the other NCL LAC health teams, sexual health services, hospital infectious disease clinics and the Refugee team at the Tavistock clinic. It incorporates physical health, infectious disease screening and treatment, sexual health and psychological health. Catch-up immunisations are organised according to Public Health England guidance.

A translator and an outreach psychotherapist from the Tavistock CAMHS team are present with the paediatrician for UASC health assessments. 1.5 hours are allocated for each assessment and onward referrals are made according to the pathway.

All UASC are referred to UCLH for infectious diseases screening. Unfortunately only a 1/3rd of young people attended their screening appointments, despite appointment letters being sent to the young person as well as their key worker and social worker. An audit of cases in 2016-2017 showed a high pick-up rate of infections not generally seen in the UK, including 4 cases of latent tuberculosis, 2 cases of malaria, 2 cases of schistosomiasis, 2 cases of tapeworm, and 2 cases of giardia infection. Data for infectious diseases identified in 2017-2018 are not yet available.

7.6.2 Health Improvement activities for looked after children and their carers

Improving long term health outcomes is one of the key tasks towards meeting health needs of children in care. Children and young people entering care have disproportionate health needs arising from prior missed opportunities for universal children’s health programmes and limited knowledge of health promotion activities.

The Health Improvement Practitioner (HIP) liaises with the LAC Health Team, foster carers and looked after young people to identify health promotion needs and offer targeted work. During 2017-2018 this has included:

• A series of health improvement workshops for looked –after children, foster carers and residential unit staff which included healthy eating, weight management, improving oral health diet, exercise, sleep, sexual health, routine surveillance, immunisations.

• The HIP provides 1 to 1 sessions to young people as indicated for individual health promotion work, usually for specific interventions and advice such as healthy eating, sexual health advice, health education about alcohol and drugs, sleep hygiene and promotion of immunisations.

• The HIP has worked extensively with keyworkers and residential units to promote the health of UASC and encourage attendance at appointments for infectious disease screening and immunisations.
• Advising on local services including sexual health, weight management services and local leisure activities
• Workshops at The HIVE youth setting:
  o Sleep hygiene and healthy eating
  o Body confidence

7.6.3 Liaison work

Multi-agency and interdisciplinary liaison
A significant amount of work is undertaken with looked after young people in between statutory reviews by the LAC specialist nurses and the health improvement practitioner, which requires good liaison between services. The LAC specialist nurses are based with the social work teams approximately 2 days per week and have built good links with the Sexual Health team, the Youth Offending Team, Substance Misuse Team and CAMHS to ensure a holistic approach for every looked-after young person and avoid duplication of services.

The LAC specialist nurse regularly attends Social Care LAC reviews and strategy meetings to provide the health input where there are concerns about medical issues, sexual health, sexual exploitation, behaviour and engagement with services.

Extensive efforts are made to engage ‘hard-to-reach’ LAC by liaison with other involved professionals. A health care plan for non-attenders is drawn up by reviewing health information from other sources for young people who persistently refuse to have their health assessment, to ensure that the health needs of these most vulnerable LAC are considered (see para 6.1.5).

Health and Development panel
The Health and Development Panel is a formal monthly multi-agency meeting to discuss any looked-after child about whom there are concerns to ensure that children’s needs are identified early and services put in place in a timely manner.

Issues discussed may be related to children’s physical health, behaviour and mental health, developmental progress, learning needs and educational issues, carer or placement issues, non-engagement and safety concerns etc. This meeting is chaired by the LAC team manager and includes the LAC health team, psychologist from the LAC CAMHS team and representative from the Sexual Health team. The Fostering & Adoption team manager, residential Pathways manager, LAC Academy and Sexual Health team managers have also attended periodically with the aim of improving regular formal liaison between services.

Liaison with Disabled Children’s Team
A small number of Camden’s LAC (approximately 5-8 % at any one time) are managed by the social care Disabled Children’s Team under Camden MOSAIC services. These children are often placed in residential units outside London and have multiple complex health, developmental and emotional needs such as severe learning disabilities, autism, neurological disorders and severe behavioural problems or psychiatric disorders. The designated doctor for LAC liaises regularly with the Disabled Children’s Team social workers and meets monthly with the team manager, in order to provide advice on medical issues and guidance on consent for any proposed medical interventions, alongside discussion and liaison with local health professionals.
8. Adoption and Fostering

8.1 Panel work
The LAC Designated Nurse holds the post of health adviser to Camden Fostering Panel. The LAC Designated Doctor holds the post of Medical Adviser to the Adoption and Permanency Team and Panel. Panels take place fortnightly, half day or full day and are attended by either the LAC designated nurse or doctor.

8.2 Adoption clinic work
The designated doctor sees all prospective adopters for counselling prior to matching and offers longer term follow up for adopted infants and children where there are actual or potential developmental issues such as foetal alcohol spectrum disorder. This is particularly important for children who have histories of antenatal drug and/or alcohol exposure, in whom developmental prognosis is uncertain and where adverse effects may not manifest until school age.

8.3 Adoption records
Under current legislation, an adopted child is given a new identity including new NHS number, which creates issues with regards to health records and pre-adoption health information relating to the child. There is no nationally agreed adoption records guidance and processes vary depending on local health information systems. With the move from RIO to System One, current processes in Camden have required review. Joint guidance across CNWL is currently being drafted in consultation with the LAC designated doctor from each service.

8.4 Adult medical reports
88 adult medical assessments (AH forms) were reviewed and reported on during the year from April 2017 to March 2018. This compares with 71 in 2016-2017 and 97 in 2015-2016. All applicants for short and long-term fostering, Special Guardianship, adoption and respite care are required to undergo a health assessment and medical examination by their GP, which is repeated every 2 years for foster carers.

The information on the AH forms is reviewed with respect to medical history, mental health history, family history and life-style factors. Additional information is obtained from the GP, hospital consultants or other health staff where necessary. A written report on each applicant is then provided to the Adoption and Fostering team by the LAC medical advisor, with a summary of the medical issues and recommendations.

8.5 Quality and safety assurance
Bi-monthly peer review meetings are held with the medical advisors for adoption and fostering from six north London boroughs to share difficult cases, obtain advice from colleagues and ensure that standards and advice are uniform. Appropriate safeguards are in place for client anonymity.

9. Service Improvements

9.1 Specific improvements/team achievements
9.1.1 Timeliness of initial health assessments
According to statutory guidance, the IHA should take place by a doctor within 4 weeks (20 working days) of becoming looked after, with a health care plan provided for the child’s social worker. There has been a huge improvement in meeting this target over the course of 2017-2018, from 14% in Q1 to 86% in Q4 (see para 6.1.3).
A combined Health and Social Care LAC placement and consent form has been developed, which incorporates parental consent for health assessments and health information sharing within the local authority parental consent to placement documentation. The form has been approved by the local authority legal team and will further streamline the process for arranging timely initial health assessments.

9.1.2 Early follow up after initial health assessments to ensure health care plan recommendations are actioned.

The process for health care plan review and follow up contact for all LAC with complex needs within 6 weeks of initial health assessment has been formalised, with the LAC designated nurse and the health improvement practitioner taking responsibility for this work. (see 6.4.4).

9.1.3 Improved support for Leaving Care Pathways and residential units

Following discussions with the Care Pathways manager, the LAC specialist nurses and health improvement practitioner offer increased practical support and training to staff and looked-after young people in residential units. This is now embedded in practice and takes the form of regular drop-in sessions alongside email and telephone liaison.

Positive outcomes include:

- To help staff and young people understand the role of the LAC health team and encourage engagement with statutory health assessments and health services
- To reduce attendances at hospital Accident and Emergency departments by offering advice and training on management of common minor ailments, accident prevention, first aid, etc.
- To empower young people to manage their own minor health issues and contribute to life skills programmes for young people
- To engage staff (in their roles as substitute parents) in ensuring that health care plan recommendations are carried out.

In addition, guidance for specific health issues is drawn up where needed by the LAC paediatricians and specialist nurses. Recent examples include:

- A ‘traffic light’ leaflet on management of minor illnesses: guidance on which ailments can be self-managed, for which to call the NHS 111 helpline and which require GP or A&E attendance
- Guidance on management of scabies
- Guidance on management of positive hepatitis B and TB test results

9.1.4 Improved information and support for care leavers

Leaving Care health discussions/reviews are offered to young people reaching their 18th birthday whose most recent health assessment took place more than 6 months previously, in order to assess and support health needs of LAC when they leave care.

A Leaving Care leaflet with personalised health information including birth details, health history, immunisations, allergies and medications is provided for all LAC leaving care, together with information on how to access health services. A copy is sent to the GP and, with appropriate consent from the young person, to their social worker.

Since 2017, local authorities have a responsibility to support care leavers to the age of 25 years. The LAC health service does not undertake formal health assessments for young people over age 18 but continues to offer health advice and signposting to adult services where needed.

To improve partnership working with the Leaving Care team, the LAC health designated or specialist nurse are to be invited to future Leaving Care transition planning meetings and to the Care Manager’s meetings.
9.2 Audit and improvement projects:

9.2.1 Unmet health needs audit
One of the key objectives of the LAC work plan 2016/2017 was to audit a sample of Initial Health Assessment (IHA) health care plan recommendations, to ascertain whether health needs identified upon care entry were resolved by the time of the Review Health Assessment (RHA). The IHA health care plans for 20 children who entered care in 2016 were retrospectively audited and findings measured against set performance indicators as an evaluation of service delivery and to identify probable causes for the unmet health needs.

The results showed that only 44.6% of health recommendations had been resolved by the time of the RHA, despite use of a health care plan database to track them. Detailed analysis identified a number of probable causes for the difficulties in implementing recommendations. These included high staff turnover within social care, communication failures (missing information, lost appointment letters), non-attendance at appointments (e.g. due to misunderstanding purpose of appointment, clashes with non-health appointments), unclear lines of responsibility, confusion about treatment, lack of agency understanding of importance of health appointments and failure of staff to encourage attendance. In some instances, the recommendations had been followed through but were not documented in the child’s LAC health record.

While disappointing, these findings confirm those of previous national and local research into health care of looked-after children, pointing ultimately to lack of consistent advocacy and clear lines of responsibility.

The audit sample consisted of IHA undertaken during 2016. Since then a number of improvements have already been made and will continue into 2018-2019.

Recommendations include:
- Rigorous follow up of health plan recommendations after IHA by LAC health staff
- Procedures in place for LAC health team to be made aware of unattended appointments
- Routine review of health plan at each review health assessment
- Improved administrative procedures, record management and filing
- Escalation of concerns to Social Care LAC manager and Head of Service where carers are not fulfilling responsibilities in terms of health.

It is anticipated that this audit will be undertaken yearly as part of a wider Quality Improvement Programme (QIP).

9.2.2 Improvements to UASC services
A retrospective audit to evaluate health care needs and management of 102 UASC between January 2015 and March 2018, based on the Camden UASC population, was undertaken by a researcher from the School of Public Health at Imperial College London.

82% (n=84) had at least one physical problem, most commonly dental issues (53%) and sleep difficulties (44%). 59 children (61%) described mental health symptoms. 83% (n=71) reported some form of abuse: 81% physical, 32% emotional, 18% sexual; 88% of abused were referred to mental health services.

The findings are currently being written up and data will be used to identify key health needs of this cohort and further develop the integrated health pathway across the North Central London LAC Network. Similar audits will be taking place in Islington, Haringey, Enfield and Barnet.

The work on the pathway and audit was presented at the International Society for the Prevention of Child Abuse and Neglect in The Hague in September 2017 by the Named Doctor for Looked After Children.
9.3 Partnership Working
The LAC health team continues to work in partnership with a wide range of professionals and clients in order to maintain a high standard of care. Members of the LAC health team are actively involved in the following partnership roles:

- Camden Corporate Parenting Board which oversees the services for looked after children and includes London Borough of Camden Children, Schools and Families division Director and Assistant Director; local Councillors; Education; Early Years Services; Youth Services; Participation Officer; foster carers; Looked After young people and care leavers; LAC service Principal Officer and LAC designated doctor.
- NHS Camden Safeguarding Board health subgroup bi-monthly meeting.
- Health and developmental panel meeting monthly: social work team managers, CAMHS, fostering and adoption team, LAC educational psychologist, sexual health nurse and LAC health team, to discuss individual children with difficulties and operational issues.
- Regular liaison and meetings with fostering team, residential unit and Care Pathways managers
- Disabled Children’s Team monthly meeting
- Regular liaison with LAC CAMHS team
- Sexual Health Network
- Children’s Society and representation at MASE meetings where appropriate, regarding looked-after children at risk of sexual exploitation
- Regular and ongoing liaison with primary care services, hospital services, youth offending team services, public health and education services
- Regular meetings with Camden’s Looked after Children Participation Officer to ensure children’s/young person’s views are heard and ensure their involvement in service development.
- Adoption and fostering panel, attended by designated professionals
- LAC health staff attend London and National LAC and Adoption Forums

9.4 User surveys

9.4.1 Feedback from foster carers and young people
A paper survey to obtain feedback from foster carers and young people on their experience of initial and review health assessments was undertaken over a 3 month period during 2017. 50 completed surveys were returned.

Age:
- 39% were from young people aged 16+ years.
- 15% were from young people aged 11-15 years and/or their carers.
- 46% were from the carers of children aged 0-10 years.

Gender:
- 39% related to female and 61% to male looked-after children/young people

Results:
- 100% of respondents said they had been treated with respect.
- On a scale of 0-10, with a rating of 10 defined as excellent:
  - 5% rated their health assessment experience as 8/10
  - 16% rated their health assessment experience as 9/10
  - 79% rated their health assessment experience as 10/10
On a scale of 0-10, with a rating of 10 defined as excellent:
- 5% rated the information they received as 8/10
- 16% rated the information they received as 9/10
- 79% rated the information they received as 10/10

9.4.2 Survey of Independent Reviewing Officers (IROs)

Independent Reviewing Officers are senior, experienced, social care staff whose responsibility is to provide independent review of the care provided by local authorities in discharging their responsibilities to looked-after children. There are 5 IROs for Camden LAC. One of their roles is to chair the 6 monthly LAC Review (multi-agency social care review for each looked after child).

The purpose of this brief survey was to ascertain whether
- Health care plans (HCP) are available at each Social Care LAC review
- Whether, in their view, health care plans were meeting the needs of LAC
- To what extent, in their view, health care plan recommendations were being met
- To invite any additional feedback about their experience of the LAC health team’s work.

3/5 IROs reported that the HCP was present most of the time and 2/5 reported some of the time.

4/5 IROs reported that the HCP always reflected the individual health needs of the child and 1 stated that it did so most of the time.

4/5 IROs reported that the recommendations set out in the HCP were mostly or always met and 1/5 reported that they were sometimes met.

Feedback comments:

I’m very pleased with the way the health advisers are so visible and available to SW staff and the IRO’s. Through this contact we’re able to talk about young people’s health needs and raise concerns with senior managers or placements so matters are formally addressed. Working alongside the health advisors has also been positive in terms of monitoring the health of young people outside the borough or London.

In my experience the health assessments are very comprehensive, are sensitive to the specific needs and vulnerabilities of Looked after children or unaccompanied minors and give very clear recommendations for the Local Authority to follow up.

The HCP are generally very comprehensive. We have good links with LAC health and communication is always very good. If we have any queries we always get a very quick response.

On most occasions, the child/YP has an up to date SHA, and good feedback is available from the LAC nurse, typical difficulties when the YP is unwilling to attend SHA, LAC nurse is proactive in outreach work.

The health assessments are very useful. However, there are some areas of health that are more sensitive and young people are not always happy for this to be shared. It would be helpful to check these issues with young people as the review forms are distributed to the whole network and it is not always appropriate for everyone (e.g. school) to know everything.

The IROs have a good relationship with the LAC health team and we are regularly consulted and updated, particularly about the more complex cases. There is a real advantage to being based in the same building.

Following the comment about sensitivity of information, the IRO manager agreed that the IRO would check with the young person prior to the meeting which information they consent to share and discuss at the meeting. Signed consent is always obtained prior to any health assessment from the young person.
There were issues raised by the IROs relating to administrative procedures and accessibility of the HCP on the social care database at the time of the LAC review; for example, the health plan should always be available but findings of this survey shows that it is not. These issues are being addressed.

9.7 Inspection updates

Ofsted carried out an inspection of services for children who need help and protection, children looked after and care leavers. This was combined with a review of the effectiveness of the Local Safeguarding Children Board.

Ofsted judged Children’s Services in Camden to be ‘good’ overall, with the following subcategories:

- Children who need help and protection: Good
- Children looked after and achieving permanence: Good
- Adoption performance: Outstanding
- Experiences and progress of care leavers: Good
- Leadership, management and governance: Outstanding

The focus of the Ofsted inspection was on social work services. However, the following comments about the LAC health service were made:

The emotional and physical health needs of children looked after are monitored and overseen effectively by a dedicated health team. However, the poor timeliness of initial health assessments is a continuing and long-standing concern. Social workers do not always prioritise referrals to the looked after children health service, and they are slow to obtain the necessary consent from parents. A well-developed and effective pathway enables unaccompanied minors and asylum seeking families to quickly access a wide range of emotional and physical health services. A health improvement practitioner tracks all referrals and is proactive in chasing up a significant number of young people who miss appointments.

Recommendations of the inspection relevant to health were:

- Ensure that managers and social workers prioritise conducting initial health assessments for children who become looked after, so that children’s health needs are understood and addressed at an earlier stage.
- Ensure that all care leavers are clear about their own health histories, and are also aware of any family health issues that may affect them as they go through life.

These have been addressed as detailed previously in this report.

No inspections of LAC health services by the CQC took place during 2017/2018.

9.6 Professional Development in the LAC Health Team 2017-2018

- The LAC designated doctor attends the regional BAAF health group meetings 3 times per year in addition to the annual national BAAF health group educational conference. She completed her second term on the national BAAF Health Group Advisory Committee in June 2017 (2 consecutive terms allowed).
- Bi-monthly designated doctor peer review meetings with colleagues in Islington, Hackney, Barnet, Enfield and Haringey
- All LAC team members are up to date with mandatory training including the required safeguarding training up to level 3.
- The specialist nurses attended the London Region Children Looked after Forum learning event: Tackling CSE Together July 17 by NHS England
- Specialist nurses attended C Card training CSCB, July 2017
• Specialist nurse and health improvement practitioner attended Supporting Looked after Children through Change (Delivered by Camden Designated Nurse & Dr on behalf of CSCB June 2017
• Specialist nurse attended Managing Psychological Trauma in Health Care and Networking Day, July 17 Queen Nursing Institute
• Specialist nurse attended Maximising Community Resilience through Mutual Aid Sept. 2017 Camden Council
• Designated nurse attended Level 3-5 Safeguarding: Safeguarding Looked After Children: Responsiveness and Wellbeing 13 Sept
• Specialist nurses and health improvement practitioner attended NHS England LAC conference November 2017
• Specialist nurse attended Kids Taking Over : engagement with Camden children and youth services November 2017
• Health improvement practitioner attended Recovery College training: recovery focussed practice-finding hope and building on strengths. November 2017
• Designated nurse attended Contact in Adoption: Pan London Training for Panel Members
• Specialist nurse attended The Association for Young People’s health conference February 2018
• Specialist nurse attended LAC half day study day – how to work with trauma – March 2018

10. Areas for development 2018-2019

The Camden LAC Health Team has addressed all areas for development outlined in the June 2017 annual health report, as documented in this report and the LAC health team work plan (Appendix 1). Almost all have been completed. The following have been identified as areas for local improvement within 2018-2019:

• Immunisation training for the LAC specialist nurse and health improvement practitioner to enable opportunistic immunisations at health assessment reviews and improve uptake.
• Implement use of combined Social Care Placement and Health Consent form to further improve timeliness of initial health assessments.
• Implementation of the Health Improvement clinic by the HIP as part of the IHA, to facilitate follow up of health recommendations and provide advice and single point of contact for carers and young people who have difficulty navigating the health care system.
• Develop and pilot a ‘Health Passport’ for each looked after child /young person which will hold important health information and serve as a communication tool for health appointments and facilitate implementation of health care plans.
• Finalise and implement use of a short health questionnaire for young people who refuse health assessments.
• Improve liaison with Leaving Care team: LAC health representative to attend future Leaving Care transition planning meetings and Care Pathways manager’s meetings.
• In response to the Ofsted inspection finding that not all care leavers had received their Health Discharge Summary, review procedure for providing this and feasibility of sending an electronic document (with appropriate IT governance arrangements), to replace paper booklet.
• Undertake case work to try and identify potential reasons for the significant increase in numbers of pregnancies during 2017-2018. Monitor trends into 2018-2019.
• Further health improvement work and liaison with social workers, carers and keyworkers to improve uptake of dental care.
• Finalise CNWL guidance for management of pre and post-adoption electronic health records on SystmOne.
## 1. Looked After Children’s team work plan 2017-2018

### LAC HEALTH TEAM WORK PLAN 2017-18

<table>
<thead>
<tr>
<th>No.</th>
<th>New /continuing objectives and areas for development 2017-2018</th>
<th>Action Planned</th>
<th>Who</th>
<th>When</th>
<th>Open/ Closed</th>
<th>Action Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify and support LAC YP refusing health assessments. Improve uptake of initial health assessments (IHA) and increase use of nurse led IHA</td>
<td>Identification of LAC who are not engaging with health services. Liaise with social worker to identify factors in child’s life that may affect engagement. Check existing assessments and complete “paper based IHA” by Education/LAC academy, MALT, substance misuse teams, sexual health, missing practitioner etc. Consider different approach to undertaking assessment of health needs such as self-administered health questionnaire. Health care plan to be drawn up based on available information.</td>
<td>To be discussed at allocations meeting LAC Team member allocated to coordinate case.</td>
<td>To be operationally embedded by September 2016.</td>
<td>Closed</td>
<td>1. Improved timescale for completion of IHA by 28 days to 86% in Q4. 2. Completed self-administered health questionnaire – operational by end July ’18. 3. Process for “paper based IHA” completed – been utilised by both consultants within year</td>
</tr>
<tr>
<td>2</td>
<td>Improve links with Care Pathways and residential unit staff for 16+ LAC. Support LAC transitioning to care pathways or independent living arrangements</td>
<td>Contribution to existing life skills programmes on health topics e.g. managing minor ailments, accident prevention, and first aid with aim of reducing A&amp;E attendances and empowering young people to manage their own minor health issues. Support for YP on how to access health services including use of pharmacies and NHS websites. To support LAC YP who have an EHC plan with individual puberty, sexual health and relationships education.</td>
<td>AA KA</td>
<td>Will be ongoing. From May/June 2017</td>
<td>Close</td>
<td>HI practitioner conducts residential pathways visits to support LAC on health topics and provide specific advice re outstanding immunisations, sexual health and accessing mainstream primary healthcare. HI Practitioner focuses strongly on supporting UASC to attend hospital and other health appointments. EHCP work completed for specified LAC YP.</td>
</tr>
</tbody>
</table>
3. Implementation of health care plan after IHA
   Structured review and follow up of all health care plans within 6 weeks of IHA. Follow up visit/phone call for health promotion where indicated.
   AA
   ALR
   From Q1 2017
   Complete
   This has been in practice since Summer ‘17

4. Unmet Health needs audit
   To show benefit/added value of IHA. How well are issues identified at IHA resolved by time of RHA
   Audit of 20 random IHA’s.
   JF/ALR
   October 2017
   Complete
   Completed and presented at Camden QG Meeting April ‘18. Now a QI project for implementation in 18-19

5. User engagement survey
   To obtain feedback from foster carers and young people on their experience of initial and review health assessments.
   If possible, obtain feedback and ideas for improvement from care-leavers eg through use of focus groups.
   All team members
   December 2017
   Complete
   All responders rated the service as 90%+. No areas of improvement currently suggested by YP or foster carers.

6. IRO survey to ensure health care plans are meeting needs of LAC.
   Undertake survey of IROs (Independent Reviewing Officers): to ascertain whether health care plans (HCP) are available at each Social Care LAC review, whether HCPs are meeting the needs of LAC and how IROs ensure their implementation.
   AA
   GC
   November 2017
   Complete
   Survey completed Sept 17.
   IROs were positive about the quality of HA’s and accessibility of LAC health staff.
   IRO’s made some suggestion bout the accessibility of HA reports on the social care database. This is under discussion with LAC Social Care.
Children Looked After Health Service (Harrow)

2017/18

Emma Hedley Named Nurse CLA Harrow
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>2 New National Guidance on CLA/National changes/guidance</td>
<td>4</td>
</tr>
<tr>
<td>3 Local Information</td>
<td>5</td>
</tr>
<tr>
<td>3.1 Demographic Information</td>
<td>5</td>
</tr>
<tr>
<td>3.2 Benchmark with National Data</td>
<td>6</td>
</tr>
<tr>
<td>3.3 Local Statistics (age/gender/ethnicity)</td>
<td>8</td>
</tr>
<tr>
<td>4 Service Summary</td>
<td>14</td>
</tr>
<tr>
<td>4.1 Staffing &amp; Supervision</td>
<td>14</td>
</tr>
<tr>
<td>4.2 Governance &amp; Reporting Arrangements</td>
<td>16</td>
</tr>
<tr>
<td>5 Performance Indicators</td>
<td>16</td>
</tr>
<tr>
<td>5.1 National Targets</td>
<td>16</td>
</tr>
<tr>
<td>5.2 Local Improvement Requirements</td>
<td>17</td>
</tr>
<tr>
<td>6 CLA Team Clinical Activity</td>
<td>18</td>
</tr>
<tr>
<td>6.1 Health Assessments</td>
<td>18</td>
</tr>
<tr>
<td>6.2 Immunisations</td>
<td>21</td>
</tr>
<tr>
<td>6.3 Dental Checks</td>
<td>22</td>
</tr>
<tr>
<td>6.4 Local Requirements</td>
<td>22</td>
</tr>
<tr>
<td>7 Other Clinical Activity</td>
<td>23</td>
</tr>
<tr>
<td>7.1 Sexual Health</td>
<td>23</td>
</tr>
<tr>
<td>7.2 Teenage Pregnancies</td>
<td>23</td>
</tr>
<tr>
<td>7.3 Substance Misuse</td>
<td>24</td>
</tr>
<tr>
<td>7.4 Emotional Health &amp; Wellbeing</td>
<td>25</td>
</tr>
<tr>
<td>7.5 Training</td>
<td>26</td>
</tr>
<tr>
<td>7.6 Other (Complex Case Work)</td>
<td>27</td>
</tr>
<tr>
<td>8 Adoption &amp; Fostering</td>
<td>32</td>
</tr>
<tr>
<td>9 Service Improvements</td>
<td>33</td>
</tr>
<tr>
<td>9.1 Specific Improvements /Team Achievements</td>
<td>33</td>
</tr>
<tr>
<td>9.2 Audits (Research)</td>
<td>33</td>
</tr>
<tr>
<td>9.3 Partnership Working</td>
<td>34</td>
</tr>
<tr>
<td>9.4 User Surveys</td>
<td>39</td>
</tr>
<tr>
<td>9.5 Inspection Updates</td>
<td>40</td>
</tr>
<tr>
<td>9.6 Professional Development</td>
<td>40</td>
</tr>
<tr>
<td>9.7 Other</td>
<td>41</td>
</tr>
<tr>
<td>10 Priorities for 2018/19</td>
<td>41</td>
</tr>
<tr>
<td>Appendix 1 Glossary</td>
<td>42</td>
</tr>
<tr>
<td>Appendix 2 Health Needs Identification Tool</td>
<td>42</td>
</tr>
</tbody>
</table>
1. Executive Summary

This Annual Health Report has been written to outline the delivery of health services to Harrow’s Children Looked After Children (CLA) during 2017/18 in line with National Statutory Guidance. It reviews performance indicators, clinical work undertaken by the CLA health team, service improvements and gaps or challenges identified. A glossary of frequent teams used in this report is attached in Appendix A.

The key points below provide a short summary of areas covered within the main report. The report outlines information on children looked after demographics and provides benchmarking of local data against national statistics.

Harrow is the 12th largest borough in London with both high levels of affluence alongside significant levels of deprivation. It has an ethnically diverse population with 63.8% of its population from the Black and Minority Ethnic (BME) communities.

At the end of 2017/18, there were 159 children looked after by the London Borough of Harrow. CNWL, in partnership with Harrow Council, has achieved 96% with regard to Review Health Assessments (RHA’s) being undertaken on time, an increase of 3% from last year. This figure is both higher than statistical neighbours and the England average.

The report looks at other clinical activity including dental checks, which are again higher than both statistical neighbours and the England average. Immunisations remain fractionally below statistical neighbours by 1.2% however this has improved from last year where immunisations were 6% below statistical neighbours. 100% of children under five have had up to date developmental assessments.

The CLA Health Team have delivered a variety of training to foster carers, professionals and students, and case studies have been included to show how the CLA health team have worked with children looked after, carers and professionals.

Service improvements include the implementation of an electronic process for requesting adult health (AH) forms, updating the health information for permanency process, and improvements in the quality of health assessments with health summaries being received from GP’s. Other new ways of working include the introduction of a weekly case discussion with CLA Social Workers.

During the third year of the service, the CLA health team met 100% of their Key Performance Indicators (KPI) every month. For one consecutive quarter, 100% of children were seen within timescales which is a first in the history of the service. This success can be attributed to the strong partnership working between CNWL and Harrow Council staff.

This year CLA have been involved in the development of the ‘health needs tool’ which allows young people to decide what they would like to change to improve their health. A successful trial period was completed regarding health passports and these are now being implemented.

The CLA Health Team achieved the priorities 2017/18. The team has undertaken a project to ascertain the impact of the new Tuberculosis (TB) referral process for Unaccompanied Asylum Seeking Children (UASC) and have also completed a second Client Satisfaction Audit. These pieces of work were highlighted as priorities in last year’s annual report.

This annual report has been written with help, advice and information from the Hillingdon CLA health team, Harrow CCG and Harrow Council.
2. **New National Guidance on CLA / National changes/guidance**

The following guidance has been published in relation to CLA:

1. ‘Caring for Better Health: An investigation into the health needs of care leavers’ The Care Leavers’ Association Department of Health (DH) 2017. This report provides a comprehensive overview of the needs of care leavers. The project team worked with ten CCGs and sought the views of care leavers and professionals. The report focuses past the age of 25 years to look at the long term health consequences for this group of young people.

2. ‘Children speak out on living in care’ Children’s Rights Alliance for England 2017. This briefing paper is a forum for the voices of CLA who describe their issues around entering and leaving care. This has highlighted the inadequate support that they receive.

3. ‘Transforming children and young people’s mental health provision: a green paper’ DoH and Department for Education (DfE) 2017. This document promotes access to high quality mental health and wellbeing support. It states that some young people who need additional or specialised support should be assessed and referred quickly.


5. ‘Staying Put; Good practice guide’ The Children’s Partnership 2017. This paper outlines accommodation support for care leavers.

6. ‘Applying corporate parenting principles to looked-after children and care leavers’ Statutory guidance for local authorities; DfE 2018. This guidance provides information on the role of local authorities and how they should meet the corporate parenting principles in section 1 of the Children and Social Work Act 2017. This guidance is designed to help local authorities and partners consider the kinds of services that may be offered to CLA.

7. ‘National Transfer Scheme Protocol for Unaccompanied Asylum Seeking Children’ DfE 2018. The National Transfer Scheme (NTS) protocol for unaccompanied asylum seeking children (UASC) has been created to enable the safe transfer of children from one local authority to another. The protocol is intended to ensure that these children access the services and support they need. The scheme is based on the principle that no local authority should be asked to look after more UASC than 0.07% of its total child population.

8. ‘Measuring the wellbeing of children in care: Views from the frontline and opportunities for change’ National Children’s Bureau 2018. This research paper explores how wellbeing is measured, and is based on the views of children in Care Councils and professionals working with CLA. The report looks at the use of Strengths and Difficulties Questionnaire (SDQ) as a measuring tool but highlights due to mixed views on its use that many professionals use their own measures. The research raises particular issues around the access to specialist mental health services.

9. ‘Foster Care in England’ DfE 2018. This document reviews foster care and the needs of those young people within these placements.

3. **Local Information**

The term ‘Looked After Children’ (LAC), Children Looked After’ (CLA) and ‘Children in Care’ (CIC) are all used to refer to children who are placed into the care system. The term ‘Looked After Children’ is currently used within statutory and government documents and is used widely to refer to teams working with this group of children. However, some Local Authorities prefer the term ‘Children Looked After’ and teams are thus named to reflect this. In the past the use of ‘Children in Care’ became popular, so may also be a preferred term within some organisations.
The terms are, therefore, interchangeable, however, in Harrow this group of children are referred to as ‘Children Looked After.’

3.1 Demographic Information

The London Borough of Harrow (LBH) is situated to the north-west of London. It borders Hertfordshire to the north and other London boroughs: Hillingdon to the west, Ealing to the south, Brent to the south-east and Barnet to the east and has been in existence since 1934. In its current form it is made up of 21 wards and is the 12th largest borough in Greater London in terms of size. Harrow has both high levels of affluence in such areas as Harrow-on-the-Hill, Pinner, and Stanmore and high levels of deprivation in Wealdstone and South Harrow. Harrow is a diverse borough, having 63.8% of its population from the BME communities.

The LBH has a population of 239,056 (2011 census); Harrow Joint Strategic Needs Assessment (JSNA) for (2015-2020 states that around 243,500 people live in Harrow and just over half of them are female. Harrow is home to 55,800 children aged 0-17 and a quarter of people in Harrow are aged 18 or less, with seven percent of the population under 5 years old. The percentage of children living in poverty is just slightly above the England average but lower than the London average.

https://www.harrow.gov.uk/jsna


3.2 Benchmark with National Data Including UASC Data


Headlines from the national data on CLA published in September 2017 are as quoted below from above link for all CLA:

- Nationally The number of looked after children continues to increase; it has increased steadily over the last nine years. At 31 March 2017 there were 72,670 looked after children, an increase of 3% on 2016. The number of children starting to be looked after in 2016-17 has also risen in recent years and has increased by 2% compared with the previous year. The number of children ceasing to be looked after in 2016-17 has fallen by 2% compared with the previous year.

- The number of looked after children ceasing to be looked after, due to adoption, increased between 2011 and 2015 from 3,100 to a peak of 5,360. Last year the number of adoptions fell for the first time since 2011, by 12% and in 2017 the number of looked after children adopted have fallen again, by 8% to 4,350.

- The increase in looked after children reflects that more children started to be looked after in 2017 than ceased. For the last two years, the changes seen in the characteristics of looked after children, those who become looked after and care leavers are influenced by the unaccompanied asylum-seeking children cohort who tend to be non-white British, older children, with a main category of need of absent parenting.

- The age profile of looked after children is very similar to last year, with little change in the proportion of children in each age group. Over recent years the numbers of looked after children aged under 1 year have been decreasing; at 31 March 2017 they are down 11% on five years ago, however we did see a slight increase this year of 280 children (8%) between 2016 and 2017. There has been very little change in the number of 1-4 year olds and 5-9 year olds this year; after decreasing slightly in recent years the 1-4 year old group has stabilised around 9,200 children in 2017 and the 5-9 year old group, after increasing in recent years, has stabilised around 14,100.
And for UASC the following point are identified:

- **After a large rise in numbers last year, the number of CLA who were unaccompanied asylum-seeking children continues to increase in 2017.** The number of looked after children at 31 March 2017 who were unaccompanied asylum-seeking children increased by 6% compared to last year, up to 4,560 from 4,300 in 2016, and up 134% from 1,950 in 2013. Up to 2009 the number of unaccompanied asylum-seeking children was steadily rising to a peak of 3,900 which was 6% of the looked after children population. Between 2009 and 2013 the numbers fell to a low of 1,950 (3% of the looked after children population) before increasing again in 2017 to the levels seen in 2009 where unaccompanied asylum seeking children represent 6% of the looked after children population. Whilst we do not collect information on the nationality of looked after children, statistics on asylum applications from unaccompanied asylum-seeking children by nationality are published by the Home Office.

- **In recent years we have seen the increase in unaccompanied asylum-seeking children being largely driven by more males, however this year there is a greater increase in females – male unaccompanied asylum seeking children rose by 5% whereas female unaccompanied asylum-seeking children rose by 19% between 2016 and 2017.** However, females still only account for 390 (8%) of unaccompanied asylum seeking children looked after at 31 March 2017. There has been an increase in the numbers of unaccompanied asylum-seeking children aged 16 years and over, up 9% to 3,540, whereas the number aged under 16 years has decreased slightly by 3% to 1,020. This means 78% of unaccompanied asylum-seeking children at 31 March 2017 were aged 16 years of age and over, and 22% were aged under 16 years. This compares to 76% and 24% in 2016 and 74% and 26% in 2013.

- **There is significant variation in the number of unaccompanied asylum-seeking children across the country – many are concentrated in areas where they first make entry into the country (for example Kent, Croydon, Hillingdon).** At 31 March 2017 the number of unaccompanied asylum-seeking children in these local authorities have reduced compared to 2016. We understand this is a result of the implementation of a National Transfer Scheme from 1 July 2016 resulting in some of these children being distributed across other local authorities within the country.

National data shows that most looked after children are up to date with their health care. Although performance nationally against KPIs is decreasing. Of the 49,750 children looked after continuously for 12 months at 31 March 2017:

- 84% were reported as being up to date with their immunisations, compared to 87% in 2016 and 88% in 2015,
- 89% had their annual health check, compared to 90% in 2016 and 2015,
- 83% had their teeth checked by a dentist, compared to 84% in 2016 and 86% in 2015.


### 3.3 Local Statistics

The following information and data has been provided by Harrow Council (Corporate Parenting report June 2018):

The number of all CLA has decreased since last year. The rate of CLA per 10,000 continues to decrease since 2016/17 and remains below the England average.

Harrow to have a higher proportion of CLA aged 16+ and a lower proportion in aged 10 – 15. 47 children will be turning 18 this year and eligible for leaving care services.

Harrow has a higher percentage of males in care.

Two thirds of Harrow’s CLA population are from BME groups.
Harrow has a lower proportion of CLA in foster placements and a higher proportion in placements in the community (independent and semi-independent placements) compared to statistical neighbours.

For CLA at 31st March 2018, the top 5 need codes are 47% became looked after due to an initial need of abuse or neglect, 15% due to absent parenting, 11% due to family dysfunction, 9% due to family in acute stress and 9% due to socially unacceptable behaviour.

In 2017-18, of the 153 children who ceased to be looked after, 62 (40.5%) returned home to live with their parents or relatives.

2017-18 published data shows Harrow above statistical neighbour averages for care leavers in suitable accommodation. However, Harrow also has a lower number of care leavers who are not in education, employment and training.

Harrow have had a similar proportion of CLA who had a missing episode in 2017 compared 2016 whilst statistical neighbours’ and England trend is an increase from the previous year.

The number of all CLA has decreased since the start of the financial year, with CLA age1+ years showing a slight decrease as well.

The rate of CLA per 10,000 population in Harrow has decreased since 16/17 Q4 and continues to remain below the England average. For 2017 Harrows rate per 10,000 increased and the statistical neighbours decreased, causing Harrow to fall only marginally below their rates.

Chart 1: CLA by Age Group
Comparator data has been published for 2015-16; this shows Harrow to have a higher proportion of CLA aged 16+ and a lower proportion in aged 10 – 15.

### Table 1: Comparative Data Regarding Age of CLA

<table>
<thead>
<tr>
<th>Age</th>
<th>Under 1</th>
<th>1 to 4</th>
<th>5 to 9</th>
<th>10 to 15</th>
<th>16+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative data (%) year ending March 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrow</td>
<td>5</td>
<td>6</td>
<td>18</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>Stat Neighbour</td>
<td>4</td>
<td>9</td>
<td>16</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td>England</td>
<td>5</td>
<td>13</td>
<td>20</td>
<td>39</td>
<td>23</td>
</tr>
</tbody>
</table>

Higher numbers of CLA aged 16+ will continue to have an impact on leaving care services. It is important to note that 47 children will be turning 18 this year.

Harrow’s CLA offending rate is higher than comparators – this is being investigated and may be due to the comparatively small numbers of young people who are looked after. Furthermore, CLA are known to have higher levels of risk and vulnerability.

### Table 2: Number of CLA known to Youth Offending Team (YOT)

<table>
<thead>
<tr>
<th>Jan 16</th>
<th>Jun 16</th>
<th>Sep 16</th>
<th>Dec 16</th>
<th>Mar 17</th>
<th>Jun 17</th>
<th>Sep 17</th>
<th>Dec 17</th>
<th>Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>10</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>7</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

During 2017/18, 7 young people were in a young offender institute at the time of their health assessment, and a Comprehensive Health Assessment Tool (CHAT) was completed for them all.

![Chart 2: CLA by Gender](chart.png)
The number of females in care has decreased slightly since last quarter whilst the number of males has decreased. Comparator data shows Harrow has a higher percentage of males in care.

<table>
<thead>
<tr>
<th>Comparative data (% year ending March 2016)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Harrow</td>
<td>64</td>
</tr>
<tr>
<td>Stat Neighbour</td>
<td>59</td>
</tr>
<tr>
<td>England</td>
<td>56</td>
</tr>
</tbody>
</table>

**Ethnicity**

In line with population projections, Harrow’s Black and Minority Ethnic groups are considerably higher than England and the statistical neighbour average.

Overall two thirds of Harrow’s children looked after population are from BME groups and more in line with the local population breakdown, Mixed, Black British and other ethnic backgrounds are overrepresented in the CLA cohort.

There are no significant changes in the ethnic breakdown of the CLA cohort since the last report.
Table 3: CLA by Ethnicity

<table>
<thead>
<tr>
<th>Comparative data (%) year ending March 2016</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>Harrow</td>
<td>28</td>
</tr>
<tr>
<td>Stat Neighbour</td>
<td>47</td>
</tr>
<tr>
<td>England</td>
<td>75</td>
</tr>
<tr>
<td>Ethnic breakdown of young people aged under18, 2011</td>
<td>30.9</td>
</tr>
</tbody>
</table>

Unaccompanied Asylum Seeking Children (UASC):
Harrow borough have a smaller number of UASC compared to statistical neighbours. The numbers over the year have remained stable at an average of 30 with a high of 35. This equates to 3 new UASC being looked after by Harrow each month. However, as these children enter the UK with significant needs; this has an additional impact upon services. Of the 107 children who have remained looked after for over 12 months 11(10%) are UASC.

The number of dual allocated CLA who also have a Child Protection Plan has decreased from the previous report. The number of CLA who are UASC has also decreased from 29 to 25.

New/Ceasing CLA
The number of new and ceased CLA continues to vary, month on month. Overall the number of new CLA for 2017/18 was 9.2 compared to 14 the previous year. The average number of ceased CLA was 12.9 for 2017/18 and increase from 10.7 in 2017/16.
The percentage of all new CLA placed more than 20 miles from home has varied throughout the year, currently at 16.7%. The percentage of all CLA at the end of each month who are placed more than 20 miles from home has averaged at 20.0% for 2017/18.

A new indicator measuring the percentage of all new CLA placed more than 50 miles from mirrors the trend of children placed more than 20 miles from home and rests at 16.5%.

In order to give a balanced view, these indicators exclude looked after children who are placed with parents, adopted or are unaccompanied asylum seekers.
The chart below shows Harrow CLA placement details at 29th February 2018:

There are no significant changes to placement types. In-house foster placements remain the most common placement type accounting for 42.3% of all placements. Comparator data with statistical neighbours shows Harrow to have a lower proportion of CLA in foster placements and a higher proportion in placements in the community (independent and semi-independent placements).

4. Service Summary

4.1 Staffing & Supervision

CNWL is jointly commissioned by Harrow CCG and Harrow Council to provide the CLA health service within Harrow. The team are based at Westmead Clinic. The CCG Designated Nurse role for Harrow is now provided by Harrow CCG and the Designated Doctor role is commissioned from and hosted by the provider services for CLA.

All members of the CLA Health Team are experienced and suitably trained within their area of expertise, and all team members maintain competencies as required within the Competency Framework (RCGP/RCN/RCPCH 2015). They undertake regular appraisals and as required are subject to revalidation.
The current staffing is as follows

**Nursing Team**
Named Nurse for CLA – 30 hours per week  
Specialist Nurse for CLA – 37.5 hours per week

**Medical Team**
Designated Dr for CLA – 1PA per week  
Medical Advisor for Adoption and Fostering – 1PA per week  
GP with a special interest (GPwSI) – 2 PA’s per week

**Administrative Team**
Administrator for CLA – 37.5 hours per week

In December 2017 the GPwSI was successfully recruited to the Designated Doctor role. The training of a local GP into the Designated Doctor role is an innovative practice that was supported by Harrow CCG. The Medical Advisor post is currently being covered by the Designated Doctor and Medical Advisor for Hillingdon.

**Supervision**
The CLA health team have the following supervision arrangements in place:

- The Designated Doctor/GPwSI and the Nurses meet on a weekly basis to review and discuss cases, quality assure work undertaken and ensure consistently high quality health assessments. This provides an opportunity to discuss any concerns, compliments, areas for development and strategic issues to be addressed.

- The Designated Professionals attend Brent, Harrow and Hillingdon (BHH) safeguarding meetings every two months in their CCG roles. They also attend a quarterly North West London Designated Professionals’ CLA meeting which has been organised with the Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Collaborative (CWHHE) to discuss and work towards enhancing the commissioning arrangements and good practice for CLA across the collaborative.

- The Nurses receives individual clinical supervision every 6-8 weeks. Supervision is also provided within monthly team meetings. However arrangements are in place for case discussion and debriefing on a daily basis. The CLA health team are managed and supervised by the Named Nurse for CLA. All staff have annual appraisals, 4-6 weekly 1:1s and ad hoc meetings to promote learning, development and supervision.

- The Harrow team is co-located with the Hillingdon CLA team, and peer safeguarding supervision is undertaken within this forum. Complex cases such as children at risk of sexual exploitation are discussed providing time for reflection and learning offered. The nurses have access to discuss any safeguarding issues with the Harrow Designated Nurse for Safeguarding Children

- Clinical staff also receives support from external meetings in both CCG and provider roles:
  - Quarterly North West London CLA peer group meeting
  - Quarterly London CLA Nurse meeting
  - Quarterly CoramBAAF London and SE health group
  - Annual RCN CLA forum
  - Annual CoramBAAF conference
  - Attendance at neighbouring boroughs network event

The CLA health team have been trialling the ‘headspace’ app for meditation and mindfulness for themselves or with CLA to promote positive mental health.
Governance & Reporting Arrangements

In terms of reporting arrangements, the CLA Health Team are accountable to the Head of Children’s Services and Operations (CNWL) and have robust governance arrangements in place:

- For CNWL, the Named Nurse provides a progress report and updates to the Goodall divisional safeguarding meeting and a bi-monthly governance report for the Clinical Governance team, which provides information on KPIs, audits, incidents, compliments and complaints, policies and guidance, risks and compliance with CQC.
- The CLA Health Team have identified the lack of sharing of health information between health providers as a risk, and this remains on the CNWL risk register.
- For Harrow CCG, the CLA Health Team have continued to strengthen the partnership working, and to inform them of any issues relating to the CLA service and any areas for commissioning to consider. Joint monitoring meetings with Harrow CCG and Harrow Council are held bi-monthly.
The Specialist Nurse for CLA continues to monitor the timeliness of requests for health assessments and their completion during the weekly monitoring meetings. She is available to the Social Workers every Wednesday afternoon to discuss cases, provide support and advice. Feedback from Harrow Council continues to be very positive about the Health Team being accessible every week for the Social Workers.

The Named Nurse compiles a monthly breach report; health needs report and additional report for Harrow CCG and Harrow Council which is discussed at the bi monthly monitoring meetings. These meetings continue to be productive, transparent and positive.

The Named Nurse ensures that the team’s self-assessment of CQC key lines of enquiry (KLOEs) – being safe, effective, caring, responsive and well-led are completed on a quarterly basis. In April 2017 the CLA team had a peer review undertaken by CNWL managers to assess the team against CQC KLOEs. This resulted in a positive review and ‘interviews with staff felt they were supported and well-led, they were passionate about the service and had a good understanding of safeguarding.’

5. Performance Indicators

5.1 National Targets

Local Authorities are required to report on eleven performance indicators i.e. the National Indicator Set (NIS), which refer to looked-after children or care leavers. (903 return) The health outcomes are reported on as follows:

- Number of children looked after at 31 March who had been looked after for at least 12 months
- Number of children whose immunisations were up to date
- Number of children who had their teeth checked by a dentist
- Number of children who had their annual health assessment
- Number of children aged 4 or younger at 31 March
- Number of children aged 4 or younger whose development assessments were up to date
- Number of children identified as having a substance misuse problem during the year
- Number of children for whom an SDQ score was received.

‘Outcomes for children looked after by local authorities’ 2017:

Performance against these is reported in section 6 in this report.

5.2 Local Improvement Requirements

During 2017/18 the following targets were set by Harrow CCG and Harrow Council as set out in the joint specification: To complete 100% of CLA initial health assessments (IHAs) within 20 operational days/28 calendar days. (Operational days are Mondays to Fridays inclusive).

Initial Health Assessments (IHAs)

Exceptions: Young people who refuse, DNAs or missing children, out of area, notifications from Harrow Council later than 3 working days. The tables below show that the health team have achieved all targets for both initial and review health assessments set within the agreed service specification, and that for 4 out of 12 months achieved 100% of children seen within timescales, for IHA which is the first time this has ever occurred in the history of the service.
### Table 4: Initial Health Assessments

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</thead>
<tbody>
<tr>
<td>CNWL</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Actual</td>
<td>71%</td>
<td>60%</td>
<td>83%</td>
<td>71%</td>
<td>60%</td>
<td>100%</td>
<td>69%</td>
<td>71%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Review Health Assessments (RHAs)**

To complete 100% of CLA review health assessments (RHAs) completed on time.

Exceptions: Young people who refuse, DNAs or missing children, out of area, notifications from Harrow Council later than 3 months before the review date.

### Table 5: Review Health Assessments

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<thead>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CNWL</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Actual</td>
<td>80%</td>
<td>75%</td>
<td>72%</td>
<td>70%</td>
<td>75%</td>
<td>60%</td>
<td>80%</td>
<td>83%</td>
<td>67%</td>
<td>78%</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### 5.3 Non-Attenders

The CLA health team strive to reduce non-attendance for health assessments by engaging with young people who do not attend (DNA) by offering flexible times, venues and respecting their wishes.

For young people who DNA, follow up is via the telephone and health information is then sent with details of how to contact the CLA Health Team. This includes the ‘Handy Hints’ leaflet which has recently been updated.

Currently, the CLA health team have 5 young people who have refused to have their health assessment: this equates to 2% DNA rate – 5 out of 240 health assessments. The CLA Specialist Nurse has liaised with Social Workers, carers, birth families, health professionals and key workers to ascertain the young people’s health needs. Written health questionnaires have been sent and 3 young people have planned face to face appointments.

A health questionnaire is sent to young people who DNA and refuse their health assessment.

A health plan is produced from the questionnaire and shared with the Social Worker. To date the Team have received 3 questionnaires from young people. This method often leads the way to a telephone health assessment or a face to face assessment.

### Flexible Working with Young People who DNA or Refuse

Young person refused to attend for their IHA whilst living out of borough and had also been non-compliant with their health needs. Joint home visit arranged with youth offending worker to placement. Young person did not attend. Appointment rearranged however young person not at the placement. YOT worker spoke to young person who was at his birth mother’s home in Harrow and then drove young person to Westmead Clinic to see the Specialist Nurse for his health assessment.
6. CLA Team Clinical Activity

This section will focus on the performance of the CLA Health Team against national and local targets.

6.1 Health Assessments

Initial health assessments are undertaken at Westmead Clinic, South Ruislip. Review health assessments are undertaken at Westmead Clinic, schools, and at the child’s home, offering increased flexibility for the day, time and venue to suit the CLA to enable completion and promote engagement in health assessments.

Health promotion is discussed at every health assessment and these include also but are not limited to, physical health, emotional well-being, diet, exercise, safety, immunisations, dental care, eye care, hygiene, sexual health, substance use and prevention of radicalisation.

The CLA Health Team also assist Harrow Council in meeting national targets for CLA:
- Ensuring all Harrow CLA have an annual health assessment within timescales
- To record and report dates of dental checks following health assessment
- To report immunisation status of each CLA following health assessment
- To report up to date developmental assessments

The CLA Health Team are required to ensure all CLA have a statutory health assessment within statutory guidance i.e. within 20 working days of becoming looked after and thereafter every 6 months for under 5s or annually for over 5s.

The following data relates to all Harrow CLA (both those placed within Harrow and out of borough) and has been taken from health assessments completed April 2017 – March 2018.

**Initial Health Assessments (IHAs)**

A total of 120 requests for IHAs were received.

A total of 91 children were seen for IHAs from April 2017-March 2018. (This includes 19 children from other authorities.)

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<td>7</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>91</td>
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Of the 29 children not seen for IHAs, these included those who ceased being a CLA, as well as those children who were seen in April 2018. For all of these children, the team were still required to undertake all of the necessary processes to arrange and provide appointments.

Of the 72 (100%) IHAs completed for Harrow children, 59 (82%) were seen within 20 days of the child becoming looked after compared to 54% in 2016/17. This may be due to a decrease in the number of children becoming looked after, as well as the experience of the GPwSI.

Of the 13 not seen within 20 days of request, exceptions within KPIs applied.

**Issues contributing to the overall performance:**

Monthly data is produced for Harrow CCG and Harrow Council to show timescales of requests for IHAs. Overall, this data has shown that the most significant reason for children not being seen within 20 days of becoming looked after is late requests received.
Other issues which impacted upon meeting the statutory timescales were: DNAs, out of borough placements, children or carers who refused/cancelled appointments or could not attend, children who were missing, interpreters who DNA and children who changed placement.

Review Health Assessments (RHAs)
A total of 163 requests for RHAs were received during 2017/18 and a total of 149 children were seen for RHAs (This includes 11 children from other authorities)

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<th>Table 7: Number of RHAs completed</th>
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Harrow Council completes data on the DfE 903 return, based on those children who have remained as CLA for over 12 months: for 2017/18 this was 103 children. This figure differs from those above, as some children would have left care during the year and thus were not included in this report. Of the 103 (99) children 96.1% had an annual health assessment within time scales. Of the 4 not seen within timescales, exceptions within KPIs applied.

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<th>England 2016/17</th>
<th>Statistical Neighbours</th>
<th>Harrow 2014/15</th>
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<th>Harrow 2016/17</th>
<th>Harrow 2017/18</th>
<th>Number of CLA</th>
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<tbody>
<tr>
<td>89.0%</td>
<td>95.0%</td>
<td>82.5%</td>
<td>93.7%</td>
<td>93.0%</td>
<td>96.1%</td>
<td>99/103</td>
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The table above shows a comparison to previous years of RHA’s being undertaken within time scales. CNWL have achieved 96.1% higher than both England and statistical neighbours.

Issues contributing to the overall performance:
There is an established process to ensure that RHA requests giving the Health Team 12 weeks' notice to complete. Overall, data analysis has shown that a significant reason for children not being seen within statutory timescales is late requests received from Social Workers, other reasons included. DNAs, Out of Borough placements, children or carers who refused/cancelled appointments or could not attend, missing children, children who changed placement and children who were difficult to engage.

In order to minimise DNAs, the team contact the carer / young person by telephone/text to offer flexible venues, dates, times (as per meeting timescales). All appointments are followed up by letter with this copied to the child’s Social Worker. The Health Team have found a reminder telephone call and text before the appointment improves attendance.

The CLA Health Team work with our out of borough colleagues to minimise these problems, however, capacity issues and KPI's in out of borough (OOB) teams impact upon timescales. The CLA Health Team have a reminder system in place, contacting the OOB provider to ask for details of the appointment. Should this information be provided, the child’s Social Worker is informed. It is important to note that, despite several reminders and processes in place, CLA may still DNA their appointments.

Areas for improvement
The CLA health team have identified late requests / consents from Harrow Council Social Work teams as an area for improvement during 2018/19. The Named Nurse continues to produce monthly breach reports for the Senior Managers in Harrow Council.
Quality of Health assessments

Quality improvement has been driven by the needs of the CLA population who require a high quality health assessment. This is to ensure that their health needs are identified and recorded as smart, measurable, achievable, realistic and timely (SMART) actions on the health recommendations. Each health assessment returned to the provider CLA Health Team is reviewed by either the Designated Doctor or Named Nurse and graded as one of five categories (excellent, good, satisfactory, needs improvement, poor). Health assessments undertaken by the Designated Doctor or Named Nurse are graded independently.

An excellent health assessment results in an email to the professional who has completed the health assessment (wherever they are situated) and where possible, a copy to their manager. This often results in a ‘thank you’ email from the recipient. No health assessments received from out of borough were poor or needs improvement this year, which may be as a result of the CLA health team challenging poor quality last year.

2017-18 91 IHA’s - 91% excellent, 7% good, 2% satisfactory.
2017-18 149 RHA’s – 88% excellent, 10% good, 2% satisfactory.

The graphs show that due to a concerted effort by the CLA health team quality of health assessments is high with 98% of IHA’s and 98% of RHA’s graded as excellent or good. This can be attributed to the experience and stability of the CLA Health Team. The 2% graded as satisfactory for both IHAs and RHAs were completed by health professionals out of borough.

The Designated Nurse for Safeguarding Children (Harrow CCG) has planned to undertake a dip sample of quality of health assessments during 2018, a quality assurance mechanism for the CCG.

6.2 Immunisations

The Harrow Council returns data on the DfE 903 based on those children who have remained as CLA for over 12 months which for 2017/18 was 103 children. Of 103 children, 77 (74.8%) were recorded as up to date with immunisations.

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<th>England 2016/17</th>
<th>Statistical Neighbours 2014/15</th>
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<th>Harrow 2017/18</th>
<th>Number of CLA</th>
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<tr>
<td></td>
<td>84.0%</td>
<td>76.0%</td>
<td>66.1%</td>
<td>72.6%</td>
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<td>74.8%</td>
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Nationally, 84% are up to date on their immunisations, a slight decrease from 87% last year.
The above table shows that the rates of immunisation for Harrow CLA are below both our statistical neighbours and the national average. This continues to be an area the CLA health team has prioritised for 2018, to ensure that we are safeguarding CLA from preventable infectious diseases.

The CLA health team identified 26 CLA who were not up to date with their immunisations. A letter was sent to their carers to encourage them to book an appointment with their GP. A copy was also sent to the child’s Social Worker and Independent Reviewing Officer.

(7 had appointments booked, 3 were missing, 1 living out of the country, 1 parental refusal, 1 child with autism, 1 on remand, 12 refusers)

The Specialist Nurse for CLA has regular liaison with the School Nurses and the Immunisation Team to identify those young people not up to date and to arrange for them to be immunised. Liaison with Social Workers to obtain consents has also improved uptake of immunisations.

- The TB process that was first implemented by the CLA Health Team, in conjunction with the TB service at Northwick Park Hospital has now been reinstated. This ensures that all UASC are screened for TB and any infectious diseases in a timely way. The Health Team have also: Liaised with Social Workers and the Paediatric TB Team for a UASC diagnosed with TB living out of borough. The Specialist Nurse for CLA has liaised with the CLA health team in Brent to discuss TB referrals.

- The immunisation status of all CLA is always reviewed and information is requested from their GP and subsequently arrangements are made for any outstanding immunisations with the GP. Where relevant this is always included in the CLA health recommendations returned to the Social Worker for the health care plan. Immunisation records are shared with professionals undertaking the health assessments and with foster carers and young people.

- After every health assessment a letter is sent to all GPs with a copy of the health recommendations and this has led to emails being received from the GPs with additional data about immunisations which in turn has been updated on SystmOne. Access to the child health information system has also helped in obtaining documented evidence of immunisation history.

6.3 Introduction of quarterly immunisation monitoring with Harrow Council

Has been productive and effective in tracking children’s immunisation status.

Dental Checks

All CLA over 3 years of age are required to be registered with a General Dental Practitioner (GDP) and all CLA should have a dental check (oral check for those under 3 years).

As part of the CLA health assessment, discussion takes place to promote good dental hygiene and young people are advised to attend for 6 monthly dental checks. Should children not be registered with a GDP or have not attended a dental check, this would be recommended as part of the health plan for that child.

Of the 103 CLA identified in the Harrow Council return 90 (87.4%) were recorded as having a dental check. This is higher than both the England and statistical neighbours’ average.

6.4 Local Requirements

Registration with a General Practitioner

In order to establish numbers of CLA registered with a GP, the CLA health team assessed data taken from the SystmOne database. Every health assessment is audited for health needs and registration with a GP is one of the data areas collected. The results were as follows:

Of Harrow’s 91 CLA seen for IHA, 7 children (8%) were showing as not registered with a GP. Of the 7 children not registered with a GP at IHA

- 1 had been placed in a young offenders institute and was in the process of registration.
- 6 were newly arrived asylum seeking children and would be in the process of being registered once immigration papers were sorted.
If they do not have a GP at the initial health assessment, the CLA Health Team Administrator checks that all children have been registered with a GP within 1 month of them coming into care. For UASC liaison is made with the Northwick Surgery as this is the nearest surgery to ‘The Gayton’ – a semi-independent home for UASC. This successful partnership has developed from the training the CLA Health Team provided to the GP practice last year.

**Optician Checks**

The provider of CLA health services ensure that at every health assessment discussion relating to optician checks and wearing of glasses if prescribed is part of the assessment. Should CLA have an outstanding optician check, an up to date check is always recommended within the health plan which is returned to the child’s Social Worker, young person, carer, GP and Health Visitor or School Nurse.

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<tr>
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<td>33%</td>
<td>25%</td>
<td>20%</td>
<td>33%</td>
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<td>25%</td>
<td>43%</td>
<td>0%</td>
<td>40%</td>
<td>25%</td>
<td>67%</td>
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<td>RHA</td>
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<td>92%</td>
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<td>79%</td>
<td>100%</td>
<td>100%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>60%</td>
<td>80%</td>
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**Developmental Assessments**

All CLA aged 4 or younger are required to have their developmental assessments completed. 100% of Harrow's CLA were up to date with their developmental assessments, is the same as last year. This high level of performance has been supported by access to the child health information system which has helped in obtaining documented evidence of developmental assessments and screening tests.

### 7. Other Clinical Activity

#### 7.1 Sexual Health

The CLA Health Team ensure that each child/young person who is seen for a health assessment is provided with sexual health and relationships advice appropriate to their age and understanding. This promotes positive sexual health messages such as consent, contraception and prevention of sexually transmitted infections. Discussions with younger children include ‘the pants are private’, ‘underwear rule’, ‘growing up, and body changes’. In addition the CLA Health Team ensure that all young people from high risk countries are asked the important questions about FGM as well as identifying CLA who require additional support.

Any CLA who is or has been sexually active is advised to use contraception, have a full sexual health screen, and the HPV and Hepatitis B vaccine is promoted, as appropriate. The CLA Health Team have referred young people to local sexual health clinics and local support groups to support them with their sexual health and understanding their sexuality.

Work continues with the Harrow child sexual exploitation (CSE) manager and the Gangs Co-ordinator. The Specialist Nurse for CLA regularly attends Harrow Council’s MASE panel and the Children at Risk Panel. Following these meetings, the CLA are discussed with The CLA Named Nurse and a plan devised.

The CLA nurses assess all CLA A&E attendances received from the Paediatric Liaison Health Visitor who is based at Northwick Park A&E department. The CLA nurses follow up any concerns with social care and attend strategic meetings in serious cases.
An example of the impact of this close work is with one case example. A 17 year old female discussed at children at risk panel due to missing episodes, risk of CSE and refusal of health assessment. A written health questionnaire was completed and followed up by the CLA Specialist Nurse, with the result that the young person attended for her health assessment.

7.2 Teenage Pregnancies

The CLA health team work closely with Social Workers and Sexual Health Services to prevent unwanted teenage pregnancies within the CLA population. The team refer to sexual health services should they consider that a young person is at risk of pregnancy.

The CLA health team also work with Social Workers in cases where young people are at particular risk. This is especially important for those young people who are pregnant or have experienced a termination of pregnancy, as research shows that they are at risk of a second pregnancy within 12 months. The following data for all of Harrow’s under 18-year population is taken from CHIMAT report dated March 2017: In 2014, approximately 11 girls aged under 18 conceived for every 1,000 girls aged 15-17 years in this area. This is lower than the regional average (approximately 22 per 1,000). The area has a lower teenage conception rate compared with the England average (approximately 23 per 1,000).

The monthly joint health and sexual health clinics have stopped during this year due to the changes in the sexual health outreach nurse post.

In the last two months there have been 3 young people who have become pregnant. 2 have had terminations and 1 care leaver miscarried after an ectopic pregnancy. All have been supported by the CLA Specialist Nurse through regular liaison with the girls, their Social Workers and key workers. Liaison has occurred with the early pregnancy units at Northwick Park Hospital and Barnet Hospital, and with the British Pregnancy Advisory service.

7.3 Substance Misuse

National data shows: “The percentage of children looked after who were identified as having a substance misuse problem has remained the same since 2015. Of the 49,750 children looked after for at least 12 months in the year ending 31 March 2017, 4% were identified as having a substance misuse problem. Almost half of these (49%) received an intervention for their substance misuse problem, compared to 50% last year, and 48% in 2014. Comparable rates for all children are not available.”

Nationally substance misuse is slightly more common in males and is more common in older looked after children. 5% of males were identified with a substance misuse problems compared to 4% of females. 11% of 16 to 17 year olds were identified with a substance misuse problem in the year ending 31 March 2017, compared to 5% of 13 to 15 year olds.


In the National tables there is no data recorded for substance misuse for Harrow.

The CLA health team continue to work with partners to support young people with health advice on smoking, drug and alcohol issues. Substance misuse is discussed at an age appropriate level with CLA during their health assessment and referrals are made to Compass the locally commissioned substance misuse service, GP’s and pharmacists.

The CLA Specialist Nurse follows up an A and E attendance. A case example identified a young person with substance misuse and issues regarding their emotional well-being. As a result the CLA agreed to a referral to Compass and Harrow Horizons for support with their substance use and emotional well-being.

The CLA Named Nurse has also met with the Senior Commissioning Manager (substance misuse, public health) and Service Manager for Compass to discuss current service, referrals and data collection. This was in response to the smoking cessation service no longer being commissioned in Harrow.
7.4 Emotional Health & Wellbeing

Nationally 76% of CLA had completed a strengths and difficulties questionnaire (SDQ) with the average score being 14.7 for males and for females (overall average 14.1). Almost half (49%) had ‘normal’ scores recorded with 12% having ‘borderline’ scores and 38% having scores which were a cause for concern. These figures have remained fairly stable over recent years.

In Harrow, 98.9% CLA had completed SDQ recorded which is higher than the national average. The average score was 13.7 which are higher than statistical neighbours and lower than the England average.

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<td>14.1</td>
<td>12.8</td>
<td>13.7</td>
<td>98.9%</td>
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Emotional health is discussed with all CLA during their health assessments. The ‘how I feel chart’ is discussed with young children and older children use a scale of 1-10.

During 2017/18 the CLA health team have undertaken partnership work with a range of professionals in order to consider the emotional needs of Harrow CLA, as below:

- Meeting with the CLA team manager to discuss sending of scoring of SDQ with every RHA.
- Monthly meetings with CAMHS YOT to discuss the health needs of children/young people under the YOT. This meeting will be reinstated in May 2018 as the CAMHS YOT Nurse role is currently being recruited to.
- Quarterly meetings with CAMHS and CLA team manager. Liaison and discussion of CLA with CAMHS and Harrow Horizons and liaison with CAMHS services OOB.
- Linking with other local services e.g. information from the Liaison Health Visitor within the Northwick Park Emergency Department (ED) or Urgent Care Centre (UCC) relating to any CLA who attends this service with an emotional need such as self–harming behaviour.
- Meeting with manager of Harrow Horizons to ensure referral processes and pathways are in place. The CLA health team are monitoring numbers of children referred and the outcome of referrals. Harrow Horizons attended a joint meeting between CLA health, education, CLA team manager, IRO and YOT. This meeting is well-established and occurs every 6-8 weeks.

‘SDQ scores are monitored via the newly formed CLA Education and Health group which meets once a term. The group ensures that pupils with identified social and emotional needs i.e. scoring 17 or above on both the school and carer SDQs, have been referred to the appropriate professional health services. The CLA nurse monitors this.’

(Mellina Williamson-Taylor, Head teacher, Harrow Virtual School)

- Young person seen for follow up of health needs following admission to hospital for exacerbation of mental health needs. Specialist Nurse visited young person at her current placement out of borough with her key worker. Health promotion advice and contact details of CLA health team given with planned follow up visit.
- Liaison with carer, Social Worker, Head Teacher of the virtual school and out of borough CAMHS team for vulnerable young person placed out of borough. This was to ensure coordination of their health needs, including an assessment of their learning needs.

7.5 Training

The health team has delivered training to a range of professionals from health services and Harrow Council as follows.

- Training about CLA and their health needs has been delivered bi-monthly as part of the ‘partnership induction’ for Harrow Council.
• Induction training to 10 new Social Workers and students about the health needs of CLA and the CLA health service.
• Training to Social Workers and partners in Harrow Council regarding the adoption medical advice process. Over 25 people attended and feedback was positive.
• Attendance at Social Work team meetings and IRO team meetings.
• Training with Health Visitors and School Nurses. New School Nurses have met with, shadowed and undertaken joint visits with the Specialist CLA Nurse, and feedback from them has been very positive.
• CLA Named Nurse delivered a teaching session about CLA and their health needs at Oxford Brooke’s University to Health Visitors and School Nurses in training. Thank you email received from Karen Storey (Course Lead) with an evaluation showing that all students rated the session as excellent with one student commenting that it was an ‘excellent session – interesting statistics and very informative’.
• Student Nurses have also benefited from training delivered by the CLA health team.
• As a result of consultation with foster carers last year the CLA health team provided training on weaning and Down Syndrome resulting in positive feedback. A training session on puberty and hygiene has been arranged.

‘The Health Team provides professional input into the annual training scheme for Harrow Foster carers. They have provided a number of excellent training sessions for our Harrow Foster Carers on various topics such as Down Syndrome, Meeting the Needs of Looked After Children and the Adoption Medical Process. They have also attended Foster Carers Support Groups to offer advice and support. The team are professional and approachable and the ongoing information they offer to Harrow Foster Carers is invaluable. It is great that we can work together in partnership to support Foster Carers in their role in looking after Harrow’s vulnerable children.’ (Clare Sullivan Training and Development Officer, Family Placement Service)

7.6 Other (Complex Case Work)
During 2017/18 the CLA Health Team have been involved with a variety of cases which are complex and require health input.

Furthermore, members of the team have been available for telephone advice and have made visits in cases where additional support is necessary. As a result of these case discussions, members of the team have been actively involved in advocating for CLA health needs, attending reviews or professionals’ meetings and taking on the role of Lead Professional.

This area of work is both time consuming and requires the ability to work well within the multi-disciplinary team. Liaison with GP’s, Health Visitors, School Nurses and other health professionals, both in Harrow and out of borough, regarding the health needs of CLA.

Follow up home visits have been made by the Specialist Nurse for CLA regarding health needs: weight, sexual health and follow up and support regarding emotional health.

Case examples of work undertaken are given below. These have been changed to protect the confidentiality of the CLA concerned.

Health assessment for child placed out of borough. Carer cancelled review health assessment appointment due to her friends and family members affected by the Grenfell Tower fire. Appointment rearranged and child seen at school within timescales.

Discussion regarding the fire with the child as another child from her school was missing.

Discussion with carer, teachers and Social Worker regarding future support.
Specialist Nurse arranged a review health assessment at short notice at Harrow Civic Centre. Young person had been non-compliant, had lots of placement changes and had been placed out of borough. Young person moved back to Harrow temporarily and Specialist Nurse and Social Worker took the opportunity to see the young person who attended for her health assessment accompanied by her birth mother.

Specialist Nurse undertook health assessment at a specialist school for children with Autism following liaison with birth mother, Social Worker and specialist support worker.

Where a CLA has special educational needs these are discussed at every health assessment. Recommendations are made about issues to be discussed at a personal education plan (PEP) meeting and are also included in the health recommendations.

An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs. These plans are considered as part of the child’s health assessment.

Excellent partnership working via termly meetings with the Head Teacher of the virtual school ensure children’s education needs are met.

Case Study 1
Child A: 17 year old vulnerable female due to the risk of CSE and has often been reported as missing.
A has a number of unresolved health problems and although has attended a number of hospitals out of borough, A has consistently not attended follow up appointments. This has been a complex case particularly as A lives out of borough (OOB), is often missing from her placement and attends different GP’s.

Specialist Nurse for CLA attended CLA reviews and case discussions with the Social Worker to try to resolve the on-going health concerns

7.6.1 Contact made with the GP who consulted the Senior Doctor in the Practice and 2 appointments were arranged but A did not attend.
7.6.2 Following a missing episode A was admitted to an OOB Hospital.
7.6.3 Telephone contact was made to the admitting Doctor and the previous concerns were highlighted.
7.6.4 Specialist Nurse for CLA contacted the Safeguarding Nurse at the hospital to highlight the ongoing concerns.
7.6.5 Following discharge from hospital a joint visit with the Social Worker was arranged. Health needs were discussed with A who agreed to attend the local sexual health clinic with her boyfriend. Appointment was attended.
7.6.6 The review health assessment completed and health recommendations made.
7.6.7 Telephone contact with the hospital medical secretary and 3 further out patient appointments were made due to previous non-attendance. A attended appointment.
7.6.8 Telephone contact was made with A to ensure attendance.
7.6.9 Liaison with the hospital to ensure A’s health needs were met.
7.6.10 A informed Social Worker and Specialist Nurse for CLA that she was pregnant. Specialist Nurse for CLA contacted Safeguarding Nurse at the hospital OOB.
7.6.11 Referral and liaison made to the Midwifery service for vulnerable women.
7.6.12 Case discussion with Designated Doctor who liaised with the GP and Hospital.
7.6.13 Ongoing Partnership working.
Case Study 2

Child B: 17 year old male non-compliant with health professionals and appointments.
B remains under the care of the youth offending service for criminality, suspected gang involvement and missing episodes. B was not up to date with his immunisations had not attended a dentist or optician for many years.
Specialist Nurse for CLA attended Strategy meetings and regular case discussions with Social Workers about his medical needs.

- B sustained a stab wound and was admitted to ITU. Regular liaison with nursing staff and Social Worker to ensure all professionals were working together.
- B discharged himself against medical advice and refused to return to his placement. Discussions with Social Worker, YOT worker and hospital staff as B would require a medical review. This was difficult due to placement changes and lack of GP.
- B registered with a local GP and the Specialist Nurse for CLA obtained discharge letters from the hospital.
- Liaison with the hospital respiratory service medical secretary and scan and chest x rays arranged.
- Through regular liaison with the YOT worker, B was supported to attend his review health assessment with the Specialist Nurse for CLA. Health needs were discussed with B, advice was given and B agreed to attend other health appointments.
- Regular liaison with the hospital, YOT worker, placement Key Worker and Social Worker ensured that appointment dates were known and B was fully supported in attending his chest x ray and scan despite one missed appointment.
- Regular liaison with the placement Key Worker ensured that B was supported in attending a dental appointment where he had descaling and a filling. Further treatment was required but he declined to re-attend. A referral to the Specialist Dental service was made by the Specialist Nurse for CLA.
- Specialist Nurse for CLA spoke to B prior to referrals and appointments to reassure him and to ascertain his wishes.
- Regular liaison with the YOT worker and placement enabled B to attend the GP for his Immunisations which are now up to date.
- B was supported by placement staff in attending the Optician.
- B attended the Drug and Alcohol Service. Specialist Nurse for CLA referred B to the smoking cessation service and discussed the case with his GP.
- B seen at CAMHS following a joint referral from CAMHS YOT Specialist Nurse and Specialist Nurse for CLA. B will have an ADHD assessment via CAMHS as B requested.
- Ongoing work and liaison with professionals continues.
8. Adoption & Fostering

The CCG commissions from CNWL the role of Medical Advisor to the Adoption and Fostering panel for Harrow Council. In common with many CCGs this role is fulfilled by the Designated Doctor and Named Nurse in their provider roles. These roles are set out in the intercollegiate document from the Royal College of Paediatrics and Child Health, Royal College of Nursing and Royal College of General Practitioners. (RCPCH, RCN and RCGP)

The CLA Health Team are actively involved in Adoption and Fostering Panels and processes. The team meet with colleagues both regionally and nationally to discuss and develop new ways of working and have regular peer group electronic discussion to consider issues which arise plus regular face to face peer group meetings.

There have been 11 joint fostering and adoption panels between April 2017 and March 2018 compared to 9 in the previous year. The Named Nurse attended 10 out of 11 panels while the Medical Advisor/Designated Doctor attended 8 panels. A Medical Advisor attended all adoption cases. Following panel the minutes have to be read and approved within 5 working days.

The breakdown of cases discussed show that there were 6 adoption matches (8 children), 2 intercountry adopter approvals, 5 long term fostering matches and 4 connected person’s matches. There were 4 foster career approvals, 15 deregistration’s (this also includes connected persons who were granted SGO (Special Guardianship Orders) 1 case where the children returned home) and 4 annual reviews discussed at the panel.

During the year 2017/18, 18 SGO’s were granted in respect of Harrow’s looked after children. Not all of the SGO’s were presented to panel due to tight court timescales as courts superseded the panel. Although there is not a requirement for such cases to be considered by the panel, it is good practice for there to be some scrutiny and oversight of this type of permanence plan.

The Medical Advisor undertook all the Comprehensive Medical Adoption Panel Reports for the children for the agency decision maker (ADM) meeting and for the matching panels. These reports require summary of the health needs of the child and the family plus the possible consequences for the CLA. The Medical Advisor met with all the prospective adopters prior to panel to discuss the health needs of the children involved.

The Medical Advisor’s role encompasses assessment of reports on adults applying for adoption and fostering, special guardianship and connected persons. These reports are completed by the applicant’s GP and the role of the Medical Advisor is to assess any possible implications for the applicant’s ability to care for a child until the age of independence. In 2017/18, the Medical Advisor reviewed 1-2 Adult Health (AH) forms a week. Some cases were complex and require much research and liaison with other medical practitioners and Social Workers.

This year training for panel members has included Special Guardianship Orders, foster carer training and the implications of maternal alcohol and drug misuse in pregnancy.

An example of good practice is where health assessments for children placed out of borough were brought forward to enable the Medical Advisor to write a report for the agency decision maker to ensure timescales were met for the child.
9. Service Improvements

9.1 Specific Improvements / Team Achievements

During 2017/18 the CLA Health Team have continued to make improvements to the services provided and have achieved the following:

- Monthly joint commissioner meetings with CNWL, Harrow CCG and Harrow Council now reduced to bi-monthly.
- Following a successful trial period this year changes have now been made to the implementation of the health passports to ensure that young people are given their passports in a meaningful and timely manner. Additions to the health passport include: details of the NHS website for harrow health services, NHS go app and the contact information for Harrow Horizons.
- Updated Harrow Council website page about the CLA Health Team including contact details, useful websites and health information.
- Meeting with CWHHE designated professionals to discuss the implementation of the new Child Health Immunisation System.
- Introduction of weekly case discussion with CLA social work team.
- Memo sent to all Harrow GP’s via Harrow CCG to thank them for their partnership working and to highlight the need to continue to improve the immunisation status of children looked after and UASC.
- Meeting with the Senior Performance Analyst in Harrow Council to look at improving data collection and monitoring.

9.2 Audits (Research)

The CLA Health Team had identified undertaking a project to ascertain the impact of the new TB referral process for UASC as a priority for 2017/18. The executive summary is detailed below.

Unaccompanied asylum seeking children (UASC) are a specific group of looked after children in the UK who have increased and specific health needs. This project looks at four set health outcomes; dental checks, eye checks, immunisations and TB screening. Data was collected in 2016 for a sample period covering six months between June and November. Further data was then sought from stakeholders who included GP practices, social workers and young people themselves. The same outcomes measures were collected again a year later in 2017 over the same six month period.

A number of changes were implemented in this time, including reactivation of a referral system to Northwick Park Hospital Paediatric TB services directly from the Children Looked After (CLA) team, visiting a GP surgery where the majority of UASC register, attending two Harrow UASC forums to educate and gain the views of the young people and attending the UASC social worker team meeting to ascertain their views.

In addition, the importance of immunisations was promoted by contacting all local GPs, giving the young person a copy of the schedule in their appointment and highlighting the priority of immunisations to the independent review officer (IRO) in order for the message to be reinforced to social workers.

The results showed an overall four fold improvement in rates of TB screening and immunisations from 22% to 83% compliance. There was with a slight decrease in rates of dental and eye checks. The health needs of the 2017 cohort were analysed to reveal a number of primary care complaints, mostly related to Dermatology and Musculoskeletal problems. In addition, 55% of these young people required dental treatment and/or glasses to correct vision.

In addition, the health outcomes of the 2016 cohort were followed up a year later and showed that all outstanding needs were either in the process of being met or the young person had turned 18 years old and was no longer under the care of Children’s Services.
Future service provision and education will encompass continued education and support to social workers, primary care staff and young people to ensure high levels of achievement are continued across these importance health areas.

Quality Improvement Project UASC report

9.3 Partnership working

The CLA health team continue to develop strong partnership working with a wide range of professionals and clients in order to maintain a high standard of care. Members of the CLA health team are actively involved in the following partnership roles:

- Harrow CCG and Harrow Council
- Weekly monitoring Meetings with Harrow Council
- Attendance at Social Work team meetings
- Business Support Officers at Harrow Council
- ‘Beyond Limits’ – children and young people’s council
- Northwick Park Hospital A&E Liaison Health Visitor and Paediatric Liaison Nurses
- Head Teacher of Virtual School
- Harrow Horizons
- CAMHS and CAMHS Youth Offending Team (YOT)
- Health Visitors, School Nurses and the Immunisation Team
- Harrow GP’s
- Children’s Participation Officer
- Foster Carer Training and Development Officer
- Harrow Council Learning and Development Officer
- CORAM Partnership Team
- Specialist Nurse for CLA attends monthly MASE meeting and Children At Risk Panel
- Attendance and initiation of strategy meetings and professional meetings for CLA both in Harrow and out of borough including CLA reviews
- CLA health team continue to meet with the Head Teacher of the Virtual School, CLA Team Manager and the YOT on a 6-8 weekly basis
- Quarterly meetings with CAMHS and CLA Team Manager

The Specialist Nurse for CLA has liaised with the Brent CLA health team regarding A and E attendances and to look at closer partnership working.

Links have been made with both the Camden and Milton Keynes CLA teams.

CNWL colleagues have been working to develop a local policy for the recording of data for children who are in the process of being adopted/have been adopted. It was expected that an agreed policy would be in place during 2017/18. However, due to the complex nature of this issue, a policy has not yet been formulated. No comprehensive national guidance is currently available, although the CLA project manager at NHS England has put forward proposals for consideration at a national level.

Joint working and sharing of learning between the Harrow CLA Health Team and the Hillingdon looked after children’s health team.
### 9.3.1 Involvement of CLA and Care Leavers

- Harrow CLA Health Team have undertaken significant work to involve CLA and care leavers.
- Met with the ‘Beyond Limits’ CLA and care leavers group along with the Children’s Participation Officer to obtain the child’s voice in the development of the CLA health service.
- Met with young people at the Corporate Parenting Board.
- The CLA health team attended the CLA awards ceremony at the Hive. This was a wonderful celebration.
- CLA Specialist Nurse and GPwSI attended Care Leaver conference. The theme for the event was cultural diversity. The CLA health team asked the young people to undertake a health quiz and to obtain their views about health. 40+ Care Leavers attended with many participating in having their height and weight checked.
- Presentation at Leaving Care Forum to 50 UASC and Care Leavers regarding general health and TB. Positive feedback from young people and from Councillor Christine Robson-Children’s Portfolio Holder.
- Health quiz included in ‘Particp8’ magazine for CLA. Children’s participation officer analysed the responses and shared the results with the CLA health team to enable targeting of health issues.
- Since 2017, local authorities have a responsibility to support care leavers to the age of 25 years. The CLA health service does not undertake formal health assessments for young people over the age of 18 but continues to offer health advice and signposting to adult services where needed.
- Children and young people’s comments and views form is given to each child looked after following their health assessment. Some of the following comments have been received:

<table>
<thead>
<tr>
<th>Comment</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that this thingy was really good for my health</td>
<td>(7)</td>
</tr>
<tr>
<td>Gave me more ideas and things to think about to do in summer like other sporty activities. I liked the way she was interested in the thing I enjoy doing. Gave me a list of people I could talk to if I’m upset. Sorted out a big problem. Overall I am happy with the way the assessment went</td>
<td>(17)</td>
</tr>
<tr>
<td>I found this very very good because Laurie asked if I wanted to be seen alone or not and not many people ask you that! Everything went well</td>
<td>(11)</td>
</tr>
<tr>
<td>I thought the review went good because I could tell the doctor everything about my health</td>
<td>(13)</td>
</tr>
<tr>
<td>It good for me</td>
<td>(6)</td>
</tr>
<tr>
<td>I found this very very interesting and I liked the fact that we always have the same nice person instead of having different people every health care meeting! P.S you are the best health caring person ever!</td>
<td>(8)</td>
</tr>
</tbody>
</table>
I thought it was quite helpful and useful. Now I am able to know a variety of new stuff that I hadn't been before all about me (13)

It was good and fun (10)

Little bit good. I answered hard questions

I think it was very useful and I found out a lot of different ways I can change for the better and I felt comfortable saying private things (16)

I don’t want to ask me about my step dad

This assessment went exactly how I expected it to go (12)

Good listener, nice (13)

Very good. The doctor is friendly and kind (16)

It was ok (15)

It went well good questions and it helped to speak about things that stress me out (17)

9.4 Feedback

Feedback from Partners:

On behalf of the CLA in Harrow, we would continue to express our thanks and appreciation to the GREAT work the CLA Health professions do (Emma & Laurie) to support the positive outcomes for our CLA young people. Both Laurie and Emma continue to go ‘over and above’ their required remit to ensure that the young people remain well and healthy and receive the required health support and (at times treatment) that they require.

The two workers are a vital link to our work and without them; many young people would not achieve the positive outcomes that they currently have. The professionals work closely with our team and have built up a good working relationship with us, carers, young people, IRO and others. They attend additional meetings if and when asked and are pleased to help and support wherever needed. We actually see them as part of our CLA Team and at times forget that they are a commissioned service as they work so seamlessly with us.

To capture a word to describe them the word “GREAT” is not enough. Thank you Emma and Laurie for all you do.

(Pam Johnson, CLA Team Manager)
The partnership with the CLA Health team has been invaluable and has gone from strength to strength. Emma and Laurie are always proactive and work collaboratively with the social work team and other professional partners to ensure that the complex needs of our Children Looked After are met and that appropriate plans are put in place. They have worked hard to engage with young people who had previously been reluctant to work with professionals. Their persistence, flexibility and child centred approach has been very successful and made a significant contribution to the positive outcomes for many young people.

Emma and Laurie are very professional and consistently deliver a high standard of service to our young people and support to their colleagues. The partnership between the CLA social work team and the CLA Health team was recognised and commended at the Harrow Staff awards.

(Peter Tolley, Divisional Director Children and Young People Services (Interim))

The UASC & Leaving Care service has benefited enormously from the looked after nurse for the last 12 months.

- Looked-after children are listened to
- Takes account of their views according to their age and understanding, in identifying and meeting their physical, emotional and mental health needs
- That helps others, including carers and schools, to understand the importance of listening to and taking account of the child’s wishes and feelings about how to be healthy
- Follow the Initial Health Assessment so it is completed on time scale.
- Providing training of health awareness to young people
- Presentation to Leaving Care Forum
- Providing Sexual Health training and advice
- Support and help any health concern for looked after children

(Negus Gebeyehu, Team Manager UASC & Leaving Care Service)

The CLA Health team are always really helpful in giving the team advice on medical matters for the children and prospective adopters that we work with. They are easy to contact and always available to give advice and support. Over the years we have had a number of cases of children with additional needs who require an adoptive family; the CLA health team always go that extra mile to research the varying medical conditions and provide advice on what the child’s future needs may be and what the prospective adoptive family will need to understand.

The CLA health team have met with all prospective adopters. This has been through either individual meetings or as part of a Child Appreciation Day. Every prospective adopter has found these meetings informative and reassuring. Overall we feel that we have had an outstanding service which we very much appreciate.

(The Coram Harrow Partnership Team)
9.4 User Surveys

The CLA health team undertook a client satisfaction survey to discover how CLA rate the health assessment service provided. This took place between September 2017 and January 2018.

All CLA who attended for their appointment in Harrow were given the opportunity to provide feedback. Our criteria included all CLA, however if the child was not able to complete the questionnaire, their carer was asked to complete this on their behalf.

In total 58 questionnaires were returned in comparison to 48 last year. This represented 34% of the total number of Harrow Children Looked After (172 average between September and January). This is an increase of 9% from last year. The samples are representative of the total Harrow CLA population and cover both IHA and RHAs.

Results continue to show a high rate of satisfaction with 98% rating the health assessment as great or good. This is a 2% increase from last year's figure of 96%.

As part of our family and friends survey, 95% said they would “definitely” or “likely” recommend us to other children looked after. This is an increase of 1% from last year.

Young people were asked if they felt that they were treated with respect of which 100% responded positively. As respect is a CNWL core value, this is an essential requirement for the service.

CLA are encouraged to provide a comment in relation to their health assessment. 55 out of 58 wrote responses this equates to 95% an increase of 10% from last year.

Some comments are shown below:

<table>
<thead>
<tr>
<th>Feedback from birth parents, family members and carers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Dear Emma thankyou so much for your patience and tenderness. All your advice is much appreciated. What a very warm welcome!’ (Birth Father)</td>
</tr>
<tr>
<td>‘Very good, got all information needed about baby and myself. The doctor was very pleasant and the health assessment went well. No concerns and I don’t think anything needs to be improved’ (Birth Mother)</td>
</tr>
<tr>
<td>‘I found it very good and helpful’ (Birth Mother)</td>
</tr>
<tr>
<td>‘I was a bit apprehensive about the appointment but it turned out great. Very relaxed way of talking about my nephew and finding tips on how to help him. Was also recommended a website I intend on visiting’ (Aunt)</td>
</tr>
<tr>
<td>‘Very professional, warm and lovely interaction with X’ (Aunt)</td>
</tr>
<tr>
<td>‘The doctor was efficient pleasant and great with the baby. Not too intrusive so the medical was over quickly’ (Carer)</td>
</tr>
<tr>
<td>‘Very polite and helpful had a very good experience and very happy’ (Carer)</td>
</tr>
<tr>
<td>‘It was helpful to have baby weighed and checked to make sure she is developing well and on target’ (Carer)</td>
</tr>
</tbody>
</table>
This is the second Harrow CLA Audit completed by the CLA health team and findings have been positive. Results are good and staff are to be congratulated on this. We plan to re audit in July 2018 to compare this year’s results.
9.5 Inspection Updates

No inspections of the CLA health services by CQC or Ofsted were undertaken during 2017/18.

9.6 Professional Development

The CLA Health Team ensure that all staff have the required training and development opportunities in order to provide excellent services to Harrow CLA.

The CLA Health Team have initiated clinical learning afternoons which provide time for team members to share relevant information and feedback from courses. This then enhances practice and improves the outcomes for CLA. During the two sessions held this year topics have included: research based information on burnout, loneliness, the provision of Book start and evaluating quality tools. Guest speakers have also been invited to these sessions providing valuable insight into the needs of UASC and how to identify when a young person may be at risk of radicalisation. On review, these events are informative and the team plan to continue to hold them during the coming year.

During 2017/18 the CLA health team have continued to ensure that team members have attended training in order to ensure safety and compliance with the knowledge, skills and competencies outlined in guidance for health staff (RCN, RCPCH March 2015).

Staff have undergone a range of training sessions including the following training: Mandatory training:
CNWL North West London CLA peer review group
RCN National Conference for CLA Nurses
Designated Professionals Updates – Brent, Harrow and Hillingdon
CCG Trafficking and Modern Slavery – Harrow SCB
Team away day – update on domestic abuse Autism Awareness – CNWL

All team members have completed Mosaic training – Harrow Council
Administrator for CLA health team has commenced CNWL administration apprenticeship course
Learning event for London Named and Designated CLA Nurses – level 4/5 safeguarding training

The CLA health team had a poster presentation accepted for the national RCN children looked after nurses’ event. The abstract for submission highlighted the involvement of CLA in the improvement of the service, the development of health literature and the joint partnership working with Harrow CCG and Harrow Council to improve the health outcomes for CLA.

9.7 Other – New Processes

9.7.1 The CLA Health Team have developed and introduced a ‘health needs tool’ to allow young people to decide what they want to talk about and to rate the importance of health issues for them. This allows the young person to decide what they want to change to improve their health. (See Appendix 2)

Comment from young person who trialled the health needs tool and feedback that it was ‘really good and informative. I like the worksheet, allowed us to clearly discuss issues and improvement towards my health’ (16).

Further process work completed in 2017/18:

9.7.2 Updated the health information for permanency process.

9.7.3 CLA health team administrator asked to input outstanding NHS numbers onto Mosaic. Process now in place for this to commence via MASH.

9.7.4 Inputting of immunisation status and dental checks directly onto Mosaic.

9.7.5 Medical Advisor liaised with Senior Neonatologist to ensure that foster carers are given information about both immediate concerns and more information about a case involving possible long term problems. As a result this will now be embedded into routine practice in the neonatal unit.
10. Priorities for 2018/19

The following have been identified as areas for local improvement within 2018/19:

- To continue to work with managers in Harrow Council to improve the timely requests for initial and review health assessments
- Work with Beyond Limits (Harrow Council Children Looked After Council) on a variety of initiatives, such as care leaver services to inform service planning and delivery
- To fully implement Care Leaver Health Passports
- To continue to work with Harrow Council and Harrow CCG to improve the uptake of immunisations for CLA. Using CHIS to monitor this information.
- To ascertain the health needs of the over 13 year age group to ensure optimum holistic care. This may include exploration of mental health, substance misuse or sexual health issues.

Emma Hedley - Named Nurse CLA
Individuals from the CLA Harrow Health Team have contributed to this report.
Thank you to the Hillingdon Looked After Children’s Health Team for their continued support.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>ADM</td>
<td>Agency Decision Maker</td>
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<tr>
<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
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<tr>
<td>BHH</td>
<td>Brent, Harrow and Hillingdon</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CLA</td>
<td>Children Looked After</td>
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<td>ChiMat</td>
<td>Child and Maternal Health Observatory</td>
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<tr>
<td>CNWL</td>
<td>Central and North West London NHS Foundation Trust</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>DNA</td>
<td>Did Not Attend</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>GDP</td>
<td>General Dental Practitioner</td>
</tr>
<tr>
<td>GP/ GPwSI</td>
<td>General Practitioner/ General Practitioner with Special Interest</td>
</tr>
<tr>
<td>HSCB</td>
<td>Harrow Safeguarding Children Board</td>
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<tr>
<td>IHA</td>
<td>Initial Health Assessment</td>
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<tr>
<td>IRO</td>
<td>Independent Reviewing Officer</td>
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<tr>
<td>ITU</td>
<td>Intensive Therapy Unit</td>
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<tr>
<td>KLOE’s</td>
<td>Key Lines of Enquiry</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
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<tr>
<td>LAC</td>
<td>Looked After Children</td>
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<tr>
<td>LBH</td>
<td>London Borough of Harrow</td>
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<tr>
<td>MASE</td>
<td>Multi-Agency Sexual Exploitation</td>
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<td>MASH</td>
<td>Multi-Agency Safeguarding Hub</td>
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<td>NHSE</td>
<td>NHS England</td>
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<td>NIS</td>
<td>National Indicator Set</td>
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<td>OOB</td>
<td>Out of Borough</td>
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<tr>
<td>PA’s</td>
<td>Programmed Activities</td>
</tr>
<tr>
<td>PEP</td>
<td>Personal Education Plan</td>
</tr>
<tr>
<td>RCPCH, RCN AND RCGP</td>
<td>Royal College of Paediatrics and Child Health, Royal College of Nursing and Royal College of General Practitioners</td>
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<tr>
<td>RHA</td>
<td>Review Health Assessment</td>
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<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td>SGO</td>
<td>Special Guardianship Order</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UASC</td>
<td>Unaccompanied Asylum Seeking Children</td>
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<td>UCC</td>
<td>Urgent Care Centre</td>
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<tr>
<td>YOT</td>
<td>Youth Offending Team</td>
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</table>
APPENDIX 2

Health Needs Identification Tool
Annual Health Report for Looked After Children
London Borough of Hillingdon
Hillingdon CCG

CNWL Looked After Children Health Service
(Hillingdon)

2017/18

Deborah Price Williams
Chisholm
Designated Dr for LAC
Nurse for LAC
Medical Advisor for Adoption and Fostering

Teresa
Designated
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>2 New National Guidance on LAC / National changes/guidance</td>
<td>4</td>
</tr>
<tr>
<td>3 Local Information</td>
<td>6</td>
</tr>
<tr>
<td>3.1 Demographic Information</td>
<td>6</td>
</tr>
<tr>
<td>3.2 Benchmark with National Data</td>
<td>7</td>
</tr>
<tr>
<td>3.3 Local Statistics (age/gender/ethnicity)</td>
<td>8</td>
</tr>
<tr>
<td>4 Service Summary</td>
<td>10</td>
</tr>
<tr>
<td>4.1 Staffing &amp; Supervision</td>
<td>10</td>
</tr>
<tr>
<td>4.2 Governance &amp; Reporting Arrangements</td>
<td>11</td>
</tr>
<tr>
<td>5 Performance Indicators</td>
<td>13</td>
</tr>
<tr>
<td>5.1 National Targets</td>
<td>13</td>
</tr>
<tr>
<td>5.2 Local Improvement Requirements</td>
<td>14</td>
</tr>
<tr>
<td>6 LAC Team Clinical Activity</td>
<td>15</td>
</tr>
<tr>
<td>6.1 Health Assessments</td>
<td>15</td>
</tr>
<tr>
<td>6.2 Immunisations</td>
<td>18</td>
</tr>
<tr>
<td>6.3 Dental Checks</td>
<td>18</td>
</tr>
<tr>
<td>6.4 Local Requirements</td>
<td>19</td>
</tr>
<tr>
<td>7 Other Clinical Activity</td>
<td>20</td>
</tr>
<tr>
<td>7.1 Sexual Health</td>
<td>20</td>
</tr>
<tr>
<td>7.2 Teenage Pregnancies</td>
<td>21</td>
</tr>
<tr>
<td>7.3 Substance Misuse</td>
<td>21</td>
</tr>
<tr>
<td>7.4 Emotional Health &amp; Wellbeing</td>
<td>21</td>
</tr>
<tr>
<td>7.5 Training</td>
<td>22</td>
</tr>
<tr>
<td>7.6 Other (Complex Case Work)</td>
<td>23</td>
</tr>
<tr>
<td>8 Adoption &amp; Fostering</td>
<td>32</td>
</tr>
<tr>
<td>9 Service Improvements</td>
<td>33</td>
</tr>
<tr>
<td>9.1 Specific Improvements / Team Achievements</td>
<td>33</td>
</tr>
<tr>
<td>9.2 Audits (research)</td>
<td>34</td>
</tr>
<tr>
<td>9.3 Partnership working</td>
<td>34</td>
</tr>
<tr>
<td>9.4 User survey</td>
<td>35</td>
</tr>
<tr>
<td>9.5 Inspection Updates</td>
<td>36</td>
</tr>
<tr>
<td>9.6 Professional development (and publications)</td>
<td>36</td>
</tr>
<tr>
<td>9.7 Other</td>
<td>37</td>
</tr>
<tr>
<td>10 Priorities for 2018/19</td>
<td>38</td>
</tr>
<tr>
<td>Appendix 1 Glossary</td>
<td>39</td>
</tr>
<tr>
<td>Appendix 2 2016/17 Annual Report</td>
<td>40</td>
</tr>
</tbody>
</table>
1 Executive Summary

This Annual Health Report has been written to outline the delivery of health services to Hillingdon’s Looked After Children (LAC) during 2017/8 in line with National Statutory Guidance. It reviews performance, clinical work undertaken by the LAC health team, service improvements and gaps or challenges. The key points below provide a short summary of areas covered within the main report.

At the 31st March 2018, there were a total of 290 children looked after by the London Borough of Hillingdon and 526 who had been looked after at some point throughout the year, (LBH) The report provides information relating to the demographics of LAC within the borough and makes comparison with national data. 79.9% had up to date immunisations and 89.9% up to date dental checks. 93.3% of LAC reported for the 903 return had an up to date health assessment.

The report shows that the LAC health team in Hillingdon have robust governance arrangements in place and provide an effective, caring and well led service for these vulnerable children.

The report highlights the CNWL LAC health team’s performance against local key performance indicators (KPIs). The report shows that 99% of IHAs and 100% of RHAs have been achieved as per the required CCG targets.

During 2017-18 a new electronic system of referral from LBH to the CNWL team was established. This partnership work has resulted in a significant improvement in meeting timescales for RHAs. There are plans in place for this the system to be introduced for IHA referrals during 2018-19.

The report showcases four examples of how well the CNWL LAC health team work with complex cases. LAC have a range of complex needs and the examples used show the important role the team play in coordinating health needs and working with other partners to improve health outcomes.

The report notes the importance of listening to young people, and the 2017 client satisfaction survey shows 98% of LAC would recommend the service, with 100% stating that they had been treated with respect.

The report outlines the achievements over the last year, which includes work with LBH on a health document to assist social workers, and work with care homes to improve the service provided to LAC in children homes.

Finally the team have highlighted some of the priorities for 2018-19 which include working with Hillingdon CCG to address transition needs and to work on improving immunisation data and updating TB pathways.

2 New National Guidance on CLA / National changes/guidance

Some of the following guidance has been published in relation to LAC.

1. ‘Caring for Better Health: An investigation into the health needs of care leavers’ The Care Leavers’ Association DoH 2017

This report provides a comprehensive overview of the needs of care leavers. The project team worked with ten CCGs and sought the views of care leavers and professionals. The report focuses past the age of 25 years to look at the long term health consequences for this group of young people.
2. ‘Children speak out on living in care’ Children’s Rights Alliance for England 2017
This briefing paper is a forum for the voices of LAC who describe their issues around entering and leaving care and the inadequate support that they receive.

3. ‘Transforming children and young people’s mental health provision: a green paper’ DoH & DfE 2017
This document promotes access to high quality mental health and wellbeing support. It states that some young people who need additional or specialised support should be assessed and referred quickly.

This document provides a review of foster placements, experiences of young people and their outcomes.

5. ‘Staying Put; Good practice guide’ The Children’s Partnership 2017
This paper outlines accommodation support for care leavers.

6. ‘Applying corporate parenting principles to looked-after children and care leavers’ Statutory guidance for local authorities; DfE 2018
This guidance provides information on the role of local authorities and how they should meet the corporate parenting principles as in section 1 of the Children and Social Work Act 2017. This guidance is designed to help local authorities and partners consider the kinds of services that may be offered to LAC.

7. ‘National Transfer Scheme Protocol for Unaccompanied Asylum Seeking Children’ DfE 2018
The National Transfer Scheme (NTS) protocol for unaccompanied asylum seeking children (UASC) has been created to enable the safe transfer of children from one local authority to another. The protocol is intended to ensure that these children access the services and support they need. The scheme is based on the principle that no local authority should be asked to look after more UASC than 0.07% of its total child population.

8. ‘Measuring the wellbeing of children in care: Views from the frontline and opportunities for change’ National Children’s Bureau 2018
This research paper explores how wellbeing is measured, and is based on the views of children in care councils and professionals working with LAC. The report looks at the use of Strengths and Difficulties Questionnaire (SDQ) as a measuring tool, however, due to mixed views on its use, many professionals use their own measures. The research raises particular issues around the access to specialist mental health services.

9. ‘Foster Care in England’ DfE 2018
This document reviews foster care and the needs of those young people within these placements.
3 Local Information

The term 'Looked After Children' (LAC), Children Looked After' (CLA) and 'Children in Care' (CIC) are all used to refer to children who are placed into the care system. The term 'Looked After Children' is currently used within statutory and government documents and is used widely to refer to teams working with this group of children. However, some Local Authorities prefer the term 'Children Looked After' and teams are thus named to reflect this. In the past the use of 'Children in Care' became popular, so may also be a preferred term within some organisations.

The terms are, therefore, interchangeable, however, in Hillingdon this group of children are referred to as 'Looked After Children'.

3.1 Demographic Information

The London Borough of Hillingdon (LBH) is the second largest and westernmost London Borough and has been in existence since 1965. The population density varies between the semi-rural north and urban south. Office for National Statistics Sub-national population projections estimate that in 2017 there are 309,300 people living in Hillingdon. 23,100 (7.5%) are aged 0 to 4 years and 43,500 (14.0%) are aged 5 to 15 years. 202,400 (65.4%) Hillingdon residents are of working age (16 to 64 years). 21,400 are aged 65 to 74 (6.9%) and 19,000 (6.1%) are aged over 75. Hillingdon is an ethnically diverse borough with 47% of residents from Black and Minority Ethnic groups.

The figure below shows the trend in the population size of each age-band and is copied from the above link.

![Population size, Hillingdon (2014 to 2024)](source)

3.2 Benchmark with National Data

Headlines from the National data published September 2017 are as quoted below from above link for all LAC:

[Links to national data sources]
The number of looked after children continues to increase; it has increased steadily over the last nine years. At 31 March 2017 there were 72,670 looked after children, an increase of 3% on 2016. The number of children starting to be looked after in 2016-17 has also risen in recent years and has increased by 2% compared with the previous year. The number of children ceasing to be looked after in 2016-17 has fallen by 2% compared with the previous year.

The number of looked after children ceasing to be looked after due to adoption increased between 2011 and 2015 from 3,100 to a peak of 5,360. Last year the number of adoptions fell for the first time since 2011, by 12% and in 2017 the number of looked after children adopted have fallen again, by 8% to 4,350.

The increase in looked after children reflects that more children started to be looked after in 2017 than ceased. For the last two years, the changes seen in the characteristics of looked after children, those who become looked after and care leavers are influenced by the unaccompanied asylum-seeking children cohort who tend to be non-white British, older children, with a main category of need of absent parenting.

The age profile of looked after children is very similar to last year, with little change in the proportion of children in each age group. Over recent years the numbers of looked after children aged under 1 year have been decreasing; at 31 March 2017 they are down 11% on five years ago, however we did see a slight increase this year of 280 children (8%) between 2016 and 2017. There has been very little change in the number of 1-4 year olds and 5-9 year olds this year; after decreasing slightly in recent years the 1-4 year old group has stabilised around 9,200 children in 2017 and the 5-9 year old group, after increasing in recent years, has stabilised around 14,100.

And for UASC:

- After a large rise in numbers last year, the number of looked after children who were unaccompanied asylum-seeking children continues to increase in 2017. The number of looked after children at 31 March 2017 who were unaccompanied asylum-seeking children increased by 6% compared to last year, up to 4,560 from 4,300 in 2016, and up 134% from 1,950 in 2013. Up to 2009 the number of unaccompanied asylum-seeking children was steadily rising to a peak of 3,900 which was 6% of the looked after children population. Between 2009 and 2013 the numbers fell to a low of 1,950 (3% of the looked after children population) before increasing again in 2017 to the levels seen in 2009 where unaccompanied asylum seeking children represent 6% of the looked after children population. Whilst we do not collect information on the nationality of looked after children, statistics on asylum applications from unaccompanied asylum-seeking children by nationality are published by the Home Office2.

- In recent years we have seen the increase in unaccompanied asylum-seeking children being largely driven by more males, however this year there is a greater increase in females – male unaccompanied asylum seeking children rose by 5% whereas female unaccompanied asylum-seeking children rose by 19% between 2016 and 2017. However, females still only account for 390 (8%) of unaccompanied asylum-seeking children looked after at 31 March 2017. There has been an increase in the numbers of unaccompanied asylum-seeking children aged 16 years and over, up 9% to 3,540, whereas the number aged under 16 years has decreased slightly by 3% to 1,020. This means 78% of unaccompanied asylum-seeking children at 31 March 2017 were aged 16 years of age and over, and 22% were aged under 16 years. This compares to 76% and 24% in 2016 and 74% and 26% in 2013.

- There is significant variation in the number of unaccompanied asylum-seeking children across the country – many are concentrated in areas where they first make entry into the country (for example Kent, Croydon, Hillingdon). At 31 March 2017 the number of unaccompanied asylum-seeking children in these local authorities have reduced compared to 2016. We understand this is a result of the implementation of a National Transfer Scheme4 from 1 July 2016 resulting in some of these children being distributed across other local authorities within the country.
National data shows that most looked after children are up to date with their health care. Of the 49,750 children looked after continuously for 12 months at 31 March 2017:

- 84% were reported as being up to date with their immunisations, compared to 87% in 2016 and 88% in 2015,
- 89% had their annual health check, compared to 90% in 2016 and 2015,
- 83% had their teeth checked by a dentist, compared to 84% in 2016 and 86% in 2015


3.3 Local Statistics (age/gender/ethnicity)

On 3.4.18, a total of 293 children were looked after by LBH. 41% (121) were within the 16-18 age group compared to 28% in England in December 2017. 47% of the 16-17 year old age group were UASC with a further 20% in the 13-15 age group.

During 2017-18 78 (27%) of the total LBH LAC were UASC. As in previous years there are a number subject to age assessment; there are also some UASC who come into care in LBH and who are then are dispersed to other local authorities (from July 2016). Local LAC numbers continue to include a number of complex/young people including those subject to CSE and those with complex health needs.

Gender and age and UASC status: a breakdown of the LAC in LBH shows male; female ratio to be 64:36% compared to 56:44% nationally (Figure 3).
LBH LAC ethnicity was also compared to National data and this can be seen in figure 6. LBH LAC – 41% were of white ethnicity 24% any Asian, 18% black/British/African and Chinese and other 10%. This reflects the nationalities of the UASC population and does not reflect the local 0-18 child population.

In March 2018 57% LAC were placed within LBH with 43% placed outside the borough. LAC brought back into LBH for HA continue to provide a financial saving in addition to a significant quality benefit for the CCG.

4 Service Summary

4.1 Staffing & Supervision

Staffing
CNWL is commissioned by Hillingdon CCG to provide the LAC health service within Hillingdon. The nursing and admin team are based at Westmead clinic; medical staff are based at the Child Development Centre at the Hillingdon Hospital site.

The following table outlines the LAC team roles and staffing capacity.

<table>
<thead>
<tr>
<th>Title</th>
<th>WTE / PA</th>
<th>Total WTE</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Nurse</td>
<td>0.8 WTE</td>
<td>1 WTE</td>
<td>Management; leadership; supervision; service lead; Advises CCG; service planning;</td>
</tr>
<tr>
<td>Designated Nurse</td>
<td>0.2 WTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAC Nurse</td>
<td>0.8 WTE</td>
<td></td>
<td>Complete health assessments; promote health of complex cases;</td>
</tr>
<tr>
<td>LAC Nurse</td>
<td>0.53 WTE</td>
<td>1.33 WTE</td>
<td>Complete health assessments; promote health of complex cases;</td>
</tr>
<tr>
<td>Associate Specialist/SASG</td>
<td>4 PA’s</td>
<td>5 PA’s</td>
<td>Clinical role; adoption work; Advises CCG; service planning;</td>
</tr>
<tr>
<td>Medical Advisor for Adoption</td>
<td>1 PA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated Dr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Trainee</td>
<td>1 PA per month average</td>
<td></td>
<td>Limited clinical role;</td>
</tr>
<tr>
<td>Secretary – LAC Team</td>
<td>0.5 WTE</td>
<td>0.5 WTE</td>
<td>Arranging SLAs; arranging health assessments; ensuring robust admin systems in place</td>
</tr>
<tr>
<td>Administrator – LAC team</td>
<td>0.98 WTE</td>
<td>0.98 WTE</td>
<td>Arranging health assessments; ensuring robust admin systems in place</td>
</tr>
<tr>
<td></td>
<td>(0.5 WTE newly appointed January 2018)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 5 – Comparison of LBH and National data – Ethnicity
The CCG Designated roles in Hillingdon are commissioned by Hillingdon CCG and hosted within CNWL, which is the health provider for LAC services. The Designated Nurse has been asked to undertake a staffing comparison with statistical neighbours. This benchmarking exercise is currently being analysed and will be available during 2018/19.

All team members ensure that they undertake training for their roles and maintain competencies as required within the Competency Framework (RCGP/RCN/RCPCH 2015).

The team has recently employed a new administrator who commenced her post in January 2018. This post will primarily allow the team to promote the expansion of the electronic health assessment request system.

**Supervision**

The LAC health team have the following supervision arrangements in place:

The Designated Doctor and Nurse meet on a weekly basis to review and discuss cases, quality assure work undertaken and ensure consistently high quality health assessments are undertaken by Hillingdon staff. This well established meeting provides opportunity to discuss any concerns, compliments, areas for development and strategic issues to be addressed.

The Designated professionals attend Brent, Harrow and Hillingdon (BHH) safeguarding meetings every two months in their CCG roles. In addition, they attend a quarterly North West London Designated Professionals’ LAC meeting which has been organised with the Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Collaborative (CWHHE) to discuss and work towards enhancing the commissioning arrangements and good practice for LAC across the collaborative.

The LAC Nurses and admin team are managed and supervised by the Lead Nurse. All staff have annual appraisals, 4-6 weekly 1:1s and ad hoc meetings to promote learning, development and supervision.

The Hillingdon team is co-located with the Harrow LAC team, and peer safeguarding supervision is undertaken within this forum. Complex cases such as children at risk of sexual exploitation are discussed and time for reflection offered. Any safeguarding issues are also addressed with the CNWL Hillingdon Safeguarding Children team.

Clinical staff also receive support from external meetings in both CCG and provider roles:

- Quarterly North West London LAC peer group meeting
- Quarterly London LAC Nurse meeting
- Quarterly CoramBAAF London and SE health group
- Annual RCN LAC forum
- Annual CoramBAAF conference

**4.2 Governance & Reporting Arrangements**

The LAC health team have the following governance and reporting arrangements in place:

The Designated Doctor and Nurse have met with the Children Commissioner and Designated Nurse for Safeguarding to discuss LAC Key Performance Indicators (KPIs), achievements and service gaps. In addition the Designated Doctor and Nurse have met with the Chief Operating Officer to inform her of any issues relating to the LAC service or any areas for commissioning to consider.

The Lead Nurse attends a monthly safeguarding operational group meeting to discuss any issues relating to LAC within Hillingdon. In addition, the Lead Nurse attends the Goodall Divisional Safeguarding meeting on a quarterly basis to provide up to date quality information to senior management within CNWL.
The Lead Nurse presents a bi-monthly governance report outlining key quality information, the performance of the service, audits, incidents, compliance with CQC and any service risks.

The LAC health team had identified the late requests for health assessments as a risk, and this was entered onto the CNWL risk register. This has now been removed as this risk lies with London Borough of Hillingdon.

The Lead Nurse ensures that the team’s self-assessment of CQC key lines of enquiry (KLOEs) i.e. being safe, effective, caring, responsive and well-led, are completed on a quarterly basis.

In January 2018 the LAC team self-evaluation results were:

<table>
<thead>
<tr>
<th>KLOE Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td></td>
<td>Good</td>
<td></td>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>Requires improvement</td>
<td></td>
<td>Requires improvement</td>
<td></td>
<td>Requires improvement</td>
<td></td>
</tr>
<tr>
<td>Inadequate</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Figure 12 – KLOE self-assessment results

In April 2017 the LAC team had a peer review undertaken by CNWL managers to assess the team against CQC KLOEs. This resulted in a positive review with overall comment of ‘Interviews with staff, they felt supported and well led, they were passionate about the service, good understanding of safeguarding etc’. An action plan is in place to address areas such as paper light and Dictaphone systems.

The Designated Doctor and Nurse attend the health and wellbeing group every two months. At this forum there is an overview of health performance, any issues which prevent the timely completion of health assessments and work on projects. This group reports directly to the Hillingdon Corporate Parenting Board - the Designated Doctor and Nurse, Head of Children Services and the Chief Operating Officer for NHS Hillingdon CCG sit on this board.

The LAC health team are accessible to LBH social workers as and when advice and support is required and can be contacted via email and telephone within working hours.

5 Performance Indicators

5.1 National Targets
Local Authorities are required to report on eleven performance indicators i.e. the National Indicator Set (NIS), which refer to looked-after children or care leavers (903 return).

The health outcomes are reported on as follows:

Number of children looked after at 31 March who had been looked after for at least 12 months
Number of children whose immunisations were up to date
Number of children who had their teeth checked by a dentist
Number of children who had their annual health assessment
Number of children aged 4 or younger at 31 March
Number of children aged 4 or younger whose development assessments were up to date
Number of children identified as having a substance misuse problem during the year
Number of children for whom an SDQ score was received.

‘Outcomes for children looked after by local authorities’ 2017
5.2 Local Improvement Requirements

From April 2017 to March 2018 the LAC team have been required to meet the following KPIs set by Hillingdon CCG:

- Complete 100% of LAC Initial Health Assessments (IHAs), including Health Plan in time for the first statutory review, within 20 operational days of child coming into care.

**Numerator:** The actual number of LAC Initial Health Assessments (IHA) – including completed within 20 operational days of a child coming into care

**Denominator:** The number of children who should be seen for an IHA within 20 operational days of coming into care

Exceptions: Young people who refuse, DNAs or missing children, out of area, UASCs undergoing age assessment, late referrals i.e. not received within 48 hours of child becoming LAC, consent delays, young people in custody:

- Children have review health assessments (RHA) completed within (national) regulatory timescales (children < 5 years every 6 months, >5 years annually)

**Numerator:** Total number of LAC Review Health Assessments (RHA) conducted, in period; within statutory timescales

**Denominator:** Number of LAC due to have a Review Health Assessments (RHA), in period; to meet statutory timescales

Exceptions: Young people who refuse, DNAs or missing children, out of area, UASCs undergoing age assessment, notifications from Local Authority with less than 3 months’ notice, consent not obtained by Local Authority, young people in custody

These KPIs are based on the requirements within Statutory Guidance and are set by Hillingdon CCG.

The LAC team also assist the LBH to:

- record and report dates of dental checks following health assessment
- report immunisation status of each LAC following health assessment

6 LAC Team Clinical Activity

6.1 Health Assessments

This chapter will focus on the performance of the LAC team against national and local targets.

The LAC team have completed 99% of IHAs and 100% RHAs as per the required CCG key performance indicators for 2017/18. Breach reports have been completed on a monthly basis which includes details of all exceptions.

The following data relates to all Hillingdon LAC (both those placed within Hillingdon and out of borough) and has been taken from health assessments requested during April 2017 – March 2018. Data from LBH for the 903 return shows that 93.3% of those who had been LAC for at least one year at 31.3.18 had an up to date health assessment.

Initial Health Assessments (IHAs)

During 2017/18 the health team met 99% of IHAs seen within CCG KPI targets.

A total of 199 requests for IHA were received and 158 were seen for health assessment.
Of the 41 children not seen for IHAs, there were children missing from care at the time of the appointment (4) and those who became no longer LAC / those transferred on National Transfer scheme (28), refusers (3), long term hospital care (1) and those due to be completed after 1.4.18 (5).

For all of these children, the LAC team are still required to undertake all of the necessary processes to arrange and provide appointments. The larger number of those who became no longer LAC or transferred out often move with very short notice, and appointments are cancelled and not able to be reallocated.

Of the 158 (100%) children seen for IHA:
98 (62%) were seen within 20 days of the child becoming LAC (45% during 2016/17)
13 (13%) of children were seen and health care reports were returned within the 20 days.
1 (1%) breach occurred in July 2017 due to paperwork not being returned within the 20 days.
84 (86%) exceptions were in place.

Of the 60 not seen within 20 days of request, exceptions within KPIs applied.

In order to meet the large number of IHAs requests, the team continue to offer Dr/Nurse clinics for older LAC. This allows 6 children can be seen within one session as opposed to 3 children (seen by one clinician). The advantages are that more appointments are available to be offered to those coming into care and means that the team are able to meet timescales more effectively. The disadvantages are that these clinics are particularly busy and there is less time to address issues such as late arrivals or interpreter issues.

**Issues contributing to the overall performance – IHA**

Monthly breach reports show that reasons why children were not seen within 20 days of becoming looked after are:
- late requests from social workers
- cancellations,
- declined appointments,
- interpreters not being arranged by LBH / attending appointments
- children placed out of borough
- placement changes
- missing children
- DNAs

A large number of children are seen within 20 days of becoming LAC – one area that the provider is trying to address is the time required by the Dr to generate the detailed LAC reports within timeframes. This issue has on occasion delayed the reports being returned within 20 days.

In order to address some of the above the health team have been working closely with partners in the following ways:

**Late requests** – this has been an issue for several years, however, from April 2018, due to the extra admin capacity within the LAC team, requests will be sent from LBH to the LAC team using an electronic system. This process has been very successful in improving RHA requests, and the LAC team are hopeful that this will improve timescales for IHA requests.

**Interpreter issues** – the LAC team complete a Datix incident form for any IHA which cannot take place due to lack of interpreter. The details are then passed onto the LBH Technical Support Coordinator to investigate.
Placement changes – the LAC team have requested that LBH put into effect a process of notification of placement so that the team are made aware of any changes as soon as possible. If this is put into place, this may assist in reducing numbers of wasted appointments.

Dr admin time – in order to assist the lack of Dr time to complete health recommendations, the LAC team will be piloting a new voice recognition software in 2018 which the team hope will assist in this area.

Review Health Assessments (RHAs)

A total of 271 requests for RHA were received during 2017/18 of which 22 children were no longer LAC or did not require a health assessment leaving a total of 249 to be seen.

Of the 249 LAC to be seen, 148 (59%) were seen in statutory timescales. Of the other 101 children, 51 were seen outside of timescales. Of those 50 which have not been seen 38 are due to be seen post April 2018, 7 are refusers / persistent DNAs and 5 were requested late, placed out of borough or have had placement changes.

For those children not seen in timescales, exceptions within KPIs applied. The health team, therefore, met 100% of RHAs seen within CCG KPI targets.

The total number of children seen at March 2018 was 199 (80%).

Issues contributing to the overall performance - RHA

The Designated Nurse maintains a database of reasons which contribute to performance, which include late requests, children placed out of borough, DNAs, children or carers who refused/cancelled appointments or could not attend, missing children, children who changed placement and children who were difficult to engage.

Late requests - during 2017/18 LBH and CNWL have established an electronic way of receiving health assessment requests which has made a significant improvement in this area.

DNAs - the team continue to follow up all appointments with reminders to improve attendance. We follow the established DNA pathway for these children.

Out of borough placements - the LAC health team work with our out of borough colleagues to minimise these problems, however, capacity issues do have an impact upon timescales.

Reasons for children not being seen within statutory timescales are discussed within the Health and Wellbeing group and at Corporate Parenting Board.

Quality of Health assessments

The LAC population require a high quality health assessment, especially the IHA, to ensure that health needs are identified and recorded as SMART actions on the health recommendations. This allows the social worker to create a health plan with the LAC and carer and for this to be reviewed at each LAC review. Health assessment paperwork (both the IHA/RHA paperwork and the health recommendations) returned to the provider LAC health team are reviewed and a sample are graded (excellent, good, satisfactory, needs improvement, poor).

An excellent HA results in an email to the professional who has completed the HA (wherever they are situated) and, where possible, a copy to their manager. This usually results in a “thank you” email from the recipient.

If a health assessment other than excellent or good is received then action is taken. This can be either training within CNWL or a complaint letter to another provider. Alternative arrangements are considered where possible for the next health assessment.
28% IHA were sampled and 46% RHA. 91% of IHA were good or excellent; training has been done for those which were “needs improvement”. 97% RHA were excellent or good.

As in previous years in order to maintain quality of health assessments LAC placed within travelling distance were brought back to clinics in Hillingdon.

In 2017-18 154 LAC were placed in Hillingdon at the time of their IHA and 43 placed out borough (OB). 26 of the OB placed LAC came back to Hillingdon for the IHA. For the 15 IHA completed outside Hillingdon there were examples of excellent and good IHA both from other LAC teams and from GPs with a variety of providers and areas.

For RHA 128 LAC were placed outside Hillingdon and 143 in Hillingdon. Of those placed outside LBH 67 health assessments were completed in Hillingdon or by the CNWL LAC health team. Of those 60% were sampled for quality and 100% of the sample were graded as excellent or good (82.5% excellent and 17.5% good). Other LAC were placed in Wales (Flintshire), the Midlands (Birmingham, Manchester), London boroughs (Tower Hamlets, Islington, Merton, Haringey) and counties (Herts, Bucks, Beds, Northants, Hants, Surrey, Sussex, Kent, Berks, Cambridgeshire, Oxford, Yorkshire and Staffordshire). For those children it was too far to travel back into LBH for their health assessments. They were undertaken by LAC teams, paediatricians and GPs.

Of the 55 which were commissioned from other providers 40 health assessments were quality assured (75%). 62.5% were graded as excellent, 25% good and 12.5% as satisfactory. In general the standard of HA has improved significantly from previous years and reflects the work done by LAC teams in the UK to improve standards of health assessments. Those assured as satisfactory were completed by a LAC team, a GP and community paediatricians. Feedback has been given to the relevant services.

### 6.2 Immunisations

The LAC health team continues to work closely with local GPs and with the TB service at Hillingdon Hospital to implement a process for all UASCs to be referred for new entrant TB screening and with GPs for those over 16 who are eligible for IGRA screening as newly registered with their GP.

The immunisation status of all LAC having a health assessment is reviewed, information is requested from their GP and recommendations about outstanding immunisations made; a copy of the health recommendations is shared with the GP. Immunisation records are shared with professionals undertaking the health assessments and with foster carers and young people especially care leavers. The 903 return reports that 79.9% LAC were up to date with immunisations at the end of March 2018.
6.3 **Dental Checks**

All LAC over 3 years of age are required to be registered with a General Dental Practitioner (GDP) and all LAC should have a dental check (oral check for those under 3 years).

Within the LAC health assessment, discussion routinely takes place to promote good oral hygiene and young people are advised to attend for regular dental checks as recommended by their GDP. This may be at longer intervals than 6 months if there no concerns.

The LBH returns data on the DfE 903 based on those children who have remained as LAC for over 12 months reports that 89.9% LAC were up to date with dental checks.

6.4 **Local Requirements**

**Registration with a General Practitioner**

At health assessment appointments the LAC team review each child’s GP registration. LAC who have been recently accommodated / moved location, may be in the process of registering with a local practitioner. For newly arrived unaccompanied asylum seeking children, the registration process may take some time due to immigration status.

In March 2018 a dip sample showed that 11 children were not registered with a local GP. 10 of these children were newly accommodated or UASC. The other child was a baby who had been in hospital since birth with no opportunity to register with a GP.

Following a health assessments, the LAC team will make recommendations in the health plan if a local GP registration is required.

To ensure good communication, GPs are sent a copy of the health plan, in order for this to be recorded on the child’s main medical records.

**Optician Checks**

The CNWL LAC health team ensure that at every health assessment discussion relating to optician checks and wearing of glasses if prescribed is part of the assessment. Should LAC have an outstanding optician check, an up to date check is always recommended within the health plan which is returned to the child’s social worker.

The health team do not routinely keep this data and the London Borough of Hillingdon do not report this within the annual DfE 903 report.

7 **Other Clinical Activity**

7.1 **Sexual Health**

The LAC team are committed to improving the sexual health of LAC and the promotion of healthy relationships. They complete this in the following ways:

- All LAC are offered a statutory health assessment and sexual health / developing healthy relationships is discussed within this assessment.
- This includes discussion on sexually transmitted infections, protection through correct condom use, sexuality and available local services.
- The LAC team recommend 1:1 PSHE support for any LAC who require additional support e.g. those who have had limited information (UASCs) or those that have a history of sexual abuse. Any LAC who is or has been sexually active is advised to use contraception, have a full sexual health screen, and the HPV and hepatitis B vaccine is promoted as appropriate.
• A multi-agency sexual health meeting is chaired by LAC Nurse and this group discusses current service provision, identifies gaps and plans new ways of working.

• The LAC nurses work in partnership with the Hillingdon Chlamydia Screening Team. The nurses are able to offer condoms and screening services (e.g. chlamydia and gonorrhoea screening) to those hard to reach sexually active teenagers living in care.

• The LAC team network with all young people’s services in Hillingdon e.g. the befriending unaccompanied minors support group, Hillingdon LGBT youth group, FGM support service and Children in Care council.

• The LAC team review all LAC A&E attendances and discuss any concerns with social care, attending strategic meetings as required. Any notifications which highlight sexual assaults, LAC who may be pregnant or need support with their sexual health are followed up.

• A LAC Nurse attends the Hillingdon multi agency child sexual exploitation meeting (MASE) every 6 weeks. A large percentage of those children who are discussed at this meeting are LAC. Information from this meeting is shared within the LAC team and the LAC Nurses follow up some of the young people identified as appropriate.

7.2 Teenage Pregnancies

The LAC health team work closely with LBH social workers and sexual health services to prevent unwanted teenage pregnancies within the LAC population.

The team refer to sexual health services should they consider that a young person is at risk of pregnancy.

The LAC health team will also work with social workers in cases where young people are at particular risk. This is especially important for those young people who are pregnant or have experienced a termination of pregnancy as research shows that they are at risk of a second pregnancy within 12 months.

The following data for all of Hillingdon’s under 18 year population is taken from CHIMAT report dated March 2017:

The teenage pregnancy rate is similar to the England average. In 2015/16, 20 teenage girls gave birth which represents 0.5% of women giving birth. This is lower than the England average.

In 2014, approximately 20 girls aged under 18 conceived for every 1,000 women aged 15-17 years in this area. This is similar to the regional average (approximately 22 per 1,000). The area has a similar teenage conception rate compared with the England average (approximately 23 per 1,000).

There is no recorded data specifically for Hillingdon LAC.

The LAC health team have identified the need to provide a service to care leavers who may be most vulnerable to an unwanted teenage pregnancy and continue to discuss this gap in service with commissioners.

7.3 Substance Misuse

National data shows that 4% of all children in care (male and female) have a substance misuse problem identified. It appears from the data to be similar in males and females but reported only in 10+ age groups. Similar numbers of males and females refuse interventions. The 903 return does not show any substance misuse in LBH LAC population. Anecdotally, from both IHA and RHA this is an underestimate.
7.4 Emotional Health & Wellbeing

SDQ questionnaires were required for 62% of the LBH LAC population. 27% of those had normal scores with 25% having scores which were indicative of moderate emotional and behavioural issues. The 8% LAC had scores which indicated severe issues and which would have been discussed with the clinical psychologist in the social care team; as would those with moderately increased scores. SDQ are still not seen by the LAC health team at every health assessment and the Health and Wellbeing group of the corporate parenting board are working on improving the availability of this information for review health assessments.

7.5 Training

The team aim to offer training to a range of health service and local authority professionals. Staffing capacity remains an issue for the team, therefore, essential training is prioritised.

Health Staff

During 2017/18 the LAC health team have ensured that new health staff within CNWL have been provided with an essential induction to LAC. Health care professionals include Registrars, School Nurses, Health Visitors and student Health Visitors. In order to promote learning for student nurses, a session on the needs of LAC is also provided within their training. If health assessments are noted to be of poor quality then work is undertaken with individuals to improve this.

Social work and residential staff

During 2017/18 the LAC health team were unable to offer extensive training to social work teams, however, training for residential care home staff was offered as part of a project to support LAC in residential care.

The LAC health team are available for support should a member of the local authority staff require health information and will provide this on a 1:1 basis.

Foster carers and Children in Care

During 2017/18 the LAC health team provided 11 foster carers with sexual health training at CoramBAAF. In addition, the attended a young men’s health event at a care home and provided 15 young men with health promotion advice.

During 2018/19 the LAC team will plan to offer some update training to social workers.

7.6 Other (Complex Case Work)

During 2017/18 the LAC health team continue to work with a range of LAC who have complex health and wellbeing needs. Members of the team provide advice and support as necessary and are actively involved in advocating for LAC health needs, attending reviews or professionals meetings.

This area of work is both time consuming and cases are usually very complex. This work requires partnership and the input of the multi-disciplinary team.

A few examples of work undertaken are given below, with some changes of information to protect the confidentiality of the LAC.

Complex Case 1 - Local child with significant issues / child sexual exploitation risks.

- 17 year old, female, brought up in the UK, family have been known to social services for many years – was on child protection plans.
- Child A entered care in 2016, due to being out of parental control; child A was violent towards her sibling and has a criminal record of damage to police property. Child A disclosed she was raped at the age of 11 by a family friend.
Concerns of serious mental health issues, child A daily defecating and vomiting in her bedroom, daily binge drinking and drug taking. Under CAMHS but refusing to attend.

Placed in high support care home due to complex needs.

Bisexual was dating an unknown female in her late 20’s, then went on to meet a sex offender boyfriend in his early 20’s, and wants to have his baby, she is not on any contraception and not using barrier methods. Child A seen in cars with unknown adults

Child A sleeps in until 2pm - LAC nurse visited child A at the care home post 2pm.

Child A has asthma using her inhalers but cannot remember her last asthma review.

Child A states that the GP says she has low iron levels but she refuses to take tablets

Child A had a seizure after drinking alcohol in 2016 but says she did not attend A&E

Child A has very poor dental health and is extremely self-conscious about the appearance of her teeth.

Child A attended the local optician with her keyworker but was told she would have to pay for an eye test as not in education,

Child A admits her diet is poor, she skips breakfast and will eat when she feels like it.

Child A is smoking 75 tobacco roll up cigarettes daily and 7-8 cannabis joints a week She also takes MDMA and cocaine, she drinks rum, scotch, whiskey every other day, at a daily cost of £10, she also get substances from friends

Child A has recently had a tattoo done by a friend at his house

Child A is not in education and the keyworker is encouraging her to engage with the virtual school.

Child A is outstanding immunisations. Child A previously refuses to see a GP but agrees to attend with keyworker

LAC nurse makes a Child Sexual Exploitation referral to the local authority

LAC nurse makes contact with Child A's practice nurse at GP surgery to explain complex needs before formulating a letter of health actions to be completed. LAC nurse arranges with GP/practice nurse an appointment later in the afternoon so Child A will be out of bed and keyworker can attend with Child A.

LAC nurse formulates a care plan for the practice nurse to follow so urgent health needs can be prioritised such as asthma. Will need separate appointments for asthma, pregnancy test, seizure follow up, mental health and blood tests/immunisations.

LAC nurse did a second home visit 28.3.18 to discuss contraception and sexual health, LAC nurse facilitates a home chlamydia/gonorrhoea test and issues a condom card and condoms. LAC nurse refers young person to GUM service for full STI screening including Blood born virus screening due to unsafe sex and tattoo and Hep B vaccinations, HPV vaccination also outstanding and advised.

LAC nurse provides a letter for keyworker to take to optician to support a free eye test is part of the statutory health assessment

LAC nurse advises social worker to refer child A to a specialist dental service

Keyworker has arranged drug and alcohol intervention with child A, supporting her by being sensitive to her issues and cleaning her room daily

LAC nurse attends an urgent multi professionals meeting due to Child A’s complex needs and high risk factors, LAC nurses recent health assessment underpins the majority of issues discussed at the meeting.

LAC nurse attends MASE meeting where child A is discussed.
Child A

- RHA, Home visits at a time to suit young person
- CSE Referral
- Liaison with GP/Practice nurse and formulation of a health care plan
- Follow up home visit for sexual health support.
- Referral to GUM/contraception service
- Letter to optician to support free eye test
- Advised social worker to refer young person to specialist dentist
- Attend urgent professionals meeting
- Attend multiagency child sexual exploitation meeting MASE
Complex Case 2 – Unaccompanied asylum seeking child with complex health in transition:

- Female 17 year old unaccompanied asylum seeking child (UASC) from Eritrea
- Child B came to UK for safety reasons as her life was at risk.
- Child B not sleeping well
- Child B vomiting on several occasions per day – weight (referral made the specialist eating disorder service)
- Physical health issues due to bulimia – Referral to GP for full blood count, ECG, blood pressure (urgent referral)
- Urinary infections (referred to GP) – some concern initially re FGM
- Child B may need full STI screening
- Child B takes pride in teeth and is worried about acid erosion due to bulimia – Referral to dentist for advice and support
- Child B begins to withdraw from all – low self-esteem. Received counselling in school. Engaged with befriending group, unable to relate to peers at school as feels different.
- Stopped attending school although educationally bright. Does not feel that she fits in.
- Child B reports loneliness.
- CBT therapy needed to help control self-destructing behaviour
- As not at school Child B has lots of free time – needs to occupy time well through exercise, voluntary work, or a part time job as at risk of depression
- LAC nurse identified that Child B did not feel supported by semi-independent care home staff eg staff not taking her to appointments. Child B could not relate to her male social worker - moved placement.
- Child B is leaving care shortly.
- LAC nurse concern that Child B’s issues may escalate and that she will not access some of the necessary services / be followed up. LAC nurse believes that Child B may need assistance in ensuring her health care needs are being actioned.
- General LAC issues to be addressed
Child B

- RHA, young person seen at school
- Referral to specialist eating disorder service
- Liaison with GP/Practice nurse
- Follow up school visit with school nurse
- Referral to UASC befriending group
- Referral to specialist dentist
- Follow up home visit when child B not attending school - liaison with social worker
- Supported in moving to a more appropriate placement
- Liaison with social worker and key worker to initiate a CBT therapeutic referral
Complex Case 3 – Local child with low self-esteem / self-harm

- Child C - 11 year old, white British female.
- Entered care 2016 due to neglect
- Initial Health Assessment completed with next Review Health Assessment (RHA) due 9th January 2018.
- LAC nurse completed RHA – child C reported bullying at school and at home from another child. Child C also noted as having low self-esteem, lack of friendships, poor body image and was engaging in self-harm activities.
- LAC nurse discussed sharing of information with Child C’s carers and Child C happy for her to do this.
- LAC nurse discussed issues with carer / keyworkers
- LAC nurse made contact with Child C’s School Nurse to ensure good communication between services. Agreed that School Nurse would provide some regular support to Child C.
- LAC nurse made contact with Head Teacher, who agreed to investigate concerns and provide support.
- LAC nurse made contact with Child C’s social worker to discuss concerns and counselling support. Social worker informed LAC nurse that Child C was due to move placement and that any counselling may need to commence in the new area.
- LAC nurse made contact with clinical psychologist to highlight Child C as needing assessment and support.
- LAC nurse attended Child C’s LAC review and provided the ‘voice of the child’ within this meeting.
- LAC nurse made contact with School Nurse team leader to enquire if Child C could be seen as part of Seasons for Growth, a programme for children and young people who have experienced significant change or loss.
- LAC nurse waiting to be informed of new placement details.
Child C

- IHA and RHA
- Bullying in school and home
- Contact with School nurse team
- Contact with Child C's Head Teacher.
- Health promotion: diet, exercise, relieving anger.
- Contact with Social Work team
- Contact with keyworkers.
- Contacted clinical psychologist for advice/support.
- Concerns for Child C's emotional/mental health.
Complex Case 4 – Child showing signs of possible radicalisation

- Child D - 17 year old, male.
- Entered care 2016 as estranged from mother.
- Initial Health Assessment completed by LAC Dr.
- LAC nurse undertook home visit to ensure child compliance with Review Health Assessment (RHA)
- LAC Nurse identified concerns for Child D’s emotional and mental health. Child D showed signs of anger and hostility, lack of empathy towards female staff and other vulnerable children.
- LAC Nurse concerned that Child D could be at risk of being radicalised due to mother’s previous concerns, which she later withdrew. Child D has interest in the aviation industry.
- LAC nurse discussed Child D with staff and Care Home Manager who also shared concern.
- LAC nurse discussed case with Designated Nurse and in safeguarding supervision. Advised to take to Safeguarding Adult lead to discuss as possible Prevent case. Safeguarding Adult Lead nurse advised that Child D does not meet the threshold for referral, however, professionals meeting to be held.
- LAC nurse attended psychologist case review meeting and raised Child D’s case for discussion.
- LAC nurse discussed with Social Worker who also discussed with their Prevent lead.
- Child D moved placement due to safeguarding issues. This second placement broke down.
- LAC nurse made several contacts to ensure professionals meeting arranged – convened with decision that Child D move back into local area. Plan for male Education Officer to work with him due to lack of engagement with females.
These complex cases provide some examples of how the team work with LAC who have identified concerns which need follow up and where other named nurses e.g. health visitor or school nurses are not involved. The cases show how the team provide a holistic approach to healthcare.

The health team are aware that LAC may be particularly vulnerable or susceptible to exploitation. They are also vulnerable to poor physical and mental health needs. The children that are prioritised are those which are assessed as those that are at high risk.

The health team are aware that LAC may also be drawn towards the process of radicalisation as they may view their situations as unfair or who are searching for identity, meaning and belonging.

The number of complex cases is rising, especially those children at risk of child sexual exploitation. Complex cases will be monitored as the time taken to work with these children has a significant impact upon the health team.
Adoption & Fostering

The role of medical advisor (MA) is commissioned by Hillingdon CCG and continues to be filled by the designated doctor for LAC. The adoption MA attended 17/20 of the scheduled panels (Jan-Dec 2017) plus 2 panel training days. Panels remain fortnightly with attendance varying from half to full days according to need. A permanent panel administrator and panel advisor plus new independent chair have been appointed. Preparation for panel is equivalent to or more than time spent at panel - for example, a match requires the child's CPR plus the adults' PAR or Form F to be read plus the APR/ASP so for 45 minutes panel time there is usually 2 hours of reading time. There has been more timely distribution of panel papers electronically. Following panel the minutes have to be read and approved within 5 working days.

The MA gives advice to the panel on relinquished children and those coming to panel for a match with both prospective adopters and for long term foster care. The MA, supported by retired medical advisor from Harrow for this role for last 12m, undertakes an assessment of reports on adults applying for adoption and fostering, special guardianship and connected persons. This involves consideration of AH forms completed by GPs and a considered report written for Panels with additional advice sought from consultant colleagues if necessary. Some cases are complex and require much research and liaison with social worker, managers and consultants. The MA responsibility is to advise LBH that the adults are healthy enough to care for a child for adoption for life (until 18). With the changes to adoption and fostering promoted by the Government the number of these assessments has increased. There were 221 reports (increasing from 143 in 16-17) written between 1.1.17 and 31.12.17.

At 28.11.17 (from 1.4.17), 10 children have been placed for adoption with a further 7 in the family finding process, 14 adoption orders granted, 13 children with permanence plans, 12 pending matches, 19 Adoption support fund applications. 9 households were in the process of being approved to foster; foster carers are being brought to panel every 3 years for review. There were 41 children for whom plan is long term fostering; 16 special guardianship approvals but 83 assessments. There were 17 reg 24 approvals. In the year there had been 2 disruptions of adoptive placements.

The MA undertook all the comprehensive medical adoption panel reports for the children for the ADM meeting (29) and for the matching panels (12) but the data for special guardianship is missing from this data as is the number of reports for care proceedings/approval to place for adoption. These reports are time consuming as they require summary of the health needs of the child and the family plus the possible consequences for the LAC. The MA continues to have meetings with the majority of prospective carers for LAC placed either for a match with adopters, long term foster carers or special guardians to inform them about health needs and history of the child/ren to be placed.

Service Improvements

9.1 Specific Improvements / Team Achievements

During 2017/18 the LAC health team have continued to made improvements to the service provided and have achieved the following:

- New process of request for RHA has now been established and showing consistent improvement in the timely request for health assessments.
- All health assessments are being completed by the provider service within agreed timescales. Exceptions are monitored and feedback to CCG / LBH.
- Work undertaken with LBH to produce a health document for social care staff.
- The Hillingdon team have had several meetings with Camden and Milton Keynes LAC teams to establish links.
LAC Nurse has commenced a CNWL Management and Leadership Apprenticeship.
LAC Nurse is piloting a care home project – providing children homes with health advice and support.
LAC Nurse has presented a complex case to CNWL Board of Governors

9.2 Audits (and research)
During 2017/18 the Hillingdon LAC team did not complete any audits other than the client satisfaction survey. Results of this are provided in Survey User section of report.

9.3 Partnership working
The LAC health team continues to work in partnership with a wide range of professionals and clients in order to maintain a high standard of care. Members of the LAC health team are actively involved in a range of partnerships such as:

- Health and Wellbeing Group
- Corporate Parenting Board
- Health Visiting team for pregnant LAC
- Hillingdon safeguarding midwife
- Hillingdon Chlamydia and Gonorrhoea screening team
- Northwest London Hillingdon Contraception and GUM service
- Local Authority Youth Early intervention service
- Multi agency Child Sexual Exploitation panel
- Hillingdon Refugee Council
- Work with Children in Care Council
- Hillingdon Hospital A&E Liaison Health Visitor
- Health promotion in children’s homes – working with CASH, Youth services
- Adoption and Fostering Panel
- Colocation with Harrow Children Looked After team – this provides the team with an opportunity to share good practice, support and quality assure work
- North West London LAC Peer Group
- BHH CCG Designated Professionals meeting
- North West London Designated Professionals meeting
- NHS Hillingdon CCG QSCR Committee – annual report
- RCN Nursing Group – Designated Nurse sits on organisation committee.
- CoramBAAF Health Advisory Group – Designated Dr elected member of health committee
- LAC health staff attend London and National LAC and Adoption Forums
9.4 User survey

The LAC health team undertake an annual client satisfaction survey to review how young people rate the health assessment service which is provided. This took place between April to September 2017.

88 questionnaires were completed, a similar number to last year. The samples are representative of the total LBH LAC population, cover both IHA and RHAs and assessments completed by a range of health professionals.

Young people or their carers (if too young to respond) were asked about their health assessment experience. Results continue to show a high rate of satisfaction with 98% rating the health assessment as great or quite good.

As part of our family and friends survey, 98% said they would “definitely” or “likely” recommend us to other LAC. Young people were asked if they felt that they were treated with respect of which 100% responded positively. As respect is a CNWL core value, this is an essential requirement for the service.

Young people are encouraged to provide a comment in relation to their health assessment. Some comments are shown below:

- *It’s good because she ask about health and I told about my past easily.*
- *I’ve been examined and asked questions. For the first time I feel someone interested in my health this much.*
- *Dr as always was very receptive and attentive. She listened to all my concerns and reassured me.*
- *I think it went well and the doctor and nurse were very nice and polite.*
- *Fabulous gave us plenty of time to give information.*
- *I was able to feel comfortable when answering questions.*
- *I just had lots of bad habits which I’m going to abandon.*
- *Dr was friendly and supportive. My child played with her, she was very patient towards her.*
- *It was good. I like it. It was helpful. It was helping my body. It was fun and funny. I love it. xxxxxxxxxx I love L (social worker) ♥ I love it x ♥*
- *Discussed most of my issues and potential causes and preventions. Very welcoming hence myself being open in conversation. Progress - Problems somewhat resolved I at least know my next step.*
- *It went very well I felt comfortable and felt like I was listened to.*
- *Staff was absolutely lovely. Very polite. Gentle with baby.*
- *The assessment went very well. I was very happy to answer all questions. All my concerns were dealt with. The physical exam was good. Several health questions were good too.*
- *Nice feedback, nice nurse*
- *It was great (x 24)*

9.5 Inspection Updates

No inspections of LAC health services by CQC or Ofsted were undertaken during 2017/18. An Ofsted inspection is due during 2018/19.
9.6 Professional development (and publications)

The LAC health team ensure that all staff have the required training and development opportunities in order to provide excellent services to Hillingdon LAC.

One of the ways this is achieved is by the LAC team arranging an annual away day. This day is planned to consider areas of quality improvement, building team relationships, and meeting competencies and skills. The away day includes guest speakers who are invited to talk about their roles and provide health care updates in their specialist field. This year the Hillingdon Safeguarding Children Advisor updated the team on domestic abuse with specific discussion on the impact upon LAC. In addition, CQC Key Lines of Enquiries (KLOEs) were reviewed to ensure the team meet high quality standards. A team building exercise concluded the day.

The LAC team have also initiated clinical learning afternoons which provide time for team members to share relevant information and feedback from courses. This then enhances practice and improves the outcomes for LAC. During the two sessions held this year topics have included: research based information on burnout, loneliness, the provision of Bookstart and evaluating quality tools.

Guest speakers have also been invited to these sessions - the BHUMP coordinator (Befriending Hillingdon Unaccompanied Minors Project) and the Prevent Lead for Hillingdon provided valuable insight into the needs of our UASCs and how to identify when a young person may be at risk of radicalisation.

On review, these events are informative and the team plan to continue to hold them during the year.

In addition the LAC health team have attended the following training in order to ensure safe delivery of services and compliance with the knowledge, skills and competencies outlined in guidance for health staff (RCN, RCPCH March 2015):

- Mandatory training – CNWL
- Management and Leadership Apprenticeship - CNWL
- Adoption and fostering panel training – LBH
- RCN National Conference
- North West London LAC peer review group three monthly
- National Designated Professionals Conferences
- Designated Professionals Updates – Brent Harrow and Hillingdon CCG
- PREVENT update training
- Paediatric Asthma training – Brunel
- CSE training - Brook Sexual health
- Update for named and designated professionals level 4-5 training safeguarding
- Coram / BAAF health group meeting London
- CoramBAF HGAC
- NNDHP Safeguarding Conference Leicester - level 4

9.7 Other

Policies

The LAC health team have been working with CNWL colleagues over the past years to develop a local policy for the recording of data for children who are in the process of being adopted/have been adopted. It was expected that an agreed policy would be in place during 2017/18 however, due to the complex nature of this issue, a policy has not yet been formulated. No comprehensive national guidance is currently available, although the LAC project manager at NHS England has put forward proposals.
Committee Work

The Designated Doctor continues to sit on the National Health Advisory group committee for Coram/BAAF.

The Designated Nurse continues to work with Royal College of Nursing as part of the LAC nurse committee.

The Designated Nurse was co-chair for the London LAC Nurse Group from September 2017 – January 2018.

10 Priorities for 2018/19

During 2018/19 the LAC team will prioritise the following areas of work:

- Hillingdon CCG and CNWL to continue to work together to address capacity issues within the LAC health team
- To promote the development of a care leaver service and work with commissioners to establish a transition pathway
- To review the current TB pathway and redesign to ensure all UASCs receive a standardised service
- To review the immunisations of LAC from CHIS
- To work with commissioners on outcome focused KPIs
- To work with LBH and establish the new IHA request system
- To have paper light systems in place
- To attend a learning set with Harrow, Camden and Milton Keynes LAC teams to share good practice.
- To work with commissioners on the signing of the LAC service specification
- To pilot a new voice recognition system

Deborah Price Williams
Associate Specialist
Designated Dr for LAC
Medical Advisor for Adoption and Fostering

Teresa Chisholm
Designated Nurse for LAC

Contributions from
Katie O’Sullivan and Audra Linklater
LAC Nurses
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADM</td>
<td>Agency Decision Maker</td>
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<tr>
<td>APR/ASP</td>
<td>Adoption Placement Report / Adoption Support Plan</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
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<tr>
<td>CASH</td>
<td>Contraceptive and Sexual Health</td>
</tr>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CDC</td>
<td>Child Development Centre</td>
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<td>ChiMat</td>
<td>Child and Maternal Health Observatory</td>
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<td>CNWL</td>
<td>Central and North West London NHS Foundation Trust</td>
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<td>COO</td>
<td>Chief Operating Officer</td>
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<tr>
<td>CPR</td>
<td>Child Permanence Report</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>CST</td>
<td>Chlamydia Screening Team</td>
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<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>DNA</td>
<td>Did Not Attend</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>GDP</td>
<td>General Dental Practitioner</td>
</tr>
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<td>HA</td>
<td>Health Assessment</td>
</tr>
<tr>
<td>Hep B</td>
<td>Hepatitis B</td>
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<tr>
<td>Hib</td>
<td>Haemophilus influenza type b</td>
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<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>IHA</td>
<td>Initial Health Assessment</td>
</tr>
<tr>
<td>IRO</td>
<td>Independent Reviewing Officer</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>KICA</td>
<td>Kids In Care Award</td>
</tr>
<tr>
<td>KISS</td>
<td>Keep It Safe and Simple</td>
</tr>
<tr>
<td>KLOE’s</td>
<td>Key Lines of Enquiry</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>LAC</td>
<td>Looked After Children</td>
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<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraceptive</td>
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<td>LBH</td>
<td>London Borough of Hillingdon</td>
</tr>
<tr>
<td>Abbr.</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual, and transgender</td>
</tr>
<tr>
<td>MAPS</td>
<td>Multi Agency Psychological Support Team</td>
</tr>
<tr>
<td>MASE</td>
<td>Multi-Agency Sexual Exploitation</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles Mumps Rubella</td>
</tr>
<tr>
<td>MYE</td>
<td>Mid-Year estimate</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NIS</td>
<td>National Indicator Set</td>
</tr>
<tr>
<td>OB</td>
<td>Out borough</td>
</tr>
<tr>
<td>PA's</td>
<td>Programmed Activities</td>
</tr>
<tr>
<td>PAR</td>
<td>Prospective Adopter's Report</td>
</tr>
<tr>
<td>PCV booster</td>
<td>Pneumococcal Conjugate Vaccine booster</td>
</tr>
<tr>
<td>PbR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal Sexual Health Education</td>
</tr>
<tr>
<td>RCPCH, RCN and RCGP</td>
<td>Royal College of Paediatrics and Child Health, Royal College of Nursing and Royal College of General Practitioners</td>
</tr>
<tr>
<td>RHA</td>
<td>Review Health Assessment</td>
</tr>
<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UASC</td>
<td>Unaccompanied Asylum Seeking Children</td>
</tr>
<tr>
<td>UCC</td>
<td>Urgent Care Centre</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
</tbody>
</table>
APPENDIX 2

LAC Annual Health Report 2016/17

Annual Report - LAC
Health Service Hillingc
Milton Keynes Annual Report
on the Health of Children in Care

1 April 2017 – 31 March 2018

Report compiled by:

Carol Baines – Named Nurse Children in Care

In conjunction with:

Dr Adeola Vaughan – Designated Doctor for Children in Care

Andrea Piggott - Designated Nurse, Safeguarding Children and Children in Care
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Executive Summary</td>
</tr>
<tr>
<td>2</td>
<td>New National Guidance on CLA/ National changes/guidance</td>
</tr>
<tr>
<td>3</td>
<td>Local Information</td>
</tr>
<tr>
<td>3.1</td>
<td>Demographic Information</td>
</tr>
<tr>
<td>3.2</td>
<td>Benchmark with National Data</td>
</tr>
<tr>
<td>3.3</td>
<td>Local Statistics (age/gender/ethnicity)</td>
</tr>
<tr>
<td>4</td>
<td>Service Summary</td>
</tr>
<tr>
<td>4.1</td>
<td>Staffing &amp; Supervision</td>
</tr>
<tr>
<td>4.2</td>
<td>Governance &amp; Reporting Arrangements</td>
</tr>
<tr>
<td>5</td>
<td>Performance Indicators</td>
</tr>
<tr>
<td>5.1</td>
<td>National Targets</td>
</tr>
<tr>
<td>5.2</td>
<td>Local Improvement Requirements</td>
</tr>
<tr>
<td>6</td>
<td>CLA Team Clinical Activity</td>
</tr>
<tr>
<td>6.1</td>
<td>Health Assessments</td>
</tr>
<tr>
<td>6.2</td>
<td>Immunisations</td>
</tr>
<tr>
<td>6.3</td>
<td>Dental Checks</td>
</tr>
<tr>
<td>6.4</td>
<td>Developmental Checks</td>
</tr>
<tr>
<td>6.5</td>
<td>Annual Health Assessments</td>
</tr>
<tr>
<td>6.4</td>
<td>Local Requirements</td>
</tr>
<tr>
<td>7</td>
<td>Other Clinical Activity</td>
</tr>
<tr>
<td>7.1</td>
<td>Sexual Health</td>
</tr>
<tr>
<td>7.2</td>
<td>Teenage Pregnancies</td>
</tr>
<tr>
<td>7.3</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>7.4</td>
<td>Emotional Health &amp; Wellbeing</td>
</tr>
<tr>
<td>7.5</td>
<td>Training</td>
</tr>
<tr>
<td>7.6</td>
<td>Other ( e.g. Complex Case Work)</td>
</tr>
<tr>
<td>8</td>
<td>Adoption &amp; Fostering</td>
</tr>
<tr>
<td>9</td>
<td>Service Improvements</td>
</tr>
<tr>
<td>9.1</td>
<td>Specific Improvements / Team Achievements</td>
</tr>
<tr>
<td>9.2</td>
<td>Audits (and research if applicable)</td>
</tr>
<tr>
<td>9.3</td>
<td>Partnership working</td>
</tr>
<tr>
<td>9.4</td>
<td>Inspection Updates</td>
</tr>
<tr>
<td>9.5</td>
<td>Professional development (and publications if applicable)</td>
</tr>
<tr>
<td>10</td>
<td>Priorities for 2018/19</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Health Screening Pathway for Asylum Seekers - Children and Young People</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Hepatitis B (HBV): Information &amp; agreement form for Foster Carers</td>
</tr>
</tbody>
</table>
1. EXECUTIVE SUMMARY

This Ninth Annual Health Report has been written to provide an overview of the statutory health services provided to Milton Keynes Children in Care (CIC) from April 2017 to March 2018. The report provides assurance to our stakeholders including Milton Keynes Clinical Commissioning Group and Milton Keynes Council that Central and North West London Milton Keynes NHS Trust (CNWL-MK) are compliant with National Guidance; the Statutory Guidance on Promoting the Health and Well-being of Children In Care (DCSF&DH 2015) and NICE guidance: Promoting the quality of life of Children In Care and young people (2010).

The vulnerability of children and young people in the care system is widely recognised both locally and nationally. Abuse and neglect remain the main reason why children come into the care of the local authority. Developmental issues particularly speech and language delay remain the most common health related problem in children under the age of five years and emotional health and behavioural difficulties in the older age group.

The term 'Looked After Children' (LAC), 'Children Looked After' (CLA) and 'Children in Care' (CIC) are all used to refer to children who are placed into the care system. The term 'Children In Care' is currently used within statutory and government documents. However, all terms may be used interchangeably. Within this annual report for Milton Keynes we predominantly use the term Children In Care.

Dr Adeola Vaughan

Consultant Community Paediatrician

Designated Doctor for Children In Care
2 NEW NATIONAL GUIDANCE/CHANGES FOR CIC

The following guidance has been published in relation to Looked After Children.

1. Caring for Better Health: An investigation into the health needs of care leavers. The Care Leavers’ Association DoH 2001. This report provides a comprehensive overview of the needs of care leavers. The project team worked with ten CCGs and sought the views of care leavers and professionals. The report focuses beyond the age of 25 years to look at the long term health consequences for this group of young people.

2. Children speak out on living in care. Children’s Rights Alliance for England 2017. This briefing paper is a forum for the voices of LAC who describe their issues around entering and leaving care and the inadequate support that they receive.

3. Transforming children and young people’s mental health provision: a green paper. DoH & DfE 2017. This document promotes access to high quality mental health and wellbeing support. It states that some young people who need additional or specialised support should be assessed and referred quickly.


6. Applying corporate parenting principles to looked-after children and care leavers. Statutory guidance for local authorities; DfE 2018. This guidance provides information on the role of local authorities and how they should meet the corporate parenting principles as in section 1 of the Children and Social Work Act 2017. This guidance is designed to help local authorities and partners consider the kinds of services that may be offered to LAC.

7. National Transfer Scheme Protocol for Unaccompanied Asylum Seeking Children, DfE 2018. The National Transfer Scheme (NTS) protocol for unaccompanied asylum seeking children (UASC) has been created to enable the safe transfer of children from one local authority to another. The protocol is intended to ensure that these children access the services and support they need. The scheme is based on the principle that no local authority should be asked to look after more UASC than 0.07% of its total child population.

8. Measuring the wellbeing of children in care: Views from the frontline and opportunities for change, National Children’s Bureau 2018. This research paper explores how wellbeing is measured, and is based on the views of children in care councils and professionals working with LAC. The report looks at the use of Strengths and Difficulties Questionnaire (SDQ) as a measuring tool, however, due to mixed views on its use, many professionals use their own tools. The research raises particular issues around the access to specialist mental health services.

9. Foster Care in England, DfE 2018. This document reviews foster care and the needs of young people within these placements.
3 LOCAL INFORMATION

3.1 MILTON KEYNES DEMOGRAPHIC INFORMATION:
(Statistics provided by MK Planning and Transport Service Group June 2017)


Key Points from local demographics are:

- The Milton Keynes population is growing in size and diversity. In 2017, the estimated population of Milton Keynes Borough will be 268,029. The population is expected to rise by around 15.1% from 268,029 to 308,498 by 2026. It is set to double in size, to a population of half a million over the next three decades. This means the city will become a ‘development location of national significance’. (MKCITIZEN 2018)

- It has a relatively youthful population with 2017 figures showing the under 16 age group estimated at 24.2%. The average age of population is 34.5 years, compared to an average age of 50 years in England. (Milton Keynes Population Bulletin 2016-17).

- The city is more ethnically diverse than the England average. Within the school population the percentage of children from black or minority ethnic heritage is 39.3%. (MK School Census 2016). The school age population is projected to be around 45,116 in 2017.

Projections on MK Age range (2017-2026) show:

- Early Year’s – 0 to 4 Year olds - projected to remain at a consistent level of around 20,000.

- School Age Population - 5 to 16 year olds - projected to rise by 16.5% from 45,116 to 52,550 by 2026.

- Young Adults - 17 to 24 year olds – projected to rise from 21,475 in 2017 to 23,795 in 2026.

With the population growing within Milton-Keynes the above projections are key for Milton Keynes Children’s Social care (MK-CSC) in terms of future planning and provision of services.
3.2 NATIONAL CHILDREN IN CARE DATA:

**Numbers:** Nationally, the number of looked after children continues to rise. There were 72,670 looked after children at 31 March 2017, a rate of 62 children per 10,000 population. This is an increase of 3% compared to 31 March 2016 and an increase of 5% compared to 31 March 2012.

**Age profile:** There has been a change in the age profile with a steady rise in the number of older children starting to be looked after and a particular increase in the proportion of 16+ year olds; this is likely to reflect the increase in asylum seeking children. 62% of children looked after in 2016 were over 10 years, compared with 56% in 2012. There has been a reduction in the number and proportion of looked after children aged 1-4 years.

**Gender:** At 31\textsuperscript{st} March 2017, 56% of looked after children were male and 44% female. These proportions have varied little over recent years.

**Reasons for rise:** The rise over time reflects the higher number of children starting to be looked after than ceasing to be looked after. It is largely accounted for by the rise in the number of unaccompanied asylum-seeking children (UASC), which increased by 54% between 2015 and 2016 and by a further 6% in 2017. There were 4560 UASC in March 2017, 4300 in March 2016, 2740 in March 2015 and 1950 in 2013. 6% of children looked after at 31\textsuperscript{st} March 2017 were UASC. This partly accounts for the changing age and ethnicity profiles.

**Ethnicity:** UK-wide, looked after children are predominantly white. At 31 March 2017, 75% were white, 9% were of mixed ethnicity, 7% were black or black British, 5% were Asian or Asian British and 3% were other ethnic groups. Children of mixed and black ethnicity appear to be slightly over-represented in the looked after children population, while children of Asian ethnicity are slightly under represented. Over the last five years there has been a small increase in the proportion of looked after children of non-white ethnicity, likely to reflect the increase in the number of unaccompanied asylum seeking children.

**Placement type:** 74% of looked after children in 2017 were cared for in a foster placement, 6% were placed with their parents and 1% were in an adoptive placement. The remainder were in a secure unit, children's home or hostel.

**Adoption:**\(^9\) 4,350 looked after children were adopted in 2017, down 8% on 2016 and down 19% of the peak of 5,360 in 2015. This fall follows a period of increasing numbers of looked after children being adopted since 2011.

3.3 MILTON-KEYNES CHILDREN IN CARE
(Statistics supplied by Performance Management Team Children's Social Care)

3.3.1 LAC Numbers

There were 538 children in the care of Milton Keynes Local Authority (MKLA) at some point in the period in comparison to last year’s figure of 540. This indicates stability in the overall figure. This figure will fluctuate month by month as children and young people come into care but then may leave depending on individual need and circumstance.

The number of children continuously looked after by Milton Keynes Children’s Social Care for 12 months or more on 31/3/18 was 286

Data indicates a significant rise of 31 cases (11%) when compared to last year’s figure of 255 and a rise of 66 cases (23%) since 2015/2016.

**Number of CIC for 12 months or more and type of placement (As of March 31\textsuperscript{st} 2018):**

Table 2: Number of CIC for 12 months

<table>
<thead>
<tr>
<th>Total: 286</th>
<th>Compared to last year's figure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children/young people placed with foster carers: 213</td>
<td>Increase of 18</td>
</tr>
<tr>
<td>Children/young people requiring support placed in residential children’s home: 28</td>
<td>Decrease of 3</td>
</tr>
<tr>
<td>Children/young people placed with a parent: 22</td>
<td>Increase of 13</td>
</tr>
<tr>
<td>Children/young people placed for adoption: 7</td>
<td>Increase of 5</td>
</tr>
<tr>
<td>Children/young people placed in residential school/residential setting: 7</td>
<td>Decrease of 11</td>
</tr>
<tr>
<td>Young people placed in supported living: 10</td>
<td>Decrease of 8</td>
</tr>
<tr>
<td>Young people in secure accommodation: 2</td>
<td>0</td>
</tr>
</tbody>
</table>

Analysis:

Milton Keynes Local Authority recognises that children are best placed as much as possible within foster placements as opposed to residential. Ensuring there is adequate community and family based support is key for best outcomes. Children with more complex needs requiring a high level of support and stability may need a residential approach. Their development is closely monitored to ensure they are progressing and that the placement is meeting their needs.

In terms of starting and ceasing being a CIC, the number of children starting to be looked after was 136 compared to 144 who ceased to be looked after. The number of children in the care of MKLA as on 31st March 2018 was 394. As last year’s total was 395, this indicates a stable figure for CIC.

3.3.2 Rates of Children In Care

Graph 3: Numbers and Rates of Children In Care Captured (2015-2018)

This shows the rate per 10,000 children and young people in the care of Milton Keynes Local Authority (age 0-17) has remained level in the last year and still below the national and statistical neighbour rates.

NB: The statistics for England, South East and our Statistical Neighbours have yet to be reported on for 2017/18.
3.3.3 Age and gender

Table 3: Age and gender of CIC

<table>
<thead>
<tr>
<th>Age and gender of CIC</th>
<th>Number and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>23 (6%)</td>
</tr>
<tr>
<td>1-4 years</td>
<td>55 (14%)</td>
</tr>
<tr>
<td>5-9 years</td>
<td>82 (21%)</td>
</tr>
<tr>
<td>10-15 years</td>
<td>158 (40%)</td>
</tr>
<tr>
<td>16+</td>
<td>76 (19%)</td>
</tr>
<tr>
<td>Gender split: Male/female</td>
<td>230 (58%) / 164 (42%)</td>
</tr>
</tbody>
</table>

The age distribution of Milton Keynes CIC is comparable to national data. The smallest number of children continues to be within the under 5 age group. The clear majority remains within the 10-15 year age group. The overall picture of causes for why children become looked after remains fairly consistent. The male/female ratio is in line with national data on CIC.

3.3.4 Causes for children becoming looked after by MKLA

Table 4: Causes for children becoming looked after by MKLA

<table>
<thead>
<tr>
<th>CATEGORY OF NEED FOR CHILDREN LOOKED AFTER AT 31 MARCH 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or neglect</td>
<td>168 (42.5%)</td>
</tr>
<tr>
<td>Disability</td>
<td>40 (10%)</td>
</tr>
<tr>
<td>Parental illness or disability</td>
<td>35 (9%)</td>
</tr>
<tr>
<td>Family in acute stress</td>
<td>56 (14%)</td>
</tr>
<tr>
<td>Family dysfunction</td>
<td>56 (14%)</td>
</tr>
<tr>
<td>Socially unacceptable behaviour</td>
<td>7 (2%)</td>
</tr>
<tr>
<td>Low income</td>
<td>2 (0.5%)</td>
</tr>
<tr>
<td>(Includes UASC) Absent parenting</td>
<td>32 (8%)</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>394</td>
</tr>
</tbody>
</table>

The distribution of category of need remains fairly stable, with the same listing as last year’s causes for children being brought into the care of MKLA. The primary need is recorded but most cases have more than one cause for being in care.

When comparing to national statistics abuse/neglect is the same highest causative factor of coming into care. Family dysfunction and absent parenting are similar with both being 1% higher in MK statistics. However, the family in acute distress is significantly higher in MK by 6% -
3.3.5 Ethnicity breakdown for CIC as of March 31st 2018

Table 5: Ethnicity breakdown for CIC

<table>
<thead>
<tr>
<th>CYP Group</th>
<th>White Background</th>
<th>Mixed Background</th>
<th>Asian/Asian British Background</th>
<th>Black/Black British Background</th>
<th>Other ethnic groups/</th>
</tr>
</thead>
<tbody>
<tr>
<td>MKC total 0-19 years*</td>
<td>67.0%</td>
<td>8.0%</td>
<td>12.0%</td>
<td>12.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>CIC</td>
<td>63% (248)</td>
<td>14% (55)</td>
<td>7% (26)</td>
<td>13% (50%)</td>
<td>4% (15)</td>
</tr>
<tr>
<td>National data</td>
<td>75%</td>
<td>9%</td>
<td>5%</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

*General population ethnic origin data only available for 0-19 from 2011 census, Ethpop.org provide predicted figures in 5 year increments – ‘not known’ cases are excluded.

There is a clear dip in LAC from an Asian background when looking at the MKC population as a whole. The increase in ‘Other’ Ethnicities in LAC is in the main due to Unaccompanied Asylum Seeking Children (UASC). There is a noticeable over-representation of children from a mixed background, however, as the MKC general data is taken from 2011 census projections, this may be out of date.

The national data shows 75% of CIC coming from predominantly white background whereas this is 67% in MK. Children and families coming from differing ethnic backgrounds may have language and culture differences which require additional support from services to ensure they feel secure and communication is clear.

3.3.6 Distance of Geographical Placements

Graph 4 Children in Care Placement figures for in and out of Milton Keynes (April 2017-March 2018)

Children and young people in the care of MKLA are predominantly placed in and around the Milton Keynes area within a 20 mile radius. A small proportion of children are placed between 21-50 miles and 51-100 miles out with Milton Keynes. The smallest number is placed 101 miles and over.
When comparing to other local authorities, MK does not have a significantly greater number of distant placements. Many of these placements are for positive reasons such as an adoption or being with a family member. There may be safeguarding and risk management issues identified indicating an out of area placement is needed or a child/young person may need to access specialist provision to meet a complex need.

3.3.7 Children and young people with disabilities:

There are currently 26 children/young people who are full time CIC cared for within the ‘Children With Disabilities Team’ (CWD). This is an increase of 8 cases from 18 children last year. This team works exclusively with children who have profound and significant learning and/or physical disabilities or life threatening illnesses and their families. They offer advice, guidance, signposting and support working in partnership with families and other professionals to safeguard all children and promote their well-being.

The CIC Health Team and the CWD are acutely aware this is a highly vulnerable group. Placements for these children may include highly specialist units, residential schools and foster care. On-going parental involvement may be central to the child’s world and that of their family, depending on individual circumstance and as such they may be involved in the health assessment process. These children will also have a range of named professionals involved in their health care on an ongoing basis. The CIC Nurses are acutely aware of the importance of effective assessment avoiding duplication and over assessment for the child. Information and medical reports are gathered to assist the assessment and also ensuring the voice of the child is central to that process.

Analysis of increase:

As part of the CAMHS transformation work a Complex and Challenging Behaviour Task and Finish Group was established. This identified that there was a gap in health provision around children with complex and challenging behaviour primarily as a consequence of Autistic Spectrum Disorder (ASD) or learning disabilities. This is a national issue as reported by Christine Lenehan in her report ‘These are our Children’ (January 2017). This has resulted in families not receiving effective early intervention or a co-ordinated health response to more significant behaviours particularly as children reach puberty. The consequence has been that this has contributed to an increase of children and young people needing residential provision and becoming looked after. The action from the Task and Finish Group is that funding has been identified to employ a Community Learning Disability Nurse for two days a week for a fixed term, based with the Children with Disabilities Team. to undertake an assessment of the needs of children held by the team in relation to their challenging behaviours. This work will quantify the level of unmet need and make recommendations about how health services can respond including what may need to be commissioned.

4 SERVICE SUMMARY

4.1 STAFFING:

The Children In Care Health Team comprises:

Designated Doctor

The Designated Doctor is a Consultant Community Paediatrician employed by Central and North West London- Milton Keynes (CNWL-MK) and commissioned by Milton Keynes Clinical Commissioning Group (MK-CCG) to deliver the role and function of the Designated Doctor.
This role combines operational and strategic responsibility for children in the care of Milton Keynes local authority allowing both CNWL- MK and MK-CCG to deliver on its responsibilities to children in care in Milton Keynes.

The post holder is also the Medical Advisor for Adoption and Fostering, managing these roles along with other responsibilities within a full time paediatric neurodisability post.

All the doctors in the team are involved in the provision of clinical services for children in care. Regular training is provided to ensure consistency in service provision.

**Desiganted Nurse**

The Designated Nurse is employed by MK-CCG and also undertakes the role of Designated Nurse for Safeguarding Children. The Designated Nurse for CIC works alongside the Designated Doctor to assist MK-CCG in effectively fulfilling its role as a commissioner of services to improve and monitor the health of all children in the care of Milton Keynes Local Authority.

**Named Nurse for Children In Care**

The Named Nurse CIC post is jointly funded by CNWL-MK and MK-CSC as a full time position. This is predominantly a strategic role, working to develop, implement and monitor local policy within CNWL-MK and MK-CSC, in line with national policy and guidelines. This post is based within MK-CSC.

**Specialist Nurse for Children In Care**

The Specialist CIC Nurse is employed by CNWL-MK and is a full time position. This is her 8th year working in and developing this role. The Specialist CIC Nurse completes review health assessments for children in the care of Milton Keynes Authority above the age of 5 year’s. One significant advantage of this role is that review health assessments are completed by the same nurse promoting consistency for the child/young person and their carer and instilling a sense of security with the health assessment process. For children placed a significant distance from Milton Keynes, an ‘Out of Area’ request for a local CIC Team to complete the assessment, is made. The Specialist CIC Nurse will travel a distance of up to 2 hours to assess a MK child placed out of area. This post is based within MK-CSC.

**Primary Mental Health Worker (PMHW)**

The PMHW for CIC is split between Corporate Parenting and Milton-Keynes Specialist CAMHS (MKSpCAMHS). The practitioner became established within the corporate parenting team in January 2018.

**Administration**

Business support for the CIC health team is provided by both CNWL-MK and MK-CSC.

The Business Support role within CSC is a full time post. This area of administration is recognised as complex and fragmented due to working across varying service providers and differing electronic systems. The *Intercollegiate Role Framework Guidance for Children In Care (2015)* highlights challenges and advises the need for this to be a dedicated role.

It is a complex task to track the volume of children entering and leaving the care system, having placement moves and ensuring assessments take place within statutory guidelines. The complexity of Ensuring paperwork is co-ordinated efficiently across services and various electronic systems are a key function in adhering to statutory timescale and ensuring confidentiality is upheld. In addition, Out of Area Assessment requests to and from other health authorities, is time consuming.

Administration for the Community Paediatric Clinic is funded by CNWL-MK for 12 hours per week. This post is based at CNWL-MK Trust Head Quarters. In light of the increase in children coming into care and as such requiring a health assessment, this does affect the pressure not just on health but also on administrative staff. The hours required for administrative work is under review.
4.1 **SUPERVISION ARRANGEMENTS:**
The CIC Health Team supervision arrangements are as follows:

- The Named CIC Nurse is managed and supervised by the CNWL-MK Named Nurse for Child Protection. The Named Nurse and Specialist Nurse meet regularly for individual supervision and peer discussion providing an opportunity to consider individual cases, management of case-loads and practice issues. The Designated Nurse for CIC also meets regularly with the Named Nurse providing the opportunity to consider service provision and wider issues relating to the CIC service.

- Once a month there is a wider team meeting with Designated Professionals, Named and Specialist Nurse to consider system wide partnership developments and to monitor quality assurance.

- Effective liaison between services and enhancing good practice spanning all areas of health for children in care is paramount. The relationship and communication process between CIC Nurses and the Community Paediatricians in Milton Keynes is very well established.

- Weekly meetings are held between the CIC Nurses with the Designated Doctor. These meetings also offer a supervision forum to discuss individual cases, practice issues and service development. Cases discussed are documented and scanned to Systm1 and ICS. The Designated Doctor is a member of the BAAF health group, the Central Midlands Looked After Children and care Leavers Designated and Named Professionals Safeguarding Forum. This forum provides valuable peer support and discussion.

- Social workers have direct access to medical advice from the CIC Health Team. The nurses also have the advantage of being able to discuss individual cases with the child’s social worker as they are based within their team and can attend strategy meetings when required.

- Close joint working between the Health Team and the Head of Delivery of Corporate Parenting is well embedded promoting joint discussion and liaison through the Health and Social Care Forum to promote the health needs of children in the care of Milton Keynes Local Authority. The Milton-Keynes Safeguarding Team including Milton-Keynes Children's Social Care (MK-CS)C), the Police Child Abuse Unit, Schools and all other partnership agencies work closely together assessing risk and quickly noticing warning signs relating to safeguarding and identifying children at risk

4.2 **GOVERNANCE AND REPORTING ARRANGEMENTS:**
The governance arrangements are as detailed below:

- CNWL-MK is a member of the Milton Keynes Children and Family Partnership and the Milton Keynes Safeguarding Board. There is a strong and consistent leadership commitment to ensure the health needs of children in care are being met. The Associate Director of Children's Health Services is the lead for safeguarding and for Children In Care. This promotes consistency and joint working across fundamental key areas within children’s health services.

- CNWL Diggory Division Safeguarding Governance sub-group covers both children and adults, meets on a quarterly basis and is chaired by CNWL-MK Divisional Nursing Director. The group reports to the CNWL Board via the Divisional Quality Forum and provides assurance to the Trust Quarterly Safeguarding Group Meeting.
The purpose of the sub group is to monitor safeguarding activity in the division, approve and ratify relevant documents and papers, share lessons learnt and assess, review and monitor safeguarding risks for the division. This remit includes ensuring that the division complies with the CIC agenda. The performance of IHAs and RHAs is also reported monthly on a Milton Keynes CCG Safeguarding Dashboard which is reviewed by the sub group and submitted to the MK-CCG on a monthly basis. This process ensures practice is monitored, statutory timeframes are being achieved and any potential difficulties hindering this highlighted.

4.3 LAC Assurance Framework:

The assurance framework for LAC has drawn from the statutory guidance ‘Promoting the Health and Wellbeing of Looked After Children’ 2015. This framework is valuable for internal and external assurance of LAC service provision. It also supports areas for monitoring following the CQC inspection August 2016 and the Ofsted inspection that followed.

Two areas remain amber:

- **Business proposal completed** to increase nursing provision in the LAC Team in line with rise in numbers of children requiring a service and intercollegiate guidance: Proposal to the CCG remains outstanding.

- **Incorporate BAAF Carers reports in the health assessment process**: This has been taken through the HSCF and implemented by health, however requires an agreed and clear process from CSC.

**Corporate Parenting Panel**

The Corporate Parenting Panel (CPP) is an all-party council members panel whose purpose is to act as parent to all the children and young people who are in the care of Milton Keynes Council and to ensure that the Council’s and its partner agencies deliver on its pledge to children in care. The CPP raises awareness of the needs of children in care across the council and its partners and seeks to encourage the development of local resources to meet the needs of children in care.

The CPP panel meets 5 times a year and will call on officers and partners to provide information and reports on progress, in accord with its annual work plan in including those relating to meeting the Health needs. The CPP itself report on an annual basis to the CYP Select Committee, Full Council and Children and Family partnership. The CIC Health team will be required to attend the CPP and present this annual report and be available to comment on any queries the panel may have.

5. PERFORMANCE INDICATORS

5.1 NATIONAL TARGETS/STATUTORY REQUIREMENTS:

MKLA sends statutory statistics to the department of health and education (DfE). DfE will publish their first national statistical release in September 2017. Statistics compiled and reported on for children in care are:

- The number of children below the age of 5 years with developmental check completed on a 6 monthly basis.

- The number of children registered with a dentist.
- The number of children/young people fully immunised in line with the national immunisation schedule.
- The number of children /young people between the ages of 4 years and 17 years with an SDQ completed.
- Substance misuse and interventions for substance misuse
- SDQ data including scoring.
- Completion of annual health assessment data.

**Efficiency & Productivity Plan for CIC Milton Keynes:**
This plan has been devised to monitor and outcome actions for service improvement and development in Milton Keynes. Key areas include:

- Monitor of capacity for timely IHA and RHA, offering choice of clinic appointments for RHA as appropriate.
- Review of administration support from both health and the local authority.
- Ensure information sharing across GP, health visiting, CAMHS, School Nursing, to inform the health assessment process.
- Develop and plan outcome measures for the monitoring of health action outcomes to ensure completion.
- Strengthen SDQ tool to include completion by children/young people and schools.
- Voice of the child captured and central to care.
- Carer's voice captured via carers report for all assessments.

6 **CIC TEAM CLINICAL ACTIVITY**

6.1 **Health Assessments**
MKLA is responsible for ensuring that arrangements are in place to carry out all health assessments within the statutory timescales. The CIC Health Team is responsible for the completion of statutory health assessments. Both agencies work closely together to ensure every child has a timely and up to date assessment.

Milton Keynes is a unitary authority with one hospital and CNWL is the community health provider. This has the advantage of the Community Paediatric Team using the same medical records system as the hospital, supporting information sharing. Close and timely communication with all health and relevant professionals is crucial for CIC.

Data recording and monitoring all children coming in to care, remaining in care and leaving care is collated on a spreadsheet. This data ensures information relating to the health assessment process is captured; children are flagged when their next statutory assessment is due and an in-depth analysis can take place to highlight any problem areas which affects performance. Specific data is also recorded to monitor health assessment performance on the council electronic recording system ICS- Liquid Logic ensuring children's health needs are effectively monitored and out-comed by CSC.
6.2 Initial Health Assessments (IHAs)

All Initial Health Assessments are completed by the Community Paediatric Team. The first assessment should be undertaken by a registered medical practitioner in accordance with the Statutory Guidance on Promoting the Health and Wellbeing of Children In Care (2015). The framework used for health assessment completion is the British Association for Adoption and Fostering (BAAF) electronic form.

In Milton Keynes the community paediatric team continues to see all children below the age of 5 for their statutory 6 monthly reviews. This is in recognition of the complexity of medical conditions that could arise in the younger age group. This also has the advantage that should an adoption medical be required a separate appointment is not required, reducing the frequency of medical appointments. The health assessment should not be seen as an isolated event but part of a continuous process reviewing and monitoring the health needs of every child and young person in care.

In line with recommendations made by the Care Quality Commission (CQC) BAAF assessment paperwork is used. This captures robust information from all health professionals. The health team have full access to Systm1-Community Health System.

The complexity of cases has increased and this has been recognised by the CIC team, although this has not been supported by the data recorded. Examples would include children significantly affected by pre and post-natal factors combined with damaging early years experiences prior to coming into care. These factors lead to significant developmental and behavioural difficulties affecting home, school and socialisation and can lead to increased risk of placement instability.

6.2.1 Completion of IHAs in the statutory timescale

Graph 5: Initial Health Assessments completed in 28 day statutory timescale (17/18)

The number of Initial Health Assessments due each month following admission into care was 134, a reduction of 40 cases from last year’s figure of 174. Number completed within 28 calendar days statutory timescale: 82=61%
There has been a significant decrease in children being brought into the care system. This has been affected positively by the 'Diversion from Care Panel' which has been running for two years advising and supporting young people and families thus avoiding coming into care. This panel is chaired by the Head of Children’s Social Work and Children and Family Practices. Members include Family Group Conference, Youth Facility and the Virtual School Team Manager. This panel hears all potential entries to care and will prescribe a package of support for the family and young person. The packages of care are monitored each week for 4 weeks to ensure they are working and are adapted with the changing situation. Returning to panel each week really does work in diverting from care, as we are able to see if the work is being done and also measure effectiveness.

This panel has been hugely successful and has changed the average age of our care population to 8 years of age. Care Proceedings have also slightly dropped last year but not significantly.

When children are accommodated, CSC teams are frequently able to return them to their families once assessments are completed prior to an IHA being triggered.

**Factors impacting on delayed Health Assessments**

<table>
<thead>
<tr>
<th>Table 6: Reasons for Delayed Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent not received in 3 day timescale:</td>
</tr>
<tr>
<td>ICO required:</td>
</tr>
<tr>
<td>Out of area request over which we have no control:</td>
</tr>
<tr>
<td>Baby/child/young person in hospital at time of appointment:</td>
</tr>
<tr>
<td>Placement moves:</td>
</tr>
<tr>
<td>Young people seeking asylum/delay if impacted by age assessment</td>
</tr>
<tr>
<td>Administration difficulties</td>
</tr>
<tr>
<td>Clinic capacity</td>
</tr>
<tr>
<td>Total DNA appointment’s offered:</td>
</tr>
</tbody>
</table>

On analysing the cause of delay it should be noted multiple factors impacting on delay are sometimes identified:

- Obtaining consent remains the highest factor in delay. The complexity of individual cases and additional pressures affecting obtaining consent is recognised, such as refusal of parental/young person engagement and if large numbers of children are brought into care from the same family. However, this would not account for the significant figure of 46% affected due to late consent.

- There were a total of five out of area requests for Milton Keynes children. When a request for completion has gone to a different local authority because of geographical distance, we have limited influence of timescale.

- Placement moves in complex cases are sometimes necessary for the child part way through the process. This will add to delay but is unavoidable. We recognise every child’s needs are assessed fully by MK-CSC and placement will only change after careful consideration.

- In two cases, capacity of clinic was an issue due to demand, and this took the timescale just outside the 28 days.
CIC Health Team receiving the paperwork and parental consent.

The Health Team aim for completion within the statutory timescale of 28 days, to the best of their ability. To reach this timeframe, it is essential the request for the assessment, all paperwork required and parental consent reaches the health team promptly.

There is an agreed target between MK-CSC and health for completion of Initial Health Assessments within a timeframe of 25 days from health receiving consent. This was in recognition that the health team do not have control over gaining consent from the parent.

Statistics for quarterly percentage of IHAs with consent being received by health within 3 days of a child/young person coming into care:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18%</td>
<td>17%</td>
<td>47%</td>
<td>49%</td>
</tr>
</tbody>
</table>

This table indicates an annual percentage of 33% and is an improvement on last year’s total annual percentage of 26%, however, there is much room for improvement.

Graph 6 Initial Health Assessments completion within 25 days of receiving consent

MK CCG look the figures from 25 days of obtaining consent. As they accept health can only complete within statutory timescale when they have prompt paperwork, hence they therefore look at both graph 6 and 7 to monitor the CIC compliance.

The total due were 133, however, those completed within the timescale of 25 days from receipt of consent: 110 = 83%. 
Table 8: Factors impacting on delay

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of area request over which we have no control</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Just outside timescale-Day 26/30</td>
<td>11 (48%)</td>
</tr>
<tr>
<td>Child moved placement</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Child unwell- unable to be brought to booked appointment</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Carers unable to take to appointment offered</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Child in Hospital</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Young person DNA two offered-missing at time of appointment</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

ANALYSIS OF FACTORS AFFECTING DELAY:

On analysing the cause of delay it should be noted multiple factors impacting on delay are sometimes identified:

- Of the IHAs due in the month following receipt of consent, 110 were completed in the 25 day timescale equating to a percentage of 83%. This is an improvement of 3% from last year's figure of 136 equating to 80%.

- The highest cause of delay in 11 cases, would relate to being seen just over 25 day timescale. We do rely on carers attending when offered however, in reality; there will be occasions where it is not possible for them to make a particular date and an alternative date takes them out-with timescale.

As can be seen from the table above, additional reasons are unforeseen and outside our control.

HEALTH ASSESSMENTS COMPLETED BY COMMUNITY PAEDIATRICIANS IN LAST REPORTING YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>IHA</th>
<th>RHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>280</td>
<td>133</td>
<td>147</td>
</tr>
<tr>
<td>2016/17</td>
<td>262</td>
<td>176</td>
<td>86</td>
</tr>
</tbody>
</table>

The numbers of IHAs completed by Paediatricians has risen due to low capacity in the nursing team.

ACTIONS BY HEALTH & CSC TO MONITOR AND IMPROVE PRACTICE:

A monthly analysis of delay is compiled by the Named Nurse to track the cause of all delayed cases. This was changed recently from quarterly reports to enable more robust monitoring. A report is available for Head of Service Delivery, Head of Corporate Parenting and Team Manager of Corporate Parenting so that any possible performance issues can be jointly addressed.

1) Timeliness of consent: This issue was discussed with CSC Management. Previously if paperwork and consent was not received from the social worker within 7 days of CIC commencing, that case was escalated to Management, so they could review cause of delay. In November, the protocol was changed so cases are escalated to Management if not received within 3 days.

As can be seen from the quarterly percentage of consent being received in 3 days of becoming LAC, this has had a positive impact.

2) Tracking statutory completion: CSC are tracking health assessment completion on a monthly basis to ensure statutory duty is being upheld and impact on delay.
3) **Reviewing performance:** Monthly meetings will be held with the Named Nurse CIC and Team Manager of Corporate Parenting to review performance.

4) **Health and Social Care Forum:** Performance continues to be reviewed at each Health and Social Care Forum. Actions if required relating to consent and paperwork process can be cascaded to teams.

5) **Business support from MK-CSC and CNWL-MK under review:**

Meetings took place on three occasions between CNWL-Management and CSC Management to review the admin requirements, procedures and processes. Currently CSC are looking at their electronic system ICS, generating pre-populated health assessment paperwork, with the aim of making the process more streamlined.

### 6.3 REVIEW HEALTH ASSESSMENT PROCESS

Annual Review Health Assessments for children and young people 5-18 years of age are completed by the CIC Nurse. This role has significant advantages for the children and young people in the care of Milton Keynes Authority. One key area being that review health assessments are completed by the same nurse therefore promoting continuity for the child/young person. This is our Specialist Nurse’s 8th Year working within the MK-CSC Team. Consistent knowledge of the health and wellbeing of the child through their time in care is highly valuable in the assessment process for the child/young person and for their carers.

The child/young person can be seen either at home, at school or at an alternative suitable venue of their choice. In addition, this year a clinic has also been run to offer an additional choice for young people (see section 9).

Liaison takes place with the child/young person’s foster carer so they can be involved as appropriate in the process. Health assessments are usually requested to be completed outside school hours so as not to interfere with education. Such appointments are offered after school and the Specialist Nurse can also offer to see young people on a Saturday on occasion if needed. An assessment for one complex case can take on average up to 6/7 hours to compile. This includes travel, seeing the child/young person, gathering multi-professionals views for a holistic overview and writing the report.

#### 6.3.1 Completion of RHAs in the timescale

*Graph 7 Review Health Assessments completed within statutory timescale:*
369 RHAs due and of these 271 = 74% were completed in the timescale, with 98 cases where a variety of factors impacted on the delay

<table>
<thead>
<tr>
<th>Table 9: Factors impacting on delay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer/young person unable to attend appointment offered</td>
</tr>
<tr>
<td>Capacity of team to book within the month</td>
</tr>
<tr>
<td>Out of area placement</td>
</tr>
<tr>
<td>Young person declined</td>
</tr>
<tr>
<td>Paperwork delay</td>
</tr>
<tr>
<td>Admin issue</td>
</tr>
<tr>
<td>Placement of child changed</td>
</tr>
<tr>
<td>Carer DNA / Carer not returning calls to book</td>
</tr>
<tr>
<td>Child in hospital/unwell</td>
</tr>
</tbody>
</table>

In comparison to last year’s figure there is a significant rise from 306 to 369.

This is an additional 63 children requiring a statutory review health assessment-indicating a 17% rise.

In the previous two years this indicates an overall rise from 286 to 369. In two years there has been an additional 81 children requiring a statutory assessment-indicating a 22.5%, which increases the demand on the CIC Health Team

**ANALYSIS OF FACTORS AFFECTING DELAY:**

Carers or the child being unable to attend appointments offered within statutory timescale has been problematic. Reasons for delay of appointments are immediately relayed to the social worker and IRO.

Team capacity has been affected due to the considerable increase in assessments requiring completion. All children and young people have been seen for their assessments but due to demand- not always viable in timescale.

Children who are placed out of area continue to have the impact on delay for RHA completion.

The CIC Nurse will travel up to two hours to see children in the care of our authority. There are occasions when the distance to travel to a child makes it impractical for the CIC Nurse to complete.

It may be more beneficial to the child if completed by a local professional who knows them and who has knowledge of local health resources. This is in line with recommended good practice: The need for a ‘child-centred approach’ is highlighted ‘staff where the child lives are more likely to be aware of the availability of local services which can meet the child’s needs’. Statutory Guidance on Promoting the Health and Well-being of Children In Care (DCSF&DH 2015).

Challenges to this process are not exclusive to Milton Keynes. This is a nationally recognised problem. It is acknowledged that timescales for completion vary in other authorities due to their own individual pressures of work load. There have been three other LAC Nursing Teams who notified us they were unable to honour our request for a health assessment due to team capacity. This not only leads to additional delay but also to time spent having to source a GP who will complete an RHA for us.

On occasions, pre-booked appointments may need to be changed at short notice, as the carer or young person may not be able to attend.

In the cases where a young person declined, we would consider each case with the social worker. Within one family- 3 teenage brothers placed with their Aunt, all declined. Although we endeavour to see all young people up to the time of leaving care, we are also respectful when a decision is made by the young person declining.
Accuracy and timeliness of paperwork from SW has been problematic. Paperwork is co-ordinated by Business Support LAC. Sometimes children are moved and health is not notified. Inaccurate paperwork being sent to health has to be returned to the SW to be reviewed and corrected. This leads to additional delay for some children and compromises timescales.

**Actions taken by health:**

1) The Nursing Team have proposed a second business plan which is with the CCG for consideration, looking at increasing Nursing and Health Team capacity, in line with the number of children requiring care. We have been authorised to advertise for Bank Nurses with specialist nursing experience to support with demand on assessments. Challenges to this relate to the specialist nature of this work and recruiting Bank Nurses who can work flexibly and independently in this area.

2) The escalation process for receiving accurate paperwork and consent on time has been reviewed and improved by CSC Management. This does however require further review as there continues to be problems of delay.

3) In the coming year, health will collate dates when paperwork is received for assessments in out of area cases to track impact on statutory timescale.

4) Inaccuracies in paperwork has been flagged and discussed with CSC Management. Paperwork is co-ordinated by Business Support LAC. Cases are delayed due to inaccurate paperwork being sent to health which then has to be returned to the SW to be reviewed and corrected. CSC are looking at the way information is held on ICS for each child, how this is updated when a child is brought into care and if a child moves placement. The intended outcome is to aim to ensure wrong information is not provided to health leading to avoidable delay on statutory timescales.

**Out of Area Requests:**

Statutory guidance states: *Under the Children Act 1989, CCG’s and NHS England have a duty to comply with requests from a local authority to help them provide support and services to Children In Care*. (Promoting the health and well-being of looked-after children-Statutory Guidance for local authorities, clinical commissioning groups and NHS England March 2015 P.8).

**Table 10 Requests to complete a health assessment for children placed in our area by another placing authority**

<table>
<thead>
<tr>
<th>Requests to complete a health assessment for children placed in our area by another placing authority:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total: 39</td>
<td>By comparison to previous reporting year this is a decrease of 12.</td>
</tr>
<tr>
<td>Completed by Consultant Paediatricians:</td>
<td>15</td>
</tr>
<tr>
<td>Completed by LAC Nurses/Bank:</td>
<td>6</td>
</tr>
<tr>
<td>Cancelled as no longer required:</td>
<td>4</td>
</tr>
<tr>
<td>IHA completed by Consultant in Oakhill:</td>
<td>5</td>
</tr>
<tr>
<td>Currently pending completion:</td>
<td>9</td>
</tr>
</tbody>
</table>

The health team prioritise MK children/young people, as other providers do for their own locality.

**6.4 UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)**

In 2017/18 there have been 18 young people come into the care of the local authority. This is an increase of 6 young people by comparison to the previous reporting year.
Statistics:

- Transferred to our care from another local authority: 1
- Male/Female ratio: 16/2
- Age assessed as above age 18 years: 9

When a young person is assessed as being above the age of 18 they are directed to adult service provision for support. Assessment for young people seeking asylum is additionally problematic due to language barriers. MK-CSC provides translators for all health assessments and for parents/carers where a language barrier is evident. It is acknowledged the process can be difficult and upsetting. Some young people present as traumatised from their journey and experience.

‘Unaccompanied children often have additional factors related to their past, experiences of loss and bereavement, often including war trauma, torture, trafficking. They may have specific health issues relating to their country of origin, experiences on their journey and situation and circumstance since entering the UK’. BAAF Promoting the health of children in public care (2015)

The health team and the Social Workers aim to handle this with the utmost sensitivity and compassion and the Initial Health Assessments are undertaken as quickly as possible. The health history for young people who are seeking asylum will be incomplete as they do not have traceable health records. Immunisations are offered as per Health Protection Agency (HPA) guidelines for ‘Incomplete or Unknown Immunisation Status’. They also tend to have travelled from countries where health resources and health screening are limited. The Consultant Paediatricians refer to ‘Country of Origin’ information, which gives guidance on the prevalence of certain health issues of concern in various countries. The Initial Health Assessment is key in identifying and actively addressing health problems in these young people.

MK Hospital have an agreed process for a direct link with the Paediatric on-call Consultant to ensure young people requiring further medical assessment or intervention when they are initially assessed are referred to the hospital and seen without delay. It is acknowledge for young asylum seekers, that their journey will have been long, distressing and frightening. They will not be used to hospital environments and as such, the care they receive from our health provision is aimed to be as supportive as possible. (See Appendix 1 Flow chart)

6.5 Care Leavers

There are currently 179 young people as ‘Care Leavers’ open to the Corporate Parenting Team. This is a significant increase of 30 cases from last year’s figure of 149. There is no targeted nursing health provision allocated for Care Leavers in Milton Keynes.

Health professionals play an important role in promoting health and helping to empower young people as they prepare to leave care. Transitions to adult health provision need to be secured in plenty of time to ensure no young person falls through a gap in service. Preparing to leave care is a highly anxious time for young people, as they incur a lot of change and disconnections from known and trusted professionals. It is imperative young people are central to all plans of care and understand who will be available for them.

A Care leaver group CIC+ was launched in Feb 2017 offered to all those age 16 and above. The group meets every other Tuesday evening.

The CIC health team recognise the importance of compiling Care Leavers Health Records when young people are leaving care. The challenge for the CIC Team has been due to pressure on nursing capacity, these have not all been able to be completed. Care Leavers have had their final RHA including advice and health promotion for maintaining a healthy lifestyle. We have not been able to provide them with an additional health passport which is recognised as recommended best practice so what are they missing then as its not clear?.

Capacity issue are presently being addressed at directorate level in the organisation. CNWL-MK are reviewing staffing requirements and looking at increasing staffing within the health team.
6.6 IMMUNISATIONS

Immunisations remain at a high completion rate in MK. There will always be some young people who refuse to have immunisations as advised despite the need being highlighted. Health promotion is always given by the health team in each case.

Other reasons are:

- There are some parents who refuse MMR’s being administered for children in care. Parent’s refusal to consent is fully documented.
- All asylum seeking young people all require immunisations as per HPA guidelines for ‘Incomplete Immunisation Status’. This programme of immunisations is given over a three month period. Despite young people having this as a clear action on their health plans, not all are actioned by the Carer/SW.
- Notification goes out to foster carers, social workers and IRO’s to heighten awareness and ensure this area remains central to health monitoring and is outcome as completed on recommendation of the health care plan.
- To address the cases where immunisation checks have not been completed, we have agreed with the CSC Management that this needs addressing this with their staff.

CIC achieved the target, as detailed below:

<table>
<thead>
<tr>
<th>Table 11: Immunisation Benchmarking Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes: Published 2016/17</td>
</tr>
<tr>
<td>Milton Keynes Average Provisional 2017/18</td>
</tr>
<tr>
<td>England Average Published 2015/16</td>
</tr>
<tr>
<td>England Average Published 2016/17</td>
</tr>
<tr>
<td>Stat neighbour Average published 2015/16</td>
</tr>
<tr>
<td>Stat neighbour Average published 16/17</td>
</tr>
<tr>
<td>South East Average Published 2015/16</td>
</tr>
<tr>
<td>South East Average Published 2016/17</td>
</tr>
</tbody>
</table>

6.7 DENTAL CHECKS

Dental check statistics completion rate remained higher than the national average. Accurate recording of when a child/young person has attended is a difficult task; however, we do endeavour to capture data as robustly as possible.

<table>
<thead>
<tr>
<th>Table 12: Completed Dental Checks Benchmarking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes: Published 2016/17</td>
</tr>
<tr>
<td>Milton Keynes Average Provisional 2017/18</td>
</tr>
<tr>
<td>England Average Published 2015/16</td>
</tr>
<tr>
<td>England Average Published 2016/17</td>
</tr>
<tr>
<td>Stat neighbour Average published 2015/16</td>
</tr>
<tr>
<td>Stat neighbour Average published 16/17</td>
</tr>
<tr>
<td>South East Average Published 2015/16</td>
</tr>
<tr>
<td>South East Average Published 2016/17</td>
</tr>
</tbody>
</table>
Some young people refuse to attend appointments despite encouragement. The SW will continue to offer support and encouragement to attend. If specialist provision is needed due to a child or young person’s complex health needs, anxiety, or additional support for any other reason, they are referred to specialist dental services.

6.8 DEVELOPMENTAL CHECKS

Table 13: Completed Developmental Checks

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes: Published 2016/17</td>
<td>100%</td>
</tr>
<tr>
<td>Milton Keynes Average Provisional 2017/18</td>
<td>94.4%</td>
</tr>
<tr>
<td>England Average Published 2015/16</td>
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</tr>
<tr>
<td>England Average Published 2016/17</td>
<td>82%</td>
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<td>93.8%</td>
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<tr>
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</tr>
<tr>
<td>South East Average Published 2015/16</td>
<td>92.90%</td>
</tr>
<tr>
<td>South East Average Published 2016/17</td>
<td>92.2%</td>
</tr>
</tbody>
</table>

There were two children who were seen outside statutory timescale. This was due to both children being placed out of the MK area which incurred delay.

6.9 ANNUAL HEALTH ASSESSMENTS

Table 14: Completed Annual Health Checks Benchmarking

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes: Published 2016/17</td>
<td>91.8%</td>
</tr>
<tr>
<td>Milton Keynes Average Provisional 2017/18</td>
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<td>86.8%</td>
</tr>
<tr>
<td>South East Average Published 2016/17</td>
<td>87.1%</td>
</tr>
</tbody>
</table>

Milton-Keynes statistic for completion of annual health assessments remains consistently high. It should also be highlighted the increase in demand of our service due to significant increase in figures as indicated in section 6.1.

6.10 LOCAL REQUIREMENTS – REGISTRATION WITH A GP

All children and young people who are CIC are registered with a GP. The SW will provide the GP for the child on the health assessment request. Once the health assessment is completed-the full document will be sent to the GP in line with statutory guidance and as the central record holder of all health information. Foster carers are educated in line with statutory guidance relating to GP registration and SW advised this needs to be full registration- unless the child is waiting for a placement move. Only in this situation can registration be deemed temporary- for a maximum of three months.
7 OTHER CLINICAL ACTIVITY

7.1 SEXUAL HEALTH

This area of health is reviewed on all age appropriate cases as a key section in their CIC health assessment. If a need is identified, consideration may include discussion with the carer as appropriate with the young person’s consent. Confidentiality for the young person can be upheld by the health team as long as there are clearly no safeguarding concerns.

Milton Keynes has a specialist service BROOK Young People’s Contraceptive and Sexual Health Services for young people up to the age of 25 year’s. Confidential services include sexual health, contraception, counselling and education. They also run a Health and Wellbeing programme which can be 1/1 or group work, supporting young people to improve their own health and wellbeing and teach life-long skills. Programmes include focused interventions helping fostering of healthy relationships, avoiding risky or in-appropriate sexual behaviour, as well as developing greater confidence and self-esteem. Young people can access the provision, or can be referred by a health professional.

MK-CSC also has regular invites to training which is free to attend. An outreach service is provided in schools, MK College and other partners’ premises developing greater accessibility for young people.

BROOK Nursing Team has a close working relationship with the CIC Nurses, recognising the vulnerability and complexity of this group of young people. Complex cases/young people identified as at risk are discussed with BROOK on an individual basis. A robust service is actioned for young people who are of significant concern. BROOK also provided an outreach service for young people difficult to engage. This is a highly valuable resource for Milton-Keynes young people.

BROOK offer targeted work with refugees and asylum seekers. Work can explore the laws within this country relating to sexual relationships, consent and safety. Often young people will not previously have received education and also may be embarrassed by the subject being broached with them. It is important to offer them a confidential space to explore any issues related to relationships, sexual health and also feeling safe.

This service will be discussed and highlighted at the young person’s health assessment.

7.2 TEENAGE PREGNANCIES

There have been three young people who became pregnant with CIC status and one who has given birth in the last reporting year. All these young Mothers have since left CIC status and are now cared for and supported by the care leaver’s team. We have 4 care leavers who are being supported who have become Fathers.

Within Milton-Keynes there is a specialist Lead Midwife for Teenage Pregnancy. She cares for young people 17 years of age or under at the time of booking. She provides all antenatal care throughout pregnancy and continues to visit postnatally. All antenatal care is provided in the family homes of the young parents unless the women request otherwise. This provides the young parents with continuity of care/carer and reduces the risk of missed appointments.

The Lead Midwife for Teenage Pregnancy she also attended Child Protection Conferences, Core Group Meetings and Family Support Meetings.

7.3 SUBSTANCE MISUSE

Substance misuse is significantly more prevalent in the looked after population; evidence cited in the Care Matters White Paper (DfES, 2006) indicates that ‘Children In Care are four times more likely than their peers to smoke, drink alcohol or use street drugs’. The Government requires local authorities to collect statistics about those who have been looked after continuously for more than 12 months. They must also capture how many of those young people identified have accepted intervention for support. BAAF: Promoting The Health of Children In Public Care (2015).
All young people have substance misuse covered as a key area in their CIC health assessment. All who are identified as having a difficulty with substance or alcohol use or who may present at risk of developing a difficulty, will have access to support. There were 7 young people identified as misusing substances in the reporting year. We are unable to compare to other MK figures as process for data collection had not been as robust as needed. The importance of early intervention and prevention is fully recognised. Social workers are active in accessing/offering support immediately a problem is identified. The importance of moving towards a wish to make change is promoted, though not always accepted by the young person.

Compass is a national charity which MK-CSC commissions to provide a service for young people under the age of 18 living in Milton Keynes. They deliver targeted and structured work supporting young people with drug and alcohol problems and also support parents/carers. Compass use a range of interventions including Cogitative Behavioural Therapy, motivational interviewing, harm reduction and solution based therapies. 1/1 work is not time limited, rather goes on the presenting needs and engagement. Guidance can also be provided for family/carers if there is a young person who is causing concern.

7.4 EMOTIONAL HEALTH AND WELLBEING

7.4.1 The Needs of Children In Care

Children In Care and young people have consistently been found to have much higher rates of mental health difficulties than the general population with almost half (three quarters of whom will be in residential homes) meeting the criteria for a psychiatric disorder. (NSPCC 2014 P.7: What works in preventing and treating poor mental health in Children In Care)? There are many reasons for this, including the experiences they have once they enter care which can further contribute to both the causes and the nature of difficulties. Despite this, there is evidence to suggest that many children, depending on individual circumstance, do better remaining within the care system as opposed to being returned home. Evidence also suggests that early intervention to promote mental health and wellbeing can prevent the escalation of challenging behaviours and reduce the risk of placement breakdown (SCIE 2010:28).

The clinical commissioning group commissions CAMHS for young people who are placed out of area and require CAMHS support from their local service.

7.4.2 Mental Health Service Provision

A Primary Mental Health Worker for Children In Care (PMHW-CIC) post is jointly funded between CSC and the Child and Adolescent Mental Health Service (CAMHS). This is in accordance with guidelines which state “In sites where CAMHS workers are co-located for part of the week, or where they are fully integrated into looked-after children and young people teams, the result is better and speedier access to CAMHS for looked-after children and young people.” (NICE guidelines CIC 2010).

7.4.3 Primary Mental Health Worker:

The role of the Primary Mental Health Worker (PMHW) fully commenced in January 2018 and is now embedded within the corporate parenting team. This position is key in offering assessment, support and guidance through analysing difficulties children may present with relating to their emotional well-being and mental health.

Interventions offered include:

- Consultation to discuss particular difficulties a child/young person may be displaying.
- Direct assessment of a child/young person’s mental health needs.
- Assessment of how a carer may be able to support a child/young person with better understanding of their behaviours and utilise supportive strategies.
- Referral to MKSpCAMHS if there is a mental health presentation or out of county CAMHS if placed out with MK.
- Direct intervention with a child or young person.
- Direct intervention with a carer/s.
- School based observation of a child/young person.
- Psycho-education for carers/staff.

Definitive themes have not emerged regarding presenting problems/symptoms however accelerated behaviours and heightened anxiety features within many of the intervention requests.

7.4.5 SDQ scores completed by carers as a statutory duty

From April 2008, all local authorities in England were required as a statutory duty to provide information on the emotional and behavioural health of children and young people in their care. The assessment tool used is the Strength and Difficulties Questionnaire (SDQ). This is a short behavioural screening tool assessing five key areas - emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also positive behaviour, plus an “impact supplement” to assist in the prediction of emotional health problems. It is completed for all who have been in care for a period of 12 months or more who are between the ages of 4 and 16 inclusive (www.gov.uk).

Analysis of SDQS found:

- **276** scores required completion and of these **197** are recorded (71%).
- This is an overall increase of 64 children requiring completion of this emotional wellbeing tool.
- It is significant that **68** children had a score of above 17 (35%). Last year’s figure indicated 38% above score of 17.
- Scores of 17 and above, indicate there is an area where the child/young person is struggling. In each case where a high score is identified, the CIC Nurses review and assess what additional support may be required or is already being provided. Case discussion can also take place with the PMHW and SW.
- The child’s Social Worker and IRO should also be monitoring the child’s progress through the year and flagging cases of concern to the PMHW for joint discussion.

To ensure SDQ’s are completed for every child between the ages of 4- up to 16 years it has been recognised that improved tracking is required. CSC management and health are in discussion to improve monitoring to support completion. Currently, the process leaves room for non-completion as there is no defined responsibility. This is identified as a priority under the ‘Priorities for the coming year’ section.

7.4.6 Adolescent Wellbeing Tool

How young people feel in themselves is central to any health assessment. The limitations of the SDQ were recognised when assessing UASC at their IHA. The Adolescent Wellbeing Scale is a tool devised as by Birleson to pick up possible depression in older children and adolescents. This scale is completed in IHA clinics for all young asylum seekers to promote assessment of their needs to ensure their emotional needs on entering care were understood.

It can also be used as one tool for any young person in the age range 11-16 as need indicates either at assessment or if concern is raised that there may be symptoms of depression emerging.
7.5 **TRAINING**

*Training has been provided for a range of stakeholders as detailed below:*

**Social Workers:** The CIC Nurses offer sessions for social workers who join MK-CSC to advise of the health assessment process and their roles and responsibilities. This also promotes positive partnership working and gives the opportunity for the social worker to know who we are and how we can help with health queries.

**Training for Foster Carers:** The CIC Nurses provide training for foster carers ‘Good Health for Children In Care’ and ‘Medication Safety’. This year we had a session from the Specialist Health Visitor for Paediatric Continence service and also a session from the PMHW, both of which were well received.

The CIC Nurses also attend training sessions run for new foster carers in order to highlight their roles and responsibilities in promoting the health of the children in their care.

**Public Health:** The CIC Nurses are members of the MK Healthy Young People’s Network which is run by public health. This gives us valuable access to up to date, evidence based health resources.

**Health Promotion:** As part of the health assessment process, all children and YP are weighed and measured. This is a great way to engage the children and many love to see how much they have grown. The BMI is calculated if we have a concern about their weight either being too low or a high. Centiles are also recorded.

*Eating problems and food-related behavioural difficulties are more common in those who are, or have been, in care. 24% of children aged 4 to 11 years who were looked after showed difficulties with eating patterns, including over eating, stealing and storing food Tarren-Sweeney (2006). Eating issues can relate to experiences of poverty, chronic neglect and emotional distress.*

The CIC health Team use the assessment process for health promotion and advise and support the child/carer where needed. Often children can be very food focused so it is important to be sensitive about this and advise accordingly.

7.6 **COMPLEX CASE WORK**

7.6.1 **Strategy Meetings**

As part of the role of the CIC Nurses, we are requested to attend strategy meetings in relation to complex or high risk cases. Tasks we have been involved with can relate to accessing health provision a young person may need, e.g. sexual health screening or support, liaising with services to fast track reports—e.g. Police medicals, child protection reports and generally giving an overview of the young person’s health or supporting identification of where risks may lie. The benefits of a multi-professional approach are well evidenced.

7.6.2 **Child Sexual Exploitation (CSE)**

Children and young people who are looked after can be highly vulnerable to child sexual exploitation. All those involved in their care must be clear and proficient at noticing warning signs, completing risk assessment screening tools and raising concerns whenever a child may be at risk of, or potentially subject to, sexual exploitation. No CIC should be considered low risk. Cases of concern are referred for discussion to the Multi-Agency Risk Management Meeting (MARMM). Social care, police, health and voluntary sector professionals will scrutinise the plans and put actions in place to protect the child, disrupt CSE activity and deal with potential and actual perpetrators. Nationally there is recognised under-identification in males.

7.6.3 **Complexity of health needs identified at health reviews**

The damaging impact of children’s experiences prior to coming into care on their emotional and behavioural needs is evident. They often present with behavioural challenges in school, which has a significant impact on their learning, self-esteem, confidence and self-belief and ability to have secure social connections.
These children often don’t reach the threshold for an ‘Educational Health Care Plan’ (EHCP) which would give them additional support within school and into adult learning. Support in primary is often manageable however in our experience, when transitioning to secondary school, the gaps in learning and change of learning environment can be extremely difficult for them to adjust. Transition planning needs to be robust and will be covered in the health plan as a multi-agency approach.

7.6.4 The importance of continuity

The importance of continuity for these children is well recognised. The Specialist CIC Nurse has worked with the children and young people for eight consecutive years.

One young person, who she had seen for 6 years, had recently returned to the care of his parents who he had not lived with since he was 9 years old.

At his review health assessment, it was noted that he presented as very quiet and gave minimal responses, which was very unlike him.

As part of the assessment process, young people are given time on their own with the nurse giving them the opportunity to speak in confidence if wished. It was at this point that he was able to speak more freely and said how he was suffering with very low mood. He felt guilty and blamed himself for him and his brother being in care. He did not want to worry his parents and did not know who to talk to. The Nurse assessed the level of risk and re-assure him was that support could be sought from the primary mental health worker, who would help and advise. The young person seemed more settled and engaged following this discussion.

An initial planning meeting was held in school with the CIC Nurse, the YP and the PMHW. Information was also able to be shared with the SW, school and with parents. Therapeutic support was provided by the PMHW in school. The young person was ultimately was able to work through this difficult stage in his life able to experience appropriate security from the adults around him.

8. ADOPTION & FOSTERING

National Adoption Statistics

Statistics for reporting year 2018 have yet to be released however there is evident decrease nationally on children adoption figures. The number of looked after children adopted has fallen, despite the rise in the number of children coming into care. Charity Adoption UK reports ‘the number of children in need of adoption is higher than adopters available’.

National statistics have been affected following court rulings in 2013, the Child and Family Courts who grant adoption status support the aim that children are placed within their family network under Special Guardianship Orders, unless there are safeguarding concerns or indications that this is not in the child’s best interest.

Milton-Keynes adoption figures in 2017/18

The adoption Team, in partnership with the service as a whole, undertake regular permanence tracking of children waiting for adoption. There is also regular tracking of adopters in assessment and those waiting which means that matches can be considered as early as possible. Adoption involvement at legal planning panels means that children and those not yet born who may have a plan of adoption are being considered for family finding at the earliest point possible. A service wide approach is being taken to drive adoption figures up through the monthly tracking meetings and early referrals from the Family Support Team to the Adoption Team.

Adopter approvals completed totalled 9. This indicates an increase of 5 cases when compared to reporting year 2016/2017 figure of 4.
Adoption orders granted totalled 9. This indicates a decrease of 2 adoption orders granted when compared to reporting year 2016/2017 figure of 11.

Children assessed as adoption being in their best interest: 30. This indicates a decrease of 6 children, when compared to reporting year 2016/2017 figure of 36.

**Age range of children placed for adoption**

<table>
<thead>
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<th>Age range of children placed for adoption:</th>
<th>Previous reporting year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range below 1 year: 3</td>
<td>5</td>
</tr>
<tr>
<td>Age range 1-4 year: 13</td>
<td>22</td>
</tr>
<tr>
<td>Age range 5-9 year: 12</td>
<td>9</td>
</tr>
<tr>
<td>Age 10-15 year: 2</td>
<td>0</td>
</tr>
<tr>
<td>Currently ‘Waiting’ for a family to be identified: 14</td>
<td>10</td>
</tr>
</tbody>
</table>

In the last twelve months there has been a conservative effort from the service to ensure there is early consideration of adoption in permanency planning. The team also promote improving adoption knowledge and practice of the children’s social workers through adoption surgeries and team visits.

**CNWL-MK Designated Doctor as Medical Adviser**

The Designated Doctor in her role as Medical Adviser is a member of the Fostering and Adoption panel. The Fostering and Adoption panel is going through a period of significant changes due to changes in legislation and national directives.

Meetings are held between the Medical Adviser and the MKC Professional Adviser to ensure all relevant health issues are fully considered for each case. The Medical Adviser also reviews the health assessments of prospective adopters and foster carers completed by their GP and provide written comments for consideration at panel.

Medical Advice and guidance are provided to panel. The Medical Adviser also meets with all potential adopters to clarify individual health needs of the child. Some may have health issues which cause the prospective adopters a level of uncertainty. It is crucial that they are given expert advice, guidance and time to explore concerns fully and openly. Advice and guidance is also offered to social workers required for presentation at fostering and adoption panels when there are particular health issues which require specific consideration for a secure placement.

Consultant appointments also take place in relation to ‘best interest’ decisions for a child. It is imperative that a child’s health needs are fully discussed to ensure they have the best possible decision made for them so their long term health needs are fully supported.

There have been 211 adult health medicals reviewed which comparable to last year’s figure of 215.

There is higher level of medical issues and lifestyle issues seen in relation to connected persons or family members being considered as carers compared to carers who are not related to the children. This has its intrinsic challenges in ensuring the welfare of the child remains paramount.

**Best interest decision and meeting with Prospective Adopters:**

There were 27 ‘best interest’ decisions in the year, compared to 15 in the last reporting year. 17 children were discussed with prospective adopters, compared to 9 of last reporting year.

There is a significant increase in the number of medical discussions with adopters, a reflection of the overall increase in the number of children placed for adoption by Milton Keynes LA.
Foster and Adoption Panel Process:

The Named Nurse and the Specialist Nurse are members of the fostering and adoption panel which meets every two weeks. Their attendance is alternated to ensure there is health representation at panel. Health representation covers all aspects of physical and emotional wellbeing in relation to the child and the prospective foster carers when considering placement suitability. Individual requirements are considered and discussed with the key focus being for a secure, stable and nurturing placement. Foster carer reviews, terminations and change to agreed placement are also heard.

This reporting year 22 panels were held—as compared to the previous reporting year of 27.

There were 16 adoption matches—as compared to 3 in the previous reporting year.

Adoption approvals are when prospective adopters are initially approved as adopters and matches are where adopters matched with children.

There were 11 adopter approvals, compared to 3 in 2016/17. the previous reporting year.

9 SERVICE IMPROVEMENTS

Priorities highlighted for addressing in the Annual Report 2017/2018 have been completed:

- ‘Consent to Placement and Medical Treatment’: Now embedded and working well.
- Meeting the emotional wellbeing and mental health needs of all CIC: Primary Mental Health Worker in post within the corporate parenting team.
- Voice of the child: Development of ‘understanding consent for a health assessment’: Completed.
- Improve the recording of substance misuse and interventions accepted by young people: Completed.
- Audit of IHA and RHA assessments to ensure effective quality assurance: Completed.

9.1 SPECIFIC IMPROVEMENTS: See also section 6.1.

9.1.1 Implementation of CIC clinics for completion of RHA

In November 2018 the CIC Specialist Nurse started to offer clinic appointments in order to offer further choice for our young people. Due to the nature of our work children and YP were selected for clinic ensuring that this was a suitable environment to offer them.

Initially this was at a health centre in Milton Keynes. It was recognised that young people may also want to come to a familiar environment and so appointments were also offered Saxon Court - Children’s Social Care building.

22 appointments have been arranged. 13 booked at the Health Centre and 9 booked at Saxon Court. Of these, 13 appointments were attended. 9 appointments were DNA. There were various differing reasons for non-attendance. One related to the young person’s emotional wellbeing in the day being too unsettled to attend. The remainder was through young people/carers forgetting/not prioritising the appointment.

For some of the YP selected it was felt that it would help develop their independent skills and also prioritise the importance of being registered with a GP.

Challenges:

The majority of the clinics have been for young people, aiming to promote their independence skills and also give them a more private area to share worries/queries with the Nurse- outside the home environment. One of the YP (who was now 17) and who had previously always been seen in his home environment shared that ‘He really didn’t like coming to clinic because it felt like I was going to give him an injection’.
Younger children have also attended with their carer. The Specialist CIC Nurses observation was that for younger children, the environment was not inviting enough. They did not have their own things to play with or entertainment that they would have had at home. When the Nurse had time to discuss their health just with the carer-they became very fidgety and bored.

Clinics technically increase nursing capacity; however when appointments are not attended, this then becomes more time consuming and risks delay in offering an alternative appointment within statutory timescale.

The process of organising the clinic is time consuming for the Specialist Nurse.

We will continue to monitor and review progress.

9.1.2 Implementation of carers reports

In line with good practice recommendations, the implementation of the carers report has been agreed with MK-CSC. This is report is a ‘Profile of behavioural and emotional wellbeing of a child/young person’ and will be completed by the child’s main caregiver/s. It is an opportunity for them to share their knowledge of the child/young person’s emotional and behavioural presentation. It can highlight individual strengths as well as vulnerabilities and captures what form of emotional support works for the individual child in alleviating any particular difficulties and what may not. The report then forms part of the child/young person’s health care record.

Previously these were completed for children who were being placed for adoption as best practice. Having these for all children and young people in care will strengthen capturing the voice and views of the carer and help the assessing clinician completing assessments have a broader understanding of their needs.

9.1.3 Implementation of Hepatitis B protocol for foster carers

Joint agreement and launch of information for Foster Carers about Hepatitis B (HBV). In addition this enables CSC to capture the signature of the foster carer confirming they have read and understood the guidance and also if they plan to have the vaccination. (Appendix 2)

9.2 AUDIT

The Designated Nurse has completed a retrospective audit on the quality of health assessments of Looked after Children. 31 Health assessments were looked at as part of the audit and cross section of Initial and Review Health Assessments, under 5s and over 5s.

There were a number of good outcomes identified:

- None of the samples group had any outstanding health appointments
- Evidence that carers views are sort as part of the assessments
- Good identification of newly identification health issues at the Initial assessments.
- Evidence of referrals to other service as needed.
- All groups had a clear Health plan in place with clear timeframes.

Areas identified for further consideration and potential development:

- Need to understand better if children and young people are being offered the opportunity to be seen alone for RHA as data shows 0% for under 5s and 33% for over 5s and if there is good rationale for exceptions.
- The data shows that the voice of the child is heard well in IHAs over 5 years but in both IHA and RHA under 5 it is not so strong. Consider how to hear the voice of younger children more effectively though health assessments.
Need to understand better the use of SDQ scores and how these are used to influence health planning for children and young people. Consider building on strengthening the use of SDQs with all children and young people to inform their journey.

The learning from this audit has informed the LAC team’s priorities for 2018/19. There are plans to repeat the audit November 2018.

9.3 PARTNERSHIP WORKING

In 2017/18 ‘Our Voice’ (Children in Care Council) focused on campaigning about Health Assessments and better relationships with Social Workers. The group developed a handover process for social workers to adopt should a change of social worker occur and designed a poster explaining what a Health Assessment is and what consent means in a child friendly way. The group have also concentrated on a ‘Coming into Care Pack’ for children over 8 explaining care, their rights and entitlements and reassuring them that there are lots of people to support them whilst they are in care. The pack was launched in December 2017 and a primary aged pack is being developed for later this year. Our Voice meets with senior managers and the Corporate Parenting Panel (CPP) to express their views and update them on their projects. They also attended and hosted, a regional event, bringing together members of other Children in Care Councils in the region to discuss common issues. The region is working on top tips for social workers, which will be turned into a film in time for National Care Day in 2019.

After the Care Leaver Review in 2017, a Care Leaver Forum was created to concentrate on care leavers issues. The group have presented to the CPP and the Senior Leadership Team about their shared experiences of being a care leaver and offered recommendations. The group want to concentrate on creating a programme around independent skills and a buddy system to support future care leavers. The group have also supported the development of a new Care Leaver website, which will house the new local offer for care leavers and have been consulted on the new finance policy.

In 2018, two new groups started. The first is for adopted and special guardianship children and young people. The group (which has juniors and seniors) will meet once a term and provide summer activities. The second group is for birth children of foster carers. Both have opportunities to develop participation activities and offer a great opportunity to hear the voices of these children and young people.

During 2017-2018 a number of young people have been involved in the Skills to Foster Training, interviewing senior staff members and being involved in commissioning projects.

**Signposting for support**

If a child/young person is overweight and it is felt support/guidance may be helpful, a referral can be made to ‘Alive N Kicking’. This service is commissioned by MK Council to deliver lifestyle programmes to children aged 5-18 years and their parent/carer, who are on/above 91st centile. This offers both a fun and learning around healthy eating, nutrition, food preparation, learning to shop healthy and actively sessions.

If a child/young person is placed out with MK then a local re-source is sought. Dietician referrals are also considered when there is concern. Health promotion is also put on the health plan as a resource for carers and young people to access together:

**CHILDREN IN CARE HEALTH AND SOCIAL CARE FORUM (HSCF)**

The Children In Care’s Health and Social Care Forum meets quarterly aiming to provide operational support to the CIC health team and the MK-CSC team to meet health needs through multi-agency working. It has been chaired by the Designated Nurse for Children In Care and Safeguarding. The Head of Delivery of Corporate Parenting will be joint chairing in this coming year. Panel members include representatives from across health and social care teams to ensure collaborative practice and the sharing of ideas. This includes the Youth Participation Worker – Children’s Social Care. Independent Review Officers are also represented. Commitment to this forum has been impressive, despite the challenges of busy schedules. Joint ownership across health and CSC is promoted.
**Standard Agenda Items:**

1) Mental health Provision for Looked After Children: Overview from PMHW/CAMHS in relation to CIC.

2) Performance statistics: IHA and RHA Statistics and any areas affecting performance.

3) Our Voice- Hearing the voice of children and young people. An update on young people’s projects including focus on health.

4) UASC: Update on areas of health requiring joint review.

5) Each team update: What’s working well? What challenges are we facing? Any joint work/focus needed?

6) Joint review of the priorities identified for the reporting year in the annual health report.

**Joint work between health and CSC taken forward through the HSCF has included:**

1) **Consent to Placement and Medical Treatment Form:** This enables signed parental consent to be obtained authorising statutory health assessments to be completed, at the same time as signing to agree for their child to come into the care of the local authority. This is now embedded at the initial care process.

   Training sessions for SW teams were provided by health to enable a robust understanding of the process and reason for implementation.

2) **Voice of the child:** Development of ‘understanding consent for a health assessment’.

   Young people developed a poster overview of consent and what this means in relation to the health assessment and a joint evening for discussion took place with corporate parenting panel members to discuss their views.

3) **Voice of the Child/Young Person:** This is a standard agenda item to promote hearing CIC views and ideas and providing the opportunity to consider service change and development.

   The Youth Participation Worker actioned direct work with young people developing the poster for promoting understanding of consent.

4) **MOMO (Mind Of My Own):** Discussed and promoted. This is an on line App which obtains YPs views and records issues enabling young people to capture their thoughts and views and send by email alert directly to the SW, IRO’s or other professionals with a problem, question or positive story. The app is being used across the service and is being adopted well by some teams.

5) **Improve the recording of substance misuse and interventions accepted by young people:**

   This statutory recording process was addressed and improvement implemented by CSC Management to ensure all cases of substance misuse and interventions offered is captured on ICS enabling accurate data collection.

6) **Implementation of Carers reports:**

   Discussion around importance of reports capturing views of carers and to be used as part of the health assessment process. Further work required.

7) **Hepatitis B Immunisation:** Joint agreement and launch of information for Foster Carers about Hepatitis B (HBV). In addition this enables CSC to capture the signature of the foster carer confirming they have read and understood the guidance and also if they plan to have the vaccination.

8) **Review of Promoting the health of children in care joint protocol:**

   The joint protocol for health and CSC has been reviewed in line with changes to practice. This has been reviewed and approved.
9.4  **INSPECTION UPDATES**

The CQC conducted a week long review of Milton Keynes health services in safeguarding and Children In Care. This report was published in October 2016.

The inspection looked at the role of providers and commissioners and the inspection report summarises the findings. The full inspection report can be found at [http://www.cqc.org.uk/sites/default/files/20161019_clas_milton-keynes-final.pdf](http://www.cqc.org.uk/sites/default/files/20161019_clas_milton-keynes-final.pdf)

9.5  **PROFESSIONAL DEVELOPMENT AND TRAINING:**

The health team have access to all training provided by Milton Keynes Safeguarding Children’s Board and all training provided by MK-CSC as a free resource. In addition the health team, MK-CSC and all foster carers have access to a free and substantial training programme run by BROOKS’s services.

The CIC Nurses attended a new LAC Nurse/LAC Administration Networking Forum run by Berkshire. This was valuable looking at challenges teams face, what is going well, and what areas that may be focused on for the future.

The Designated Doctor and Named Nurse CIC attended NHS England training day looking at standard approaches to meeting the needs of CIC. Tools from this study day are being used within the Health Team Efficiency & Productivity Plan for CIC Milton Keynes (see section 5).

10  **PRIORITIES FOR THE COMING YEAR:**

1)  **Dental Pathway-signed consent**

Health and CSC to develop an agreed pathway with specialist dental service in relation to streamlining process for signing consent for children requiring anaesthetic.

2)  **Implementation of M&B forms**

Health and CSC to develop process to ensure signed Maternal consent is obtained by the SW so that information from maternal birth records can be obtained for all babies coming into care. This is to ensure there is a robust understanding of maternal health needs, and subsequently the health needs of the child.

3)  **Develop TB Pathway to ensure all UASC are screened promptly and efficiently when entering care**

Pathway to be progressed by ‘Public Health’ to agree process and access for TB screening for all UASC.

4)  **Carers report required for all IHA and RHA assessments**

Health and CSC to ensure process for completion is in place and all are completed in a timely manner for assessments.

5)  **SDQ’s to be completed by young people and schools as appropriate alongside carers statutory completion- to ensure this tool is used as effectively as possible for monitoring children’s emotional well-being**

Health and CSC process to be agreed to ensure carer’s statutory completion for all children aged 4-16 years and in addition all young people and schools as appropriate.

6)  **Health statutory data reporting for CSC**

CSC to ensure a robust process is in place which will evidence promptly when one of these health needs has not been addressed.

CSC to ensure a robust process is in place for capturing completion of health requirements for every child.
APPENDIX 1

References

The Adolescent Wellbeing Scale is a tool devised by Birleson  www.corambaaf.org.uk


Department of Health, Care Matters: Time for change (2007)

Department of Health: Healthy lives, brighter futures: The strategy for Young People’s Health (2009)

Department of Health: Making sure health and social care services work together.

Milton Keynes Clinical Commissioning Group/Milton Keynes Council: Joint Strategic Needs Assessment Executive Summary (2012/2013)


SCIE: Looked-after children and young people, NICE public health guidance 28 (2010)

Strategy for Children in Care: MKCSC (2013-2016)