

## NOTICE OF MEETING

# CORPORATE PARENTING ADVISORY COMMITTEE

**Monday, 3rd October, 2016, 7.30 PM or on the rise of the informal meeting with Aspire - Haringey Civic Centre**

**Members:** Councillors Patrick Berryman, Bob Hare, Jennifer Mann, Liz Morris, Felicia Opoku, Anne Stennett and Elin Weston (Chair)

Quorum: 2

### **1. FILMING AT MEETINGS**

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

### **2. APOLOGIES FOR ABSENCE (IF ANY)**

To receive any apologies for absence.

### **3. URGENT BUSINESS**

The Chair will consider the admission of late items of urgent business. Late items will be considered under the agenda item they appear. New items will be dealt with at item 14 below.

### **4. DECLARATIONS OF INTEREST**

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the consideration becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member' judgement of the public interest.

**5. MINUTES (PAGES 1 - 10)**

To consider the minutes of the meeting held on 4<sup>th</sup> July 2016.

**6. MATTERS ARISING (PAGES 11 - 12)**

Discussion of the follow up actions following the earlier meeting with Aspire.

**7. PERFORMANCE (PAGES 13 - 18)**

**8. DISCUSSION AROUND FUTURE MEETING SET UP/AREAS OF FOCUS (PAGES 19 - 50)**

**9. LAC NUMBERS & DEMAND LEVELS (PAGES 51 - 64)**

**10. FOSTER CARE RECRUITMENT UPDATE**

Verbal update

**11. PAN-LONDON ADOPTION BID**

Verbal update

**12. UPDATE ON THE SITUATION AND FUNDING OF UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC) (PAGES 65 - 70)**

**13. UPCOMING SCRUTINY REVIEW ON CORPORATE PARENTING (PAGES 71 - 74)**

**14. NEW ITEMS OF URGENT BUSINESS**

As per Item 3.

**15. TERMS OF REFERENCE AND MINUTES FROM THE HARINGEY CHILDREN IN CARE OPERATIONAL GROUP (PAGES 75 - 128)**

**16. EXCLUSION OF THE PRESS AND PUBLIC**

That the press and public be excluded from the meeting for consideration of any items that contain exempt information as defined in Section 100a of the

Local Government Act 1972 (as amended by Section 12A of the Local Government Act 1985): Paragraphs 1 & 2: namely information relating to any individual, and information likely to reveal the identity of an individual.

**17. MINUTES**

To consider the exempt minutes of the meeting held on 4<sup>th</sup> July.

**18. ANY OTHER BUSINESS**

Date of next meeting: 12 January 2017.

Philip Slawther, Principal Committee Co-ordinator  
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Bernie Ryan  
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Date 26<sup>th</sup> September 2016

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Councillors Cllr Weston [Chair], Cllr Berryman, Cllr Mann, & Cllr Opoku

Apologies Cllr Morris & Cllr Stennett

Also attending Jon Abbey (Interim Director of Children's Services), Neelam Bhardwaja (Assistant Director – Safeguarding and Social Care), Dominic Porter-Moore (Head of Children in Care & Placements), Annie Walker (Service Manager Children in Care), Lesley Kettles (Service Manager for Adoption and Fostering), Fiona Smith (Virtual School Head), Margaret Gallagher (Corporate Performance Manager), Philip Slawther (Clerk), Lyn Carrington (Nurse - Whittington Health NHS).

**CPAC337. APOLOGIES FOR ABSENCE (IF ANY)**

Apologies for absence were received from Cllr Morris & Cllr Stennett.

**CPAC338. ACTIONS ARISING FROM THE MEETING WITH ASPIRE**

NOTED: The actions listed in the notes of the meeting with Aspire.

The next Aspire meeting would be extended to 1 hour and the agenda would include reports on; the Aspire budget, housing issues and proposals for updating the Haringey Pledge.

**CPAC339. URGENT BUSINESS**

NONE

**CPAC340. DECLARATIONS OF INTEREST**

NONE

**CPAC341. MINUTES**

The minutes of the meeting held on 4 April 2016 were AGREED.

An example of PEP's, Care Plan & Pathway Plan was circulated to the Committee.

In relation to the previous action around extending the one-to-one support with Drive Forward, which was currently offered to LAC third year university students around CV development; the AD Safeguarding confirmed that she had spoken to Emma Cumbergen and that the programme would be brought forward to offer support to students at an earlier stage in their studies but would also maintain the offer at year 3 as well.

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**CPAC342. MATTERS ARISING**

The Committee NOTED the Corporate Parenting Agenda Plan 2016/17

**CPAC343. TERMS OF REFERENCE**

The Committee NOTED the Corporate Parenting Advisory Committee Terms of Reference for the 2016/17 municipal year and plans for future CPAC meeting set up.

The Chair advised that going forward she would like the meetings to consider a smaller number of agenda items in order to facilitate greater discussion and place an emphasis on looking forward as opposed to being reactive. The Chair proposed that a number of reports would be for noting and taken by exception, and then a significant part of the agenda would be devoted to discussions around key issues and that it was hoped that the Committee could help steer the policy agenda.

**Clerk to note**

The Committee was requested to review the handout tabled from the Centre for Public Scrutiny entitled: "10 questions to ask if you're scrutinising services for Looked After Children" along with the Committee's Terms of Reference, for discussion at the next meeting about which areas the Committee should focus its attention upon going forward. In particular the Chair drew the Committee's attention to aspects around Health which were not routinely discussed at present.

**Action: Members**

Lynn Carrington, Designated Nurse Children in Care enquired whether the Committee would like to receive the minutes from the operation group involving the ILO at future meetings as they were not currently reviewed by another body. The Committee AGREED that the future minutes of the operation group would be reviewed, on an exception basis.

**Action Lynn Carrington**

**CPAC343. PERFORMANCE**

RECEIVED the report on Performance for the Year to the end of May 2016. Report included in the agenda pack (pages 15 to 21).

NOTED in response to discussion:

- An overall improving trajectory in relation to the majority of performance indicators.
- 431 children were in care on the last day of May 2016 or 73 per 10,000 population including 30 unaccompanied asylum seeker children. There had been a gradual increase in the level of children in care in comparison to the position at the end of March 2016, with 22 more children in care. However a reduction in Haringey's rate of looked after children in 2015/16 placed LBH

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within the inter-quartile range of our statistical neighbours (a rate of 69 per 10,000 population), although the current rate remained above the London (52) and national average (60) rates.

- A performance review system put in place by the Head of Service for Children in Care in October 2015 yielded some excellent performance improvements. Weekly meetings with Team Managers run by the Head of Service and facilitated by a representative from performance were continuing and focused on new improvement challenges.
- As of the end of June: 85% of school aged children had completed an up to date Personal Education Plans (PEP); 96% of looked after children aged 16-17 had up to date Pathway Plans; and 95% had completed an up to date Care Plan. Performance had improved dramatically in this area over the past 12 months.
- 94% of Children in Care had an up to date review at the end of May above the 90% target.
- At the end of May, 96% (382 out of 402) of children in care for over a month had an up to date health assessment, above target and continuing the positive trend. We are also now tracking 18 year olds leaving care that receive their health history and the position at the end of May was 78% for that indicator.
- 17 (7%) of looked after children (aged 10 and over) were convicted or subject to a final warning during the year 2015/16, a reduction and improvement on our 2014/15 position of 8.4% and significant improvement on the 11% for 2013/14. This remained higher than the latest published England average rate of 5% but was in line with our statistical neighbour average of 6.9%.
- Data for the period April 2015 to March 2016 revealed that the average duration of care proceedings for concluded cases was 34 weeks, the same duration as that recorded for 2014/15. 45% of cases were concluded in less than the 26 week statutory timescale, an improvement on the 34% achieved in 2014/15 with the shortest average case length of 29 weeks in quarter 4.
- 95 children or 24% were placed 20 miles or more from Haringey at the end of May 2016, an additional 19 children since the position at end of January 2016 although the number of looked after children also increased over the same period. Performance was worse than the 16% target and provisional March 2016 end of year position (23%). Although higher than national levels this proportion is only slightly above the average for London and our Statistical Neighbours (18%).
- Provisional data for the end of year looked after children government return shows that 82% or 254 children who were in care for over 12 months had their teeth checked by a dentist. This is a decline on the reported level of 91.5% in 2014/15 but close to our statistical neighbour position of 85.4%. Focussed

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effort to ensure all children in care for over 12 months with an outstanding dental check is on-going to see if we can capture any additional children who have had their teeth checked maybe as part of their health assessment.

- Performance on care leavers in suitable accommodation and in education, employment and training for 2015-16 was below levels achieved in 2014-15. However, like for like comparison cannot be made, as the SSDA903 OC3 cohort previously included former relevant care leavers whose 19<sup>th</sup>, 20<sup>th</sup> or 21<sup>st</sup> birthday fell in the reporting year. Provisional data currently showed 39% of *all* former relevant care leavers aged 17-21 were in EET (56% of those who were *in touch* with the local authority around their 17<sup>th</sup>, 18<sup>th</sup>, 19<sup>th</sup>, 20<sup>th</sup> or 21<sup>st</sup> birthday). 60% of all care leavers were in suitable accommodation or 87% of those who were *in touch*.
- Children missing numbers have been relatively stable in 2015/16 but more recently the children missing from care numbers have been showing an increasing trend. In May, 22 children were recorded as missing from care at any point during the month. 20 children were away from placement without authorisation.
- The SSDA903 data for 2015-16 also showed an increase of children missing from care (72 children in comparison to 45 in 2014-15). There were 237 missing/away from placement episodes compared to 90 in 2014/15. This figure was closer to our 2014-15 statistical neighbour average of 252 missing/away episodes. Some of this increase may be attributable to improved systems for recording data on missing children and real time tracking of children who went missing using a register.
- There has been a 30% reduction in Haringey's rate of looked after children since 2011 compared with a 10% reduction in London and a 3% increase nationally. The graphs below shows the 7 year trend to March 2016 in comparison with the number and rate of our statistical neighbours. Since the end of March there has been a net increase of 16 children coming into care (6%) but Haringey's rate of looked after children is not dissimilar to that of our statistical neighbours.

AGREED to note the report.

The Committee sought clarification on who were Haringey's statistical neighbours. In response officers advised that it was a group of around 7 or 8 London boroughs which had a similar make up and demographics to Haringey. The Corporate Performance Manger agreed to circulate the list of statistical neighbouring boroughs to the Committee.

**Action: Margaret Gallagher**

**CPAC344. PAN-LONDON ADOPTION BID**

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NOTED the verbal update given by the AD Safeguarding on the Pan-London Adoption bid. The Committee was reminded that two options for the Pan-London Adoption model were: 1) A local authority trading company delivery model with a strategic VAA partnership operating in a hub and spoke, or 2) a local authority/voluntary adoption agency joint venture operating in a hub and spoke model. The Committee noted that following detailed assessment of the respective viability of the two options London Councils had, following the receipt of legal advice, expressed a preference for the first option. The reason that option 1 was preferred was as a result of the additional steps required to implement option two and the greater uncertainty for stakeholders, as well as the likely delay involved in setting up the model and the additional expense. Whereas, option 1 offered a quicker and more cost-effective model. The next steps involved further development of the preferred option to better understand what this would mean in practice

The original rationale for the regionalisation of adoption services was outlined as a consideration by central government that 33 London local authorities, each with their own separate adoption service was not an efficient or effective way to run adoption services. The focus was highlighted as being on adoptive recruitment and matching, with recognition that each of the London local authorities was essentially trying to recruit from one large catchment area and the negative consequences that this entailed, as well as the financial benefits that result from the economies of scale. The Chair highlighted to the Committee that the Secretary of State had powers to force local authorities to join a regionalised body and the general consensus was that it was better for authorities to voluntarily come together to determine what the best model was.

In response to a question, the AD Safeguarding advised that in terms of the implementation date, the bottom line was 2020, however there was significant political pressure to implement this as soon as was practicable. The DCS advised that he was expecting a pan-London briefing paper to come to Members in the autumn. The DCS further clarified that the bid related to just adoption bids and not Special Guardianship Orders.

In response to a further question, the AD Safeguarding advised that there was a National Adoption Board, chaired by Andrew Christie and there was also a London Adoption Board, which was working with advisory groups and stakeholders to develop the proposal on behalf of London local authorities. Officers also reassured Members that adoption services in Haringey would continue business as usual, whilst this process unfolded.

**CPAC345. UPDATE ON FOSTER CARER RECRUITMENT AND FUTURE  
MODELS OF PROVISION**

NOTED the update given by the Head of Service, Children in Care and Placements on the progress on recruiting a provider to undertake training and recruitment of in-house foster carers. The report was included in the agenda pack (pages 23 to 26). The Committee noted that an options appraisal to consider the preferred delivery model proposed that the service continue to be commissioned externally and that a

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procurement exercise was undertaken to seek a provider to deliver this contract over the next period. No provider came forward to bid for this work.

The Committee noted that following a process of consultation with potential bidders to understand why they did not bid and what would be required for them to bid in future, a decision had been made to return to the market. It was noted that the timescales for this process were still to be determined through discussions between the Head of Service, Children in Care and Placements and AD Commissioning. The Committee were advised that if there was little further interest from that market then negotiations may recommence with NRS about them continuing to deliver the service but concerns remained over performance issues.

Head of Service CIC advised that alongside the above, the authority would be looking into a series of options in the medium to long term. These options included building collaborative relationships with neighbouring boroughs to develop a shared service model across borough boundaries for the provision of foster care. A further option was the development of proposals to use a micro-enterprise model to support people to become foster carers. The committee was advised that this approach would work at a community level but neither building collaborative relationships nor a micro-enterprise model would deliver a pipeline of potential carers in the short and medium term. The final option was noted as return to proposals to develop an in-house service. This was not the preferred option when the appraisal was carried out earlier this year, given capacity issues within the service and the fact that there are significant fixed costs in establishing a new team with no guarantee of foster care recruitment. Head of Service CIC advised that a key lesson was the need for the service to drive its own marketing and communications strategy in any future adoption contract.

AD Safeguarding advised that one of the main issues in the contract with NRS was a failure to specify the need for carers across the whole range of ages of foster children and not just babies and young children. The Chair requested a further update on the second bidding process to the next meeting of the Committee.

**Action: Dominic Porter Moore**

**CPAC 348. IMMIGRATION ISSUES FOR LAC**

RECEIVED a report updating the Committee on the key implications for LAC without a settled immigration status. The report was included in the agenda pack (pages 27 to 35 to 23).

NOTED that There were three main categories of looked after children and young people and care leavers who may be subject to immigration control.

- i) Unaccompanied Asylum Seeking Children (UASC) how tended to get Leave to Remain until the age of 17 an a half.

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- ii) Children and young people brought into the UK from outside the EU as visitors and who remain in the UK after their period of leave expires and have become looked after children. This excluded children who had been privately fostered and were known to Children's Services as they were not looked after children. Children from families without recourse to public funds (NRFP) were also not looked after.
- iii) Children from within the European Union. European Economic Area (EEA) nationals could access public funds but may be prevented from claiming public funds if they did not satisfy the eligibility criteria attached to a specific welfare benefit or council housing allocation. Eligibility related to the basis on which the EEA national was living in the UK. EEA nationals have a right to reside in the UK as long as they are exercising Treaty Rights in the UK; this meant working (including being a job seeker), studying, being self-sufficient or otherwise being incapacitated and therefore unable to work. A former looked after child, in education and being supported by the local authority, may not be able to access income support or social housing.

The Council had general duties towards looked after children which were set out in Section 22 of the Children Act 1989 and these apply irrespective of the child's Immigration status. The general duties were:

- To safeguard and promote a child's welfare; and
- to make such use of services available for children cared for by their own parents as appears to the authority reasonable in this case.

The Committee were advised that duties were discretionary and therefore were not mandatory, which left significant scope for Judicial Reviews being taken out against local authorities. The process of resolving a child's immigration status was considerably easier as an undertaking than it was once they reached adult hood. In considering a child's welfare the authority should also try to ascertain their wishes and feelings having regard to their age and understanding. In the event that the child's immigration status was not resolved before the age of 16, this should be considered as part of the planning for the child's transition to the leaving care service. In order to qualify for leaving care services a child must have been looked after for at least 13 weeks between the ages of 14 and 16 and for some time after their 16<sup>th</sup> birthday.

The Committee was advised that there were significant consequences for care leavers whose immigration status remains unresolved in the UK at the age of 18. They were unable to access state support with housing, education and benefits. An application to the Visa and Immigration Service (VIS) in the Home Office for a right to remain would also be treated less favourably once they reached 18. If an application to VIS was made before age 18 one of the criteria is to have lived continuously in the UK for at least seven years. If the application to remain takes place when the care leaver is aged between 18 years and 25, the bar is raised considerably as the criteria means they have to have spent at least half their life in the UK or at least 20 years resident in the UK.

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The Immigration Act 2016 came into effect in May 2016. One of the drivers behind this Act was that the current Government did not consider that the Children Act 1989 was the appropriate mechanism for providing support to adult care leavers when the courts have determined that the care leaver has no lawful basis to remain in the UK and could return to their country of origin.

In response to a question from the Committee, officers advised that they had recently commissioned a policy writer to look at the authority's policies across the board in relation to the immigration status of LAC, how the policy evolved would be determined by expert legal advice. In response to a question around increased figures as a result of the refugee crisis in Syria, officers advised that the Government were also looking at a nation strategy for the dispersal of refugees from Syria to ensure that the spread across local authorities was equitable. The Chair requested a further update on the immigration issues for LAC to the next meeting of the Committee.

**Action: Dominic Porter Moore**

**CPAC 348. VIRTUAL SCHOOLS EXECUTIVE SUMMARY**

RECEIVED a report which summarised the educational performance of Haringey's LAC and Young People for 2014-2015. The report highlighted the key achievements and areas for focus in 2016. The report was included in the agenda pack (pages 37 to 40).

NOTED that

- Overall, the educational performance of Haringey's LAC was above the national average and within the top quartile for London. The educational performance of Haringey's LAC at the end of KS4 was within 10% of the country.
- In the Early Years Foundation Stage, 50% of the group achieved both the 'expected' and 'good' level of development across the 17 measures.
- At KS1, where a quarter of the group had a statement of Special Educational Need, 55% reached at least level 2 in reading, writing and maths. This compared with 87% of non-LAC.
- At KS2, 65% of pupils attained level 4 or above in reading, writing and maths, 26% attaining a level 5 in reading.
- There were 286 school aged Children and young People looked after by Haringey, 78 (27%) attended schools in Haringey and 208 (73%) attended schools out of the authority. 90% of LAC attended a school rated as good or outstanding an improvement from 81% in 2014. This compared with 93% of Haringey's non-looked after pupils.

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- There were 56 looked after pupils with a statement of Special Educational Need or an Education Health Care Plan (EHCP) which was 19.5% of the total cohort.
- The percentage of children attending school for over 95% of the time was 65%, the same as the previous year and increasing this figure would be an area of focus in 2015-16.
- Increasing the completion rate of Personal Education Plans (PEP) remained a key priority for social care and the Virtual School. Performance improved steadily from the start of the academic year from 51% to 70% but remained significantly lower than the target figure of 95%. The Head of Virtual Schools advised the Committee that her service were revisiting the introduction of an electronic PEP format.

In response to a question from the Committee, officers advised that that the usual standard was that all LAC would be placed in schools that were either rated as 'good' or 'outstanding', whether that was inside or outside the borough. Officers acknowledged that there would be circumstances where the child would be allowed to attend a school that was not rated as either 'good' or 'outstanding', on an exception basis, if for instance they were already attending that school before becoming part of the LAC.

The Chair commended the overall performance levels achieved and the committee noted their thanks to Virtual Schools for the improvements that had been made.

**CPAC348. NEW ITEMS OF URGENT BUSINESS**

None.

**CPAC348. EXCLUSION OF THE PRESS AND PUBLIC**

None.

**CPAC 349. NEW ITEMS OF URGENT EXEMPT BUSINESS**

None.

**CPAC350. ANY OTHER BUSINESS**

Future meetings

NOTED the following dates:

3<sup>rd</sup> October 2016

12<sup>th</sup> January 2017

3<sup>rd</sup> April 2017

Meetings are scheduled to start at 6.30pm.

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The meeting ended at 21:00 hours.

**Cllr Elin Weston  
Chair**

## Corporate Parenting Agenda Planning 2016/17

Corporate Parenting meeting Date	Agenda Items	Lead Officer
4 <sup>th</sup> July 2016	<ol style="list-style-type: none"> <li>1. Performance</li> <li>2. CPAC and Aspire notes with update on actions</li> <li>3. Pan-London Adoption Bid</li> <li>4. Update on foster carer recruitment and future models of provision</li> <li>5. Immigration issues for LAC <ul style="list-style-type: none"> <li>• Previous Minutes from 4<sup>th</sup> April 2016</li> </ul> </li> </ol> <p><b><u>Verbal Updates</u></b></p> <ol style="list-style-type: none"> <li>6. Plans for future CPAC meeting set up</li> <li>7. Virtual Schools Executive Summary</li> <li>8. Update on Drive Forward and potential for providing support at earlier stage in care leavers' university placement.</li> </ol> <p>*Training requirements</p> <p><b>Draft Reports will be due with Jon Abbey on 20th June and due for publication on 24th June</b></p>	<p>Margaret Gallagher</p> <p>Jon Abbey</p> <p>Neelam Bhardwaja</p> <p>Dominic Porter-Moore</p> <p>Dominic Porter-Moore / Neelam Bhardwaja</p> <p>Chair</p> <p>Fiona Smith</p> <p>Neelam Bhardwaja</p>
3rd October 2016	<ol style="list-style-type: none"> <li>1. Performance</li> <li>2. CPAC and Aspire notes</li> <li>3. Pan-London Adoption Bid</li> <li>4. CPAC – Discussion around Future meeting set</li> </ol>	<p>Margaret Gallagher</p> <p>Jon Abbey</p> <p>Neelam Bhardwaja</p> <p>Chair</p>

## Corporate Parenting Agenda Planning 2016/17

	<p>up/Committee Terms of Reference.</p> <p><b><u>Main Presentation item</u></b></p> <p>5. Demand levels and pressures on back-end of the system</p> <p><b><u>Action Updates</u></b></p> <p>6. Foster Care Recruitment (update on bidding process).</p> <p>7. Update on Immigration Issues for the LAC</p> <p><b>Draft Reports will be due with Jon Abbey on 16th September and due for publication on the 23<sup>rd</sup> September.</b></p>	<p>Jon Abbey</p> <p>Dominic Porter Moore</p> <p>Dominic Porter Moore</p>
12 Jan 2017	<p>1. Performance</p> <p>2. CPAC and Aspire notes</p> <p><b><u>Action Updates</u></b></p> <p><b>Draft Reports will be due with Jon Abbey on 22<sup>nd</sup> December and due for publication on the 4<sup>th</sup> January 2017</b></p>	
3rd April 2017	<p>1. Performance</p> <p>2. CPAC and Aspire notes</p> <p>3.</p> <p><b>Draft Reports will be due with Jon Abbey on the 17<sup>th</sup> March and due for publication on the 24<sup>th</sup> March.</b></p>	

**Report for:** Corporate Parent Advisory Committee: 3 October 2016

**Item number:** 7

**Title:** Performance for the year to August 2016

## Report

**Authorised by:** Jon Abbey, Director, Children's Services



**Lead Officer:** Margaret Gallagher, Corporate Performance Manager  
[margaret.gallagher@haringey.gov.uk](mailto:margaret.gallagher@haringey.gov.uk)

**Ward(s) affected:** All

**Report for Key/  
Non Key Decision:** Non key

## 1. Introduction

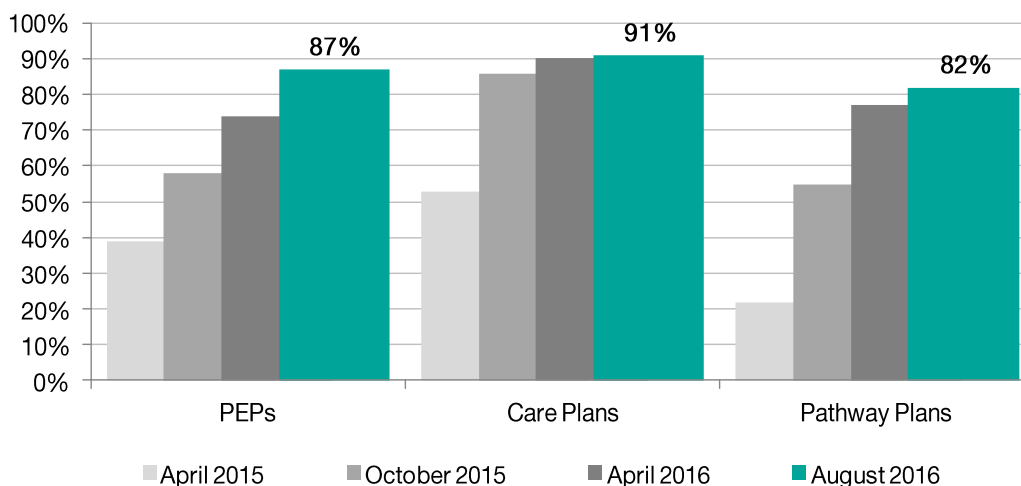
- 1.1. This report provides an analysis of the performance data and trends for an agreed set of measures relating to looked after children on behalf of the Corporate Parenting Advisory Committee.
- 1.2. Section 2 and 3 contain performance highlights and key messages identifying areas of improvement and areas for focus.
- 1.3. Section 4 provides an overall assessment of performance in the service as relating to Children in Care so that Members can assess progress in key areas within the context of the Local Authorities' role as Corporate Parent.

## 2. Positive or Improving Performance

- 2.1. 430 children were in care on the last day of August 2016 or 72 per 10,000 population including 32 unaccompanied asylum seeker children. There has been a gradual increase in the level of children in care in comparison to the position at the end of March 2016 - 23 more children in care. However reduction in Haringey's rate of looked after children in 2015/16 places us within the inter-quartile range of our statistical neighbours (a rate of 69 per 10,000 population), although the current rate remains above the London (52) and national average (60) rates.
- 2.2. At the end of August, 91% of looked after children had an **up to date Care Plan**. Performance in this area has consistently remained above target since February 2016 as a result of activity tracking in weekly meetings held by the Head of Service for Children in Care.

- 2.3. At the end of August, 82% of looked after children aged 16-17 had **up to date Pathway Plans**. Performance in this area dipped slightly since June 2016 where 96% of pathway plans were up to date however completion of pathway plans is much higher than that reported at the same period last year. Although performance remains short of the 90% target, it is hoped that with further effort from the 16+ children in care team, the 90% target will be achieved.
- 2.4. Performance of PEPs was slightly short of the target (87% up to date at the end of August). This area continues to be a priority of performance tracking.

**Performance of PEPs, Care Plans and Pathway Plans  
(April 2015 to August 2016)**



- 2.5. At the end of March 2016, there were 35 pupils in Year 11 who were looked after continuously for 12 months or more. Of these, 13 (37%) attained 5 GCSEs A\*-C incl. English & Maths – a significant increase compared to 28% in 2015.
- 2.6. Indicators around **stability of placements** for looked after children remain in line with statistical neighbours and targets. In the year to August 2016, 9% of **children had three or more placement moves**, below the statistical neighbour average (10%). 76% of children under 16 who had been in care for at least 2.5 years had been in the same placement for at least 2 years, slightly above our statistical neighbour average (67%).
- 2.7. 91% of Children in Care had an **up to date review** at the end of August, above the 90% target.
- 2.8. At the end of August, 94% of children in care for over a month had an **up to date health assessment**, above target and continuing the positive trend.
- 2.9. Timeliness of children placed for adoption continues to be positive. In the year to August 2016, **children waited an average of 298 days from becoming looked after to being placed for adoption**. This compares favourably with the national threshold (426 day average for 2013-16).

- 2.10. Haringey's latest 3 year rolling average position as published in our Adoption Scorecard in March 2016 was 691 days for the period 2012-15, higher than the national threshold and England position of 593 days but close to our statistical neighbour average of 696 days. Adoption scorecards are used to track national progress on adoptions and adopter related data. Current data for Haringey shows we are averaging well below the threshold so far for 2016-17 albeit that this only relates to a relatively small number of adoptions (5).

### 3. Areas for Focus

- 3.1. The 2015/16 trend towards the reduction in the number of **care proceeding applications** has shifted towards an increasing trend in Q1 2016/17. It is unclear what has led to this increase, however it reflects the national trend. There has also been a significant increase in applications regarding children under 1, from 35% in 2015/16 to 44% in Q1 2016/17.
- 3.2. Data for the period April to June 2016 confirms that the **average duration of care proceedings for concluded cases** was 37 weeks, slightly higher than that recorded for 2015/16 (34 weeks). Q1 data for 2016-17 shows 10% were concluded under the 26 week statutory timescale.
- 3.3. The outcomes for 40% of care proceeding cases issued between April and June 2016 was for children to remain with or reunify with their parents compared to 54% of children in 2015/16. In a further 13% of cases issued, children remained in their family of origin under SGOs and in 43% of cases children were placed on care orders.
- 3.4. The data shows a decrease in the number of children who remained with their parents and in the number of children who remained in their family of origin under SGO; and an increase in the number of children made subject to care orders compared to 2015/2016.
- 3.5. 84% of **Children in Care visits** were recorded as completed in the relevant timescales in August. Performance in this area has remained below target since October 2014 mainly due to recording issues. This is now being tracked at performance meetings held by the Head of Service for Children in Care.
- 3.6. 20% of Looked After Children at 31<sup>st</sup> August were **placed 20 miles or more from Haringey**. Performance is worse than the 16% target however slightly improved since March 2016 end of year position (23%). Although higher than national levels this proportion is only slightly above the average for London and our Statistical Neighbours (18%).
- 3.7. 83% of the current LAC cohort had an **up to date dental visit** as at August 2016. There were 78 children without a recorded up to date dental check. Of these, 56% were aged between 15 and 17 years old many of whom refuse dental checks.

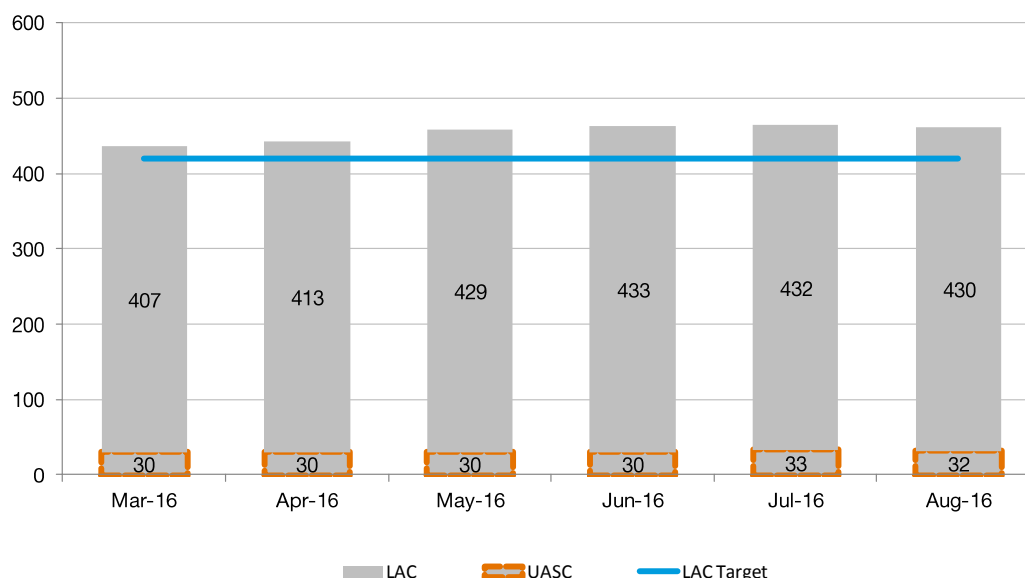
- 3.8. End of year data for the looked after children government return showed that 81% or 246 children who were in care for over 12 months had their teeth checked by a dentist. This is a decline on the reported level of 91.5% in 2014/15 but close to our statistical neighbour position of 85.4%.
- 3.9. In the year to August 2016, only 7 permanency orders have been achieved (5 adoptions and 2 special guardianship orders (SGOs) – 10 fewer than the same period last year and the lowest recorded for many years. There are a further 10 adoption orders in the pipeline, bar unforeseen circumstances. 5 babies are to be placed for adoption in the next 2 months and it is expected that the adoptions will proceed relatively smoothly. Special guardianship referrals continue to be low and it is likely that no more than 15 will be achieved by the end of the financial year.
- 3.10. Performance on care leavers in suitable accommodation and in education, employment and training for 2015-16 data shows 45% of *all* former relevant care leavers aged 17-21 were in EET (57% of those who were *in touch* with the local authority around their 17<sup>th</sup>, 18<sup>th</sup>, 19<sup>th</sup>, 20<sup>th</sup> or 21<sup>st</sup> birthday). 69% of *all* care leavers were in suitable accommodation or 87% of those who were *in touch*.
- 3.11. Fortnightly meetings are currently held between the performance team and Young Adult Service to address the low position of care leavers in EET and suitable accommodation in the year to date 2016-17.

## Overall Assessment of Performance

### Looked After Children

- 4.1. There has been a 30% reduction in Haringey's rate of looked after children since 2011 compared with a 10% reduction in London and a 3% increase nationally. Over the last 6 months, the number of Looked After Children has increased slightly however continues to remain in line with Haringey's target.

#### Looked After Children and UASC, last 6 months



- 4.2. A new Sufficiency Development scorecard has been implemented to measure outcomes for looked after children in conjunction with agreed objectives. The scorecard includes the tracking of reducing LAC admissions/increasing the number returning home or leaving care, reducing costs per LAC placement and increasing the number/speed of LAC achieving permanency.
- 4.3. The majority (72%) of children in care are in foster placements – 42% were placed with in house carers whilst 30% were placed with independent fostering agencies. Overall, the number of in-house placements is on an upward trend whilst the number of IFA placements is gradually reducing.

## 5. Contribution to strategic outcomes

- 5.1. Priority 1: Enable every child and young person to have the best start in life, with high quality education.

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# 10 questions to ask if you're scrutinising services for looked after children

Revised June 2012





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# Introduction

This guide has been produced by the Local Government Association in partnership with the National Children's Bureau. It follows on from a previous guide produced by the Centre for Public Scrutiny (CfPS) for Local Government Improvement and Development and forms part of a suite of offers for elected members and others working in children's services.

The Centre for Public Scrutiny is an independent national charity which carries out research, supports online networks and provides training, development and events to promote and improve public scrutiny and accountability across government and the public sector.

The Local Government Association has sector-led improvement as a key corporate priority. Councils are the most improved part of the public sector, and local politicians and senior managers lead the transformation of place. A significant sector-led improvement programme is established in children's services with governance provided through the children's improvement board and funding to the board from the Department of Education (DfE).

The National Children's Bureau is a leading research and development charity working to improve the lives of children and young people, reducing the impact of inequalities. It works with children, for children to influence government policy, be a strong voice for young people and frontline professionals, and provide practical solutions on a range of social issues.

The National Children's Bureau has been funded by the Department of Education to develop materials that will support councils in their role as corporate parents. More detailed briefings on specific topics of relevance to corporate parents and self-audit tools are being developed by the National Children's Bureau and will be available shortly. A National Voice, an organisation providing a voice for looked-after children and care-leavers, is also producing 'top tips' for corporate parents on working with their children in care council.

This guide aims to provide clear and succinct advice for scrutiny members and officers on the key issues to cover in a scrutiny review of corporate parenting, as well as jargon-busting, links to further information and case studies.

The ten question areas can be used by overview and scrutiny committees (OSCs) to scope a review that takes an overview of all services relevant to looked-after children, or to focus on an area of particular interest. They can also be used by corporate parenting groups or other elected members to support them in their ability to scrutinise and challenge the service provided by their council to looked-after children.

If corporate parents are to assess whether the standard of care would be good enough for their own children, they need good quality information on which to base their judgements. These questions will provide a framework to structure this information.

# Key points

Children in the care of a local authority are one of the most vulnerable groups in society. The majority of children in care are there because they have suffered abuse or neglect. At any one time around 65,000 children are looked after in England, although over 90,000 pass through the care system each year. There has been an overall increase in the numbers of children entering care since 2007 and a rise in the proportion who are removed through the intervention of the courts as opposed to coming into care by agreement with parents.

When they are elected, all councillors take on the role of ‘corporate parent’ to children looked after by their local authority. They have a duty to take an interest in the wellbeing and development of those children, as if they were their own. Although the lead member for children’s services has particular responsibilities, the role of corporate parent is carried by all councillors, regardless of their role on the council.

Overview and scrutiny offers a key way in which councillors can fulfil this responsibility, by giving them the opportunity to ask searching questions of a range of service providers and assure themselves that children in the care of the local authority are being well looked after.

Overview and scrutiny also offers opportunities for councillors to hear directly from children looked after by the authority and to ensure that their voices are heard

when considering the effectiveness and impact of services. This should include not just children’s social care, but other services which may have an impact on the lives of children in care (including care-leavers and those on the edge of care), such as housing provision, crime and feeling safe in the community, access to public transport and the quality of schools and leisure activities.

In April 2011 the government introduced new regulations and guidance to improve the quality and consistency of care planning, placement (where and how children are looked after) and case review for looked-after children. It includes statutory guidance on independent reviewing officers, the ‘sufficiency duty’ requiring local authorities to ensure there is enough accommodation locally for looked-after children, as well as guidance on improving their educational attainment. This was part of the implementation of the Children and Young Persons Act 2008, and it updated and consolidated previous guidance on the Children Act 1989 and other legislation.

Local authorities are required to collect data about their performance in relation to looked-after children, and to report this to the Department for Education. This data is published annually and, although it is no longer accompanied by targets, provides a useful benchmark for comparisons between an authority’s present and past performance and with that of other authorities.

# Jargon busting

## ‘Looked-after children’, ‘children in care’

The terms ‘looked-after children’ or ‘children in care’ refer to all children under the age of 18 being looked after by a local authority. It includes both those subject to a care order under section 31 of the Children Act 1989 (see below); and those looked after by a voluntary agreement with their parents under section 20 of that Act. Once they become looked-after, children may be placed by the local authority with family members, foster carers or in a residential children’s home. The purpose of the ‘care’ system is to look after children where parents are unable to do so, for a variety of reasons. These include situations where parents are abusive or cannot provide adequate care for them, or where there is no parent or relative available, such as asylum seeking children or those whose parents have died.

## ‘Care leavers’

Care leavers are those who have been in ‘care’ for at least 13 weeks from the age of 14 onwards and therefore qualify for services to support them once they leave. This support should be provided up to the age of 21 or until they have completed their education if this is longer.

## Care order – Section 31 Children Act 1989

Care orders are made by the court if a ‘threshold of significant harm’ is reached and there is no likelihood of improvement in the standard of care provided for a young person. The local authority then shares parental responsibility with the parent(s) and can make the decisions that a parent would normally make. A care order expires when the young person reaches 18 or when another Order is made placing the child with an alternative family, such as an adoption or ‘special guardianship order’. It can also be discharged by the court before the age of 18 if it is considered that the child would no longer be at risk of harm if they returned home.

## Children ‘at risk’ of harm

These are children where there are concerns that they are suffering or are likely to suffer harm through abuse or neglect. Children considered ‘at risk’ have a ‘child protection plan’ which should be regularly reviewed.

## ‘Children in need’

Children in need are a wider group of children and young people who have been assessed as needing the help of services to achieve a reasonable standard of health or development. They have a ‘child in need plan’ to address the difficulties identified in the assessment

## Interim care order – Section 38 Children Act 1989

If the local authority is concerned that a child is suffering or is likely to suffer ‘significant harm’, they can apply to the court for an ‘interim care order’, which is a time-limited order renewed while care proceedings for the child continue through the courts.

## Emergency protection order section 44 Children Act 1989

An ‘emergency protection order’ removes a child into accommodation provided by or on behalf of the local authority and is granted by the court (or magistrate outside court hours) if there is reasonable cause to believe that the child is likely to suffer significant immediate harm. It is to be used only where the child is thought to be at immediate risk and for a maximum of eight days, although this can be extended by the court for a further seven days. It allows the child to be cared for in a place of safety whilst further enquiries are made.

## The pledge

Each local authority is required to develop a ‘pledge’, setting out its commitments to the children in its care. The Care Matters Initiative envisaged the pledge as a key communication tool between children and young people and the authority responsible for ensuring they receive the parenting they need. Every child and young person’s care or pathway plan should reflect how the commitments made in the pledge will be delivered for that individual child and it is monitored by the local ‘children in care council’ (see below).

## Regulation 33 visits

These are the scrutiny visits that have to be made at least once a month to children’s homes in order to quality-assure the service being provided. This includes checking that the home is compliant with regulations, that the environment is suitable and seeking the views of staff and residents. Where an authority operates its own children’s homes, councillors may be involved in undertaking these visits.

## Children in care councils

The Care Matters Initiative created the expectation that local authorities should to set up a ‘children in care council’ to represent the views of looked-after children and to enable them to be involved in developing services. There should also be mechanisms in place for involving young people in care in the recruitment of key staff members, such as the director of children’s services. The local children in care council is also responsible for helping to develop and monitor the implementation of the pledge.

## The ‘sufficiency duty’

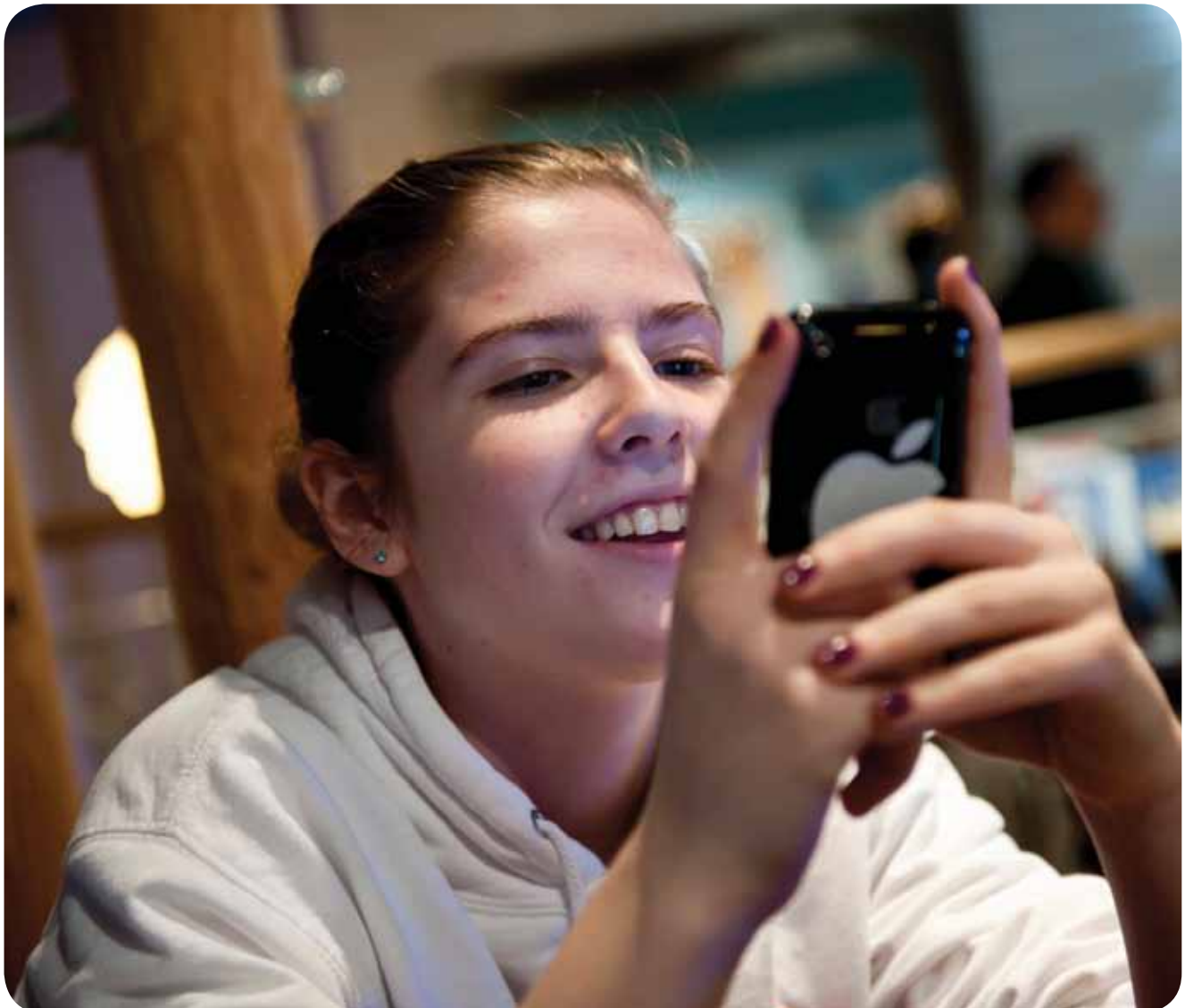
This is a duty placed on local authorities under 22 (G) of the Children Act 1989 (amended by the 2008 Act) to ensure there is sufficient accommodation to meet the needs of their looked-after children. Sufficient accommodation must be provided “where reasonably practical” (lack of resources is not considered a barrier), and having “regard to the benefit of having a number of providers and a range of accommodation”.

## Commissioning

The process by which an authority decides what level and type of services it wants in order to meet identified needs, and seeks providers of those services, often through a competitive process. Increasingly this is done jointly, for example with the local health service, and in the context of looked-after children should be based on an analysis of their needs. Commissioned services should be monitored and evaluated, and constantly reviewed to make sure they are continuing to meet changing needs.

## Independent reviewing officers (IROs)

The Children and Young Persons Act 2008 requires local authorities to appoint a named IRO for each looked after child. Their role is to oversee the child's care plan, monitor the case and challenge the local authority if the plan is not meeting the child's needs or is not being implemented effectively. The IRO must communicate directly with each child they are responsible for to establish the child's wishes and feelings and ensure that these are taken into account.



## 1

## How well does your authority do in commissioning or providing services for looked after children?

### Policy context

As corporate parents, members need access to information to enable you to identify how well your authority is doing in relation to outcomes for your looked-after children, and to any areas for improvement. National performance data will enable you to assess how well your local authority is doing in comparison with others. It is also useful for analysing trends within your own authority.

Ofsted inspections provide an independent perspective on the quality of your service.

As part of the sector-led improvement programme for children's services, the Safeguarding Children peer review is on offer to all authorities. This peer review can be tailored to the requirements of individual authorities and can have a focus on looked-after children. It is important that scrutiny members participate in the peer review process in their authority and also consider the findings of the peer review team. This will provide valuable insight from a 'critical friend' perspective.

Whatever these sources of information tell you, there is always a need for additional local mechanisms for you to judge whether the quality of care provided would be good enough for your own child. Statistics alone are not enough: it is important to ask questions of those responsible about the factors that affect your authority's performance, and to seek qualitative

information about the experiences of the children themselves.

The circumstances and needs of looked-after children vary widely, with some children just spending a short period in care during a family crisis while others effectively grow up in care. Each child must have a 'care plan' that sets out the long-term plan for the child and the action that needs to be taken to provide them with good quality care.

### Questions to ask

Who are your looked-after children in terms of age, gender, ethnicity, religious or cultural background and disability, and what needs and challenges does this profile present?

- Do you have a system for seeking feedback from looked-after children and care-leavers about the services they receive?
- Do you receive a copy of the annual report from the IRO service, and is it used to identify gaps in services?

The services provided must meet the identified needs of the children, while offering 'value for money'. Members need to ensure that arrangements for commissioning services are effective.

- Do arrangements for commissioning services involve all relevant council departments and other agencies?
- How will any changes in local health service structures, for example the move to GP commissioning, impact on any joint commissioning arrangements?
- Does your local joint strategic needs assessment (JSNA) include information on the needs of your looked after children and care-leavers?
- Do you have mechanism for reviewing the effectiveness of the services you commission, based on outcomes?

Cost comparisons can be one indicator of how your authority compares with others, for example:

- What is the cost of your residential provision by comparison with other areas?
- How much do you spend on out-of-area placements for looked-after children? Is this rising or falling?

London Borough of Enfield developed a commissioning strategy for looked-after children which had the reduction in the number of children placed in residential care as one of its aims. The implementation of this strategy has been effective in this aim, reducing the numbers of looked-after children in residential placements from 17 per cent in 2004 to 6.5 per cent in 2010. This has ensured that more of the most complex young people can benefit from a family setting. The financial efficiencies achieved have been reinvested into preventive services to allow more children and young people to be cared for within their own families<sup>1</sup>.

<sup>1</sup> <http://www.c4eo.org.uk/themes/vulnerablechildren/vipdetails.aspx?lpeid=381>

## 2

## How well do your children in care do at school, both academically and in terms of other kinds of achievements?

### Policy context

A better education for children in care (Social Exclusion Unit 2003) identified five reasons why looked-after children may underachieve in education

- their lives are characterised by instability
- they spend too much time out of school
- they do not have sufficient help with their education if they fall behind
- primary carers are not expected or equipped to provide sufficient support and encouragement for learning and development
- they have unmet emotional, mental and physical health needs which impact on their learning.

Statutory guidance makes it clear that corporate parents must tackle this, and have high aspirations for the children they care for.

”Though some do well, the educational achievement of looked-after children as a group remains unacceptably low. That is why the Children Act 1989 (as amended by the Children Act 2004) places a duty on local authorities to promote the educational achievement of looked-after children.”

The way in which local authorities should fulfil this duty is set out in Promoting the educational achievement of looked-after children: statutory guidance for local authorities (DCSF 2010), with a specific section for corporate parents. Responsibility is shared by all schools, including free schools and academies, and the schools admissions code describes the priority governing bodies must give to looked after children.

Personal education plans (PEPs) are completed for all looked-after children within ten days of becoming looked-after and are part of the care plan. There is a joint responsibility for the PEP between the child’s school and the local authority children’s service.

Ensuring looked-after children have the right support to be able to participate fully in school life, and that their school career is not disrupted by constant placement moves can make a big difference. Looked-after children tell us that they value education and want support to do well.

In one authority looked-after children often missed out on after-school activities and trips because of delays in getting permission from social workers and their managers. As a result of the scrutiny review which brought this to light, the authority changed the system so that social workers could delegate the decision to foster carers, ensuring that looked-after children were not missing out.

- What do looked-after children and young people themselves say about their education and aspirations?

Celebrating the non-academic achievements of children in care and enabling them to benefit from all the opportunities school can offer is also important. Children in care should be cared about and not just cared for.

## Questions to ask

- What results are achieved by looked-after children compared with other children at local schools, and with looked-after children in other authorities?
- How well are children placed outside your local authority area doing at school?
- What plans does the council have to raise the educational attainment of looked-after children?
- Do you have a 'virtual school head', designated teachers and designated school governors in place? How effective are these arrangements?
- How are individual children and young people supported to achieve, both within and outside school?
- How are children supported to continue in further and higher education?
- How do schools' admissions policies treat looked-after children, for example are they able to attend the same school as other children in their foster family, and how many looked-after children get into the highest performing schools?
- Do all looked-after children have a PEP and are these audited for quality?

In one authority a young person was unable to attend an after-school photography course because for two years no-one would buy her a camera: when this came to light during a scrutiny review, councillors intervened and got action taken to sort it out.

- Are looked-after children able to participate in after-school activities and enjoy learning and achievement in all its forms? If not, what are the barriers?
- Does your council have a way to celebrate the achievements (whether sporting, academic, musical, attendance, personal bests) of looked-after children, and are councillors given regular updates?
- Do you monitor the numbers of looked-after children excluded from school, and do you know what alternative provision is available for them?

## 3

## How good is the health and wellbeing of children in your care?

### Policy context

Looked-after children and young people share many of the same health risks and problems as their peers, but they frequently enter care with a worse level of health due to the impact of poverty, abuse and neglect. Evidence suggests that looked-after children are nearly five times more likely to have a mental health disorder than all children.

As with educational attainment, there is statutory guidance on Promoting the health and wellbeing of looked-after children (DCSF 2009). This applies to local authorities, primary care trusts and strategic health authorities but consideration will need to be given to the impact of the NHS reforms.

The health needs of each looked-after child must be assessed within four weeks of a child becoming looked-after and should form the basis of their health plan. As with the PEP, this feeds in to the child's care plan.

Local authorities are also required to make sure that a 'strengths and difficulties' questionnaire is completed to assess for emotional and behavioural difficulties.

### Questions to ask

- What proportion of children's health assessments and dental checks are carried out on time?
- Is there a designated doctor and nurse for looked-after children?
- Are looked-after children a priority group for getting access to child and adolescent mental health services (CAMHS) and how long are waiting times for referrals?
- As an at-risk group, what access do looked-after children and young people get to services to help with substance misuse, sexual health and teenage pregnancy?
- What support is given to foster carers and young people themselves about promoting healthy lifestyles?
- Do you receive regular reports on the health needs and outcomes of looked-after children?
- What do looked-after children and young people themselves say about their health needs and priorities and how well they are met?
- Is this evidence about outcomes and experiences used to inform the commissioning of services?

## 4

## How stable and secure are the lives of your looked-after children while they are in your care?

### Policy context

When children and young people enter care and are placed either with foster carers, in residential homes or even at boarding school, they risk losing regular contact not only with family members but also with friends or other significant people in their lives.

This is exacerbated if the 'placement' has to be out of the area, perhaps because of a lack of local foster families or children's homes. If the placement breaks down, they may have to move again, causing yet more anxiety and disruption. Yet children themselves tell us that stable and supportive relationships are crucial if they are to thrive in care.

Ensuring placements are stable and work well for children and young people is therefore key to their wellbeing. The 'sufficiency duty' requires local authorities to take steps to secure sufficient accommodation within the authority's area which meets the needs of its looked-after children, and they must demonstrate how they are fulfilling this responsibility. To do this, there must be a good understanding of who your children are and what they need.

Every council has to collect data on how far placements are from the child's home and the number of placements that children experience but the quality of the care offered must also be taken into account. It is not good enough to place a child in a stable placement, within the local authority boundary, if the child is unhappy there.

There are important links with safeguarding: children who come into care should do so at a point where their experiences have not been so damaging that they cannot settle.

### Questions to ask

How stable are your placements? How many children move placements three or more times during a year or remain in the same placement for two or more years?

- What do you know about the children who experience changes of placement?
- What are the needs of children that require them to be placed out of the area of the authority?
- If additional services were provided either by the local authority or by partner agencies, could they be looked after within the area of the local authority?
- How are you fulfilling your 'sufficiency duty'?

- What choice and information do children and young people have about their placements, for example, do they get to meet potential foster carers or visit children's homes before they go to live there?
- If children have to move placement, what arrangements are made to keep them at the same school, for example transport?
- Are you satisfied that children are supported to maintain relationships with people that are significant to them?
- What do looked-after children say about their placements?

As a result of one authority's scrutiny review, a looked-after children and care leavers' drop-in centre was developed, to provide a safe space for looked-after children and young people to go to find out information and meet support workers and others in one place.



## 5

## How well does your authority do at finding appropriate adoptive families for children for whom it is decided this is the right option?

### Policy context

If a child or young person's birth family have completely broken down or it has been decided that they will never be able to care for the child safely, the best option for a long-term stable family environment may be adoption. The law governing adoption is in the Adoption and Children Act 2002, which aligned adoption practice with the 1989 Children Act, making the welfare of the child the paramount consideration.

The government has recently announced An Action Plan on Adoption (DfE 2012) to increase the numbers of children being adopted from care, and to speed up the process. The measures it proposes include considering the suitability of adoption for children at an earlier stage; streamlining bureaucratic processes that can lead to delay and encouraging a broader range of potential adopters. This includes the relaxation of expectations about matching the ethnicity of children and adopters if this will cause delay.

These changes will be accompanied by stronger systems for holding local authorities to account, with a new framework for inspection and a new 'adoption scorecard'. This will indicate how each local authority has performed in relation to placing children for adoption and in responding to prospective adopters.

It is important not to forget that there are other ways of securing a permanent home for children within the care system. For some, family and friends may be able to care for them if the right support is available. For others, particularly older children, adoption may be unsuitable but foster carers make the commitment to offer the child a permanent home. These alternative routes to permanency can be secured legally through arrangements such as 'residence orders' or 'special guardianship'.

South Tyneside Council routinely places over 12 per cent of its looked-after population for adoption and is one of the best performing councils in placing them within one year of the decision being made. This has been achieved through the use of 'concurrent planning' in which, if children are not rehabilitated to their birth family, they are adopted by their foster carers<sup>2</sup>.

<sup>2</sup> <http://www.c4eo.org.uk/themes/vulnerablechildren/vlpdetails.aspx?lpeid=363>

## Questions to ask

- What percentage of children have a permanence plan by their second review?
- What percentage of children are placed for adoption within 12 months of the decision to adopt and are subsequently adopted?
- How long does it take to make the decision to place a child for adoption, particularly for new-born babies?
- What is the profile of your children in care compared with prospective adoptive families, and if there is an imbalance, what steps are being taken to address this?
- How are sibling groups treated and what steps are taken to ensure they stay together, whether in adoption, fostering or residential care?
- What is the profile of children waiting for a permanent placement and what are the barriers to finding them a home?
- How long does it take to respond to prospective adopters and what are their views on how they have been treated?
- What do children and young people, for example in your local children in care council, say about adoption processes?



# 6

## How well do your foster care arrangements work?

### Policy context

Nationally, the proportion of children in care placed with foster carers as opposed to children's homes or other placements is about two thirds. Fostering is generally seen as a preferable option because it enables children and young people to live in a family environment.

Foster carers can play a valuable role in stabilising and caring for children from disrupted backgrounds for both short and longer periods of time, but nationally there is a shortage of people willing to take on the role. In the 1990s, independent or private fostering agencies developed and there is now a mixed economy. The way in which foster carers are supported, the fees they receive and their access to information may all play a role in making them feel valued, ensuring that they in turn can value and support the children they look after in the most effective way. The extent to which they hold delegated responsibility for day-to-day decisions on matters such as 'sleep-overs' or school trips can make a difference to their role satisfaction and the child's sense of belonging.

The Foster Carers' Charter sets out the expected commitment that foster carers and local authorities will make. It is designed to be used locally to develop a shared understanding and to encourage challenge.

Some 'family and friends' foster carers are approved only for a specific child, where they have an existing relationship and the local authority has decided that it is in the child's best interests to stay with them.

'Private' foster placements are those where the child's parents have made the arrangement directly with the foster family. The local authority should be informed in these situations so that they can check the suitability of the arrangement and monitor the care being provided.

Dreamwalls project in Southampton provides 'time-out' breaks for foster carers and has reduced by 95 per cent the proportion of foster carers leaving fostering. The cost equated to £674.43 per child per year, and 182 children received the service. Using the social return on investment (SROI) method of calculating value and benefits as well as costs, there was a £1.63 return for every £1.00 invested in the project.

## Questions to ask

- Do you have a sufficient pool of suitable foster carers locally to meet the needs of children needing placements? If not, what steps are being taken to address this?
- What support is given to your foster carers, including family and friends carers, and how easily can they access it, both for themselves and the child in their care?
- What do foster carers themselves say about the support they receive, including out-of-hours support and about their relationships with social workers and other professionals?
- Are there clear arrangements for delegating responsibility to foster carers for day-to-day decisions?
- Is there more 'in-kind' support that would facilitate and make the fostering role easier, such as bus passes, access to leisure centres etc?
- What do looked-after children and young people themselves say about their experience of fostering?
- What is the turnover of foster carers and do you know the reasons why carers leave?



## 7

## How good is the standard of residential care provided or used by your authority?

### Policy context

For some children, a placement in a children's home may be more suitable than a foster home. For example, they may find it difficult to cope with family-based life as a result of their experiences, or because of a strong sense of loyalty to their birth family.

DfE has a challenge and improvement programme for children's homes to support good practice. As part of the programme, it produced a data pack to enable local authorities to examine and compare their use of children's homes (DfE 2011)<sup>3</sup>. Some local authorities operate children's homes themselves but 76 per cent of placements are in the private or voluntary sector. About nine per cent of looked-after children are in residential care and most are over the age of 12. The placements are more likely than foster care to be out of area. Interestingly, some authorities use residential care much more than others.

Councillors have said that taking part in 'Regulation 33' visits or other arranged visits to homes can really bring to life what it is like to live in residential care, although they have to be carried out with sensitivity. Ofsted inspects residential homes and these reports (along with the reports from Regulation 33 visits) should provide a source of information and assurance to scrutiny about the standard of care provided there.

### Questions to ask

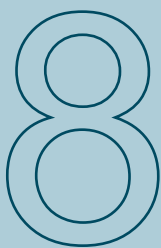
- What is the profile of the children placed in residential care by your authority?
- Who provides the residential placements used by your authority and what is their Ofsted rating?
- What are the outcomes of children in residential care compared to the rest of your looked after children?
- Do you have any children placed in 'secure care'?
- How is the experience of children placed in residential care outside the authority monitored?
- How does your use of residential care compare with other similar authorities?
- If your authority operates its own children's homes, what are the arrangements for undertaking Regulation 33 visit and how effective are these?

<sup>3</sup> <http://tinyurl.com/82p2qda>

- What do looked-after children and young people themselves say about their experience of living in residential care?
- How are any complaints about standards of care in residential homes and issues such as bullying dealt with? How many are there and what happens as a result?

In Kirklees, looked-after children can access the KicK (Kids in care Kirklees) website. From here they can go on a virtual tour of all the residential homes by watching a video made and narrated by looked-after young people who live there, to tell them what it's like. The website also enables them to 'rate' their reviews and foster placements online, as well as read, listen to and watch first-hand accounts of children and young people's experiences of care.





## What support does your authority provide to young people leaving care and how effective is it?

### Policy context

For many young people, leaving care can be daunting: they are expected to be independent at an earlier age than their peers, in spite of the additional difficulties that many face. Care leavers are over-represented in prison populations and the unemployed, demonstrating that the experience of being in – and leaving – care still does not prepare young people well for adult life. If looked-after children followed the same paths as other children into further education, training and jobs, it could save the economy £50 million each year.

The Children (Leaving Care) Act 2000 sets out local authorities' responsibilities to develop a 'pathway plan' within three months of every looked-after child's 16th birthday to help them towards independence, with the support of a personal adviser.

Young people cease to be looked after at the age of 18, although some may choose to leave before this. The local authority continues to have responsibilities towards them at least up to the age of 21 and longer if they are receiving education or training. Young people eligible for adult services, such as those with a disability, are also entitled to extended support as care leavers.

Statutory guidance on local authority responsibilities towards care leavers is contained in Children Act 1989 guidance and regulations: Volume 3: Planning Transition to Adulthood for Care Leavers (DCSF 2010). Support may be financial, practical and emotional.

The Staying Put programme enabled children in 11 pilot authorities to remain with their foster carers beyond the age of 18, replicating the experiences of most families. The evaluation was broadly positive<sup>4</sup>, particularly in enabling the young people to remain in education.

In Rotherham Metropolitan Borough Council, scrutiny called representatives from Job Centre Plus, the council's Revenues and Benefits and Care Leavers Services to a hearing following concerns expressed by care leavers about distress caused by late payments of benefits. The NCH Bridges Project reported that since the intervention of scrutiny, delays in processing benefits for care leavers were much reduced. As well as reducing the further risk of social and financial exclusion to vulnerable care leavers, there was also a reduction in the number of emergency payments to care leavers.

<sup>4</sup> DfE (2012) Evaluation of the Staying Put: 18 Plus Family Placement Programme: Final report

## Questions to ask

- How many care leavers is your authority still in touch with a year after they have left the care of the authority? How many are they in touch with after three years?
- What do you know about the outcomes of the children who were formerly in your authority's care?
- How many formerly looked-after young people are NEETs (not in education, employment and training)?
- What support do young people leaving care receive to access housing, tenancy support, employment, access to benefits, further and higher education and training?
- Do you make any provision for young people to stay in their placement beyond the age of 18?
- What do former looked-after children and young people themselves say about their experience of leaving care and the support that is or was provided?

In one authority a specialist scrutiny group on corporate parenting enabled looked-after young people to feed views directly to scrutiny. As a result of this group, the 'care leavers grant' (given to all young people leaving care to buy things for setting up home when they left care) was increased from £750 to £1000. Young people said £750 wasn't enough, members agreed and although officers were initially reluctant, comparison with other authorities showed that the grant level was low, so it was agreed to increase it.





## How effective is your professional workforce of social workers and others responsible for running services for and working with looked-after children?

### Policy context

It is essential that each child has an individualised care plan based on a thorough assessment of their needs, and this is the responsibility of their allocated social worker. Many authorities have struggled to recruit and retain sufficient numbers of suitably qualified social workers to do the difficult job of working with vulnerable children. This can be a key cause of poor performance but will also have an adverse effect on the experiences of the children and their carers. Children find it distressing to have frequent changes of worker and can feel uncared for as a result.

The IRO service is important both in terms of its ability to challenge individual instances of poor practice and to have an overview of the effectiveness of care planning across the authority. The IRO may be the most constant figure in some children's lives.

While senior officers are responsible for managing staff and services, members can play an important role in checking that there is a skilled and stable workforce in place. Although social workers are key, other council officers should also be aware of their responsibilities to looked-after children, such as those in housing departments, environment and leisure services, education, legal services and the public health service.

### Questions to ask

- What are the levels of social work vacancies, turnover, stress-related sickness, use of agency staff and ratios between newly qualified and experienced social workers and what action are management taking to address these?
- What continuity of social worker support is there for looked-after children and what are the case loads carried by social work staff?
- What proportion of social workers' time is spent doing face-to-face work with looked-after children as opposed to paper work and could this be improved?
- What does the annual IRO report say about the effectiveness of care planning in the authority and is action taken to address any weaknesses that it identifies?
- Are there enough opportunities for social workers to develop their skills and to engage in reflective learning?
- Is there evidence that staff from across the authority and other partners are working together to deliver what looked-after children need?
- What do looked-after children and their carers say about their experience of engaging with social workers and other professionals?
- Are looked-after children and young people involved in recruitment and development of services?

# 10 What more could be done to fulfil the council's responsibilities as a 'corporate parent'?

## Policy context

Although elected members will not all have the same level of involvement with the service for looked after children, they all share responsibility for satisfying themselves that is good enough. As former Secretary of State Frank Dobson MP's original letter to all councillors about their role as corporate parents, launching the Quality Protects Programme said:

“Elected councillors have a crucial role. Only you can carry it out. You can make sure that the interests of the children come first. You bring a fresh look and common sense. As councillors you set the strategic direction of your council's services and determine policy and priorities for your local community within the overall objectives set by government.”

This is as valid today as it was then. All councillors should be made aware of their responsibility as a corporate parent, and what this means in practice. As part of this process, it is crucial to ensure that councillors can hear directly from looked-after children about what matters to them. This could be through informal discussions, visits by elected members to children's homes or involving looked-after children when reviewing services.

It is not only councillors who are corporate parents. Council officers across the council (not just in children's services departments) share in the responsibility and other partners also have a duty to cooperate to ensure looked-after children's needs are met.

## Questions to ask

- Does your council have an effective structure for the governance of corporate parenting, including councillors?
- Do looked-after children know who their 'corporate parents' are? What do they
- say about what they expect from local councillors and others acting as their 'corporate parents'?
- Do all members receive mandatory training on their roles and responsibilities as corporate parents when they are elected and is this refreshed during their term of office?

- Are there appropriate opportunities for elected members to meet and listen to looked-after children and young people, and to celebrate and praise their achievements when they do well?
- Is there an active children in care council which regularly meets with elected members and others in authority (across the council and other partners) to express the views and needs of your looked-after children?
- Is the children in care council happy with the way in which its views influence policy and practice?
- How are children and young people's complaints responded to and what is learnt from them?

One authority has encouraged councillors to 'adopt' a residential home in order to encourage greater responsibility for, and interest in, each home by elected members and provide continuity between visits. These members could be important witnesses to any scrutiny inquiry.



# Case studies

## London Borough of Newham

The Children and Young People Scrutiny Commission carried out a review of the council's new approach to corporate parenting – in particular its targets to reduce the number of children in its care, and improve provision for those who remain in care. The commission endorsed the families directorate's investment of intensive resources into those families with children on the edge of care, at an early stage alongside the immediate removal of children where there are risks to their safety, followed by a permanent placement wherever possible. The commission made a number of recommendations, including increased support for foster carers, and closer working arrangements with partnership agencies. The report is available in the CfPS library: <http://tinyurl.com/7ko94k2>

## Cheshire East Council

The Children and Families Scrutiny committee undertook a review of fostering services. They identified a need to improve systems and recommended a number of measures to improve the experience of foster carers. They also stated that, in line with the corporate parenting strategy, all corporate policies must consider their impact on looked-after children. The review also suggested related topics for review, such as the 16 plus service. The report is available in the CfPS library: <http://tinyurl.com/6v4kr3r>

## Buckinghamshire County Council

The Children's Services Overview and Scrutiny Committee undertook a review 'Maximising the potential of looked-after children' – examining issues affecting educational attainment of looked-after children in the county, including post-16 and their ability to participate in other aspects of school life. Recommendations focus on support at transition stages and support for foster carers to enable them to better support the children they look after. The report is available in the CfPS library: <http://tiny.cc/g1dt6>

## Rotherham Metropolitan Borough Council

Rotherham Looked-After Children Scrutiny Sub-Panel has undertaken two reviews of corporate parenting. The most recent review made a number of recommendations in three main areas:

- looked-after children council and pledge
- governance arrangements
- training and guidance to elected members.

The report is available in the CfPS library: <http://tiny.cc/6pfck>

## Hartlepool Borough Council

The Children's Services Scrutiny Forum undertook an investigation into the provision of support and services to looked-after children and young people. It took evidence from a range of stakeholders including children and young people, frontline staff and carers. It also invited a presentation from a neighbouring authority. A detailed profile of the looked-after population was undertaken to inform the investigation. It arrived at a number of recommendations for improvement. The report is available in the CfPS library: <http://tinyurl.com/7fzanrz>

## Bracknell Forest Council

The council has a specific overview and scrutiny panel that regularly monitors the performance of the children, young people and learning department mainly through review of its quarterly service reports (QSRs), inspection reports and the children's social care statutory complaints report. The QSRs enable the panel to question executive members and officers in detail about trends, pressures and priorities. Specific areas considered recently have included the stability of foster care placements. The report is available in the CfPS library: <http://tinyurl.com/6r4dpgr>



# References and further information

## Key legislation and guidance

### **Children Act 1989**

<http://tiny.cc/qrzro>

### **Adoption and Children Act 2002**

<http://tiny.cc/lf98m>

### **Children and Young Persons Act 2008**

<http://tiny.cc/951i3>

### **Care planning, placements and case review regulations (England) 2010 and statutory guidance**

These documents specify the current requirements for care plans, including health and education plans, placement decisions and monitoring, and case reviews. They consolidate previous regulations and guidance, providing a central source of reference for local authorities' work with looked-after children and can be found on the DfE website: <http://tiny.cc/7xt9g>

### **Promoting the educational achievement of looked-after children: statutory guidance for local authorities (DCSF 2010)**

Statutory guidance setting out the responsibilities of local authorities and their partners in relation to the education of looked-after children. <http://www.torbay.gov.uk/promotingtheeducationalachievement.pdf>

### **Promoting the health and wellbeing of looked-after children (DCSF 2009)**

Statutory guidance setting out the responsibilities of local authorities and their partners in relation to the health of looked-after children. <http://tinyurl.com/yaevzg2>

## Resources

### **Welcome to corporate parenting – a councillor development learning resource**

A booklet and audio CD was produced by Kirklees, Bradford and Calderdale Councils working with a group of looked-after young people.

Contact: Angie Aspinall, Councillor Development Officer, Kirklees Council, [angie.aspinall@kirklees.gov.uk](mailto:angie.aspinall@kirklees.gov.uk) or 01484 416 930  
<http://tinyurl.com/726mylr>

### **Improving educational outcomes for looked-after children and young people, and improving the emotional and behavioural health of looked-after children and young people**

Two useful knowledge reviews containing detailed evidence of what works, produced by the Centre for Excellence and Outcomes in Children's Services (C4EO), September 2010, available on [www.c4eo.org.uk](http://www.c4eo.org.uk)

**Putting corporate parenting into practice: developing an effective approach**

Materials to support corporate parents, by Hart, D and Williams, A National Children's Bureau and currently being updated.  
[www.ncb.org.uk](http://www.ncb.org.uk)

**LILAC**

LILAC is a project run by a National Voice. It involves care experienced young people in carrying out assessments of how well services involve and consult with their children and young people, and delivering training on participation and the LILAC standards. [www.lilacnv.org](http://www.lilacnv.org)

**What young people from CiCCs say... ten top tips for corporate parents**

Suggestions from children in care councils about how corporate parents can work most effectively with them

ANV (forthcoming)

**Must knows for lead members in children's services – Local Government Association**

<http://tinyurl.com/726mylr>

**3. How do you know your council is serving the most vulnerable children and young people well?**

[Top tip three \(PDF, 8 pages, 554 KB\)](#)

**4. How do you know your council is being effective in keeping children and young people safe?**

[Top tip four \(PDF, 8 pages, 528 KB\)](#)

**Data profiles for local authorities – LG Inform. Register through the LGA website.**

[www.local.gov.uk](http://www.local.gov.uk)

**Improvement support**

**Information on children's improvement board**

<http://tinyurl.com/892zfcml>

**LGA support for members**

<http://tinyurl.com/7bzpoxd>

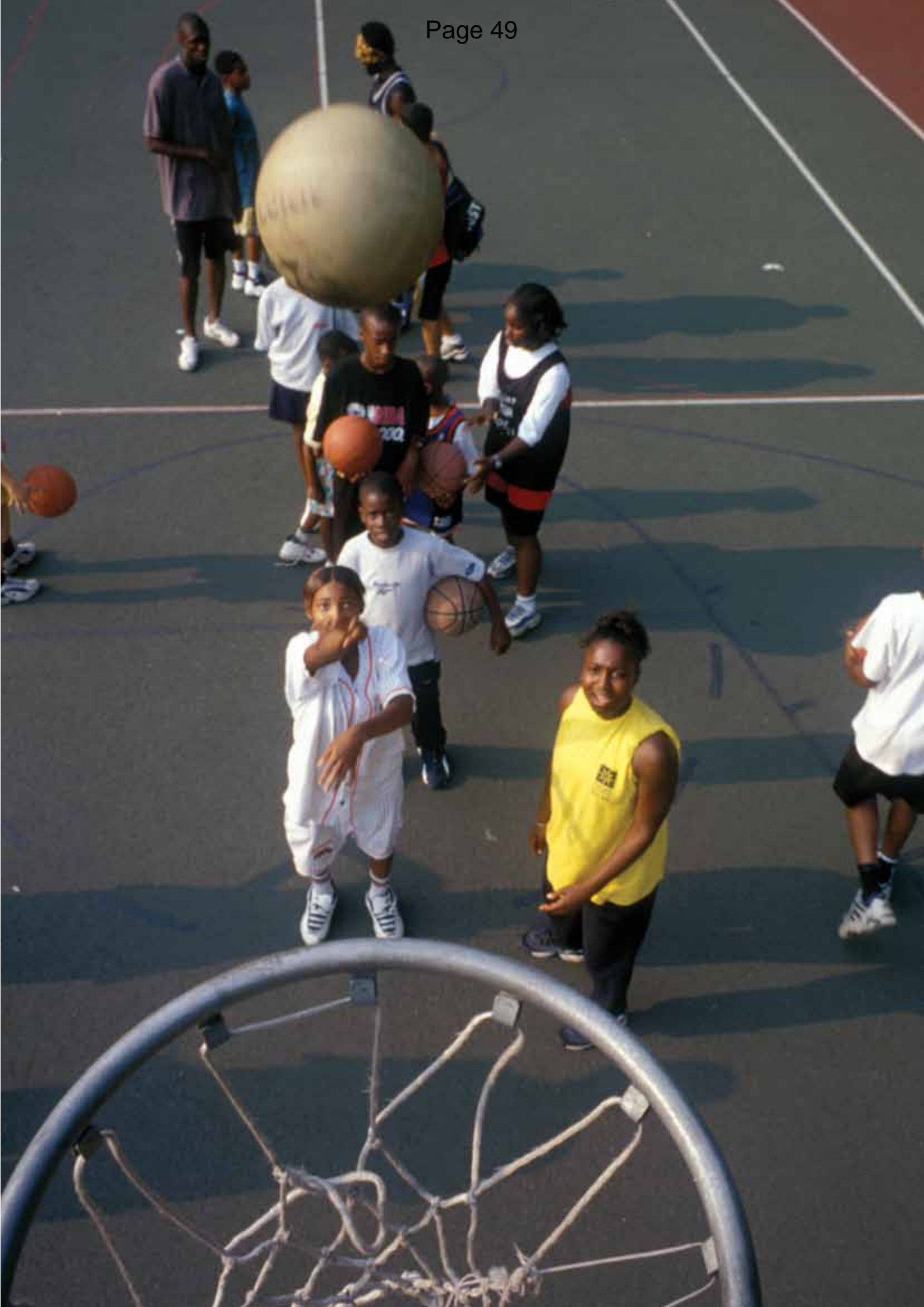
**Safeguarding children peer review**

<http://www.local.gov.uk/safeguarding-children-peer-reviews>

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# Deep Dive Follow up Session

## Children's Single Point of Access

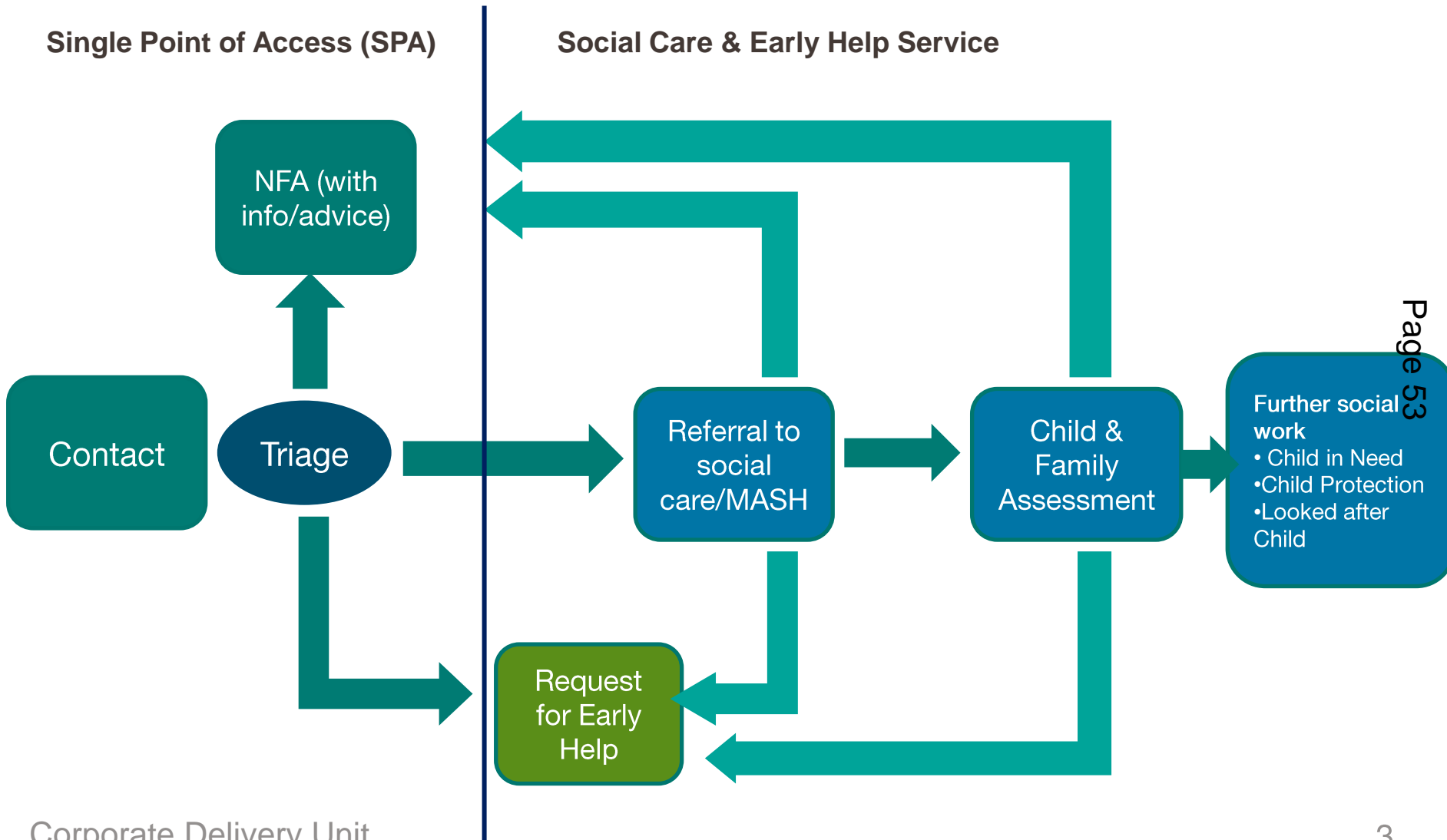
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*Corporate Delivery Unit*

September 2016

# Operating Model

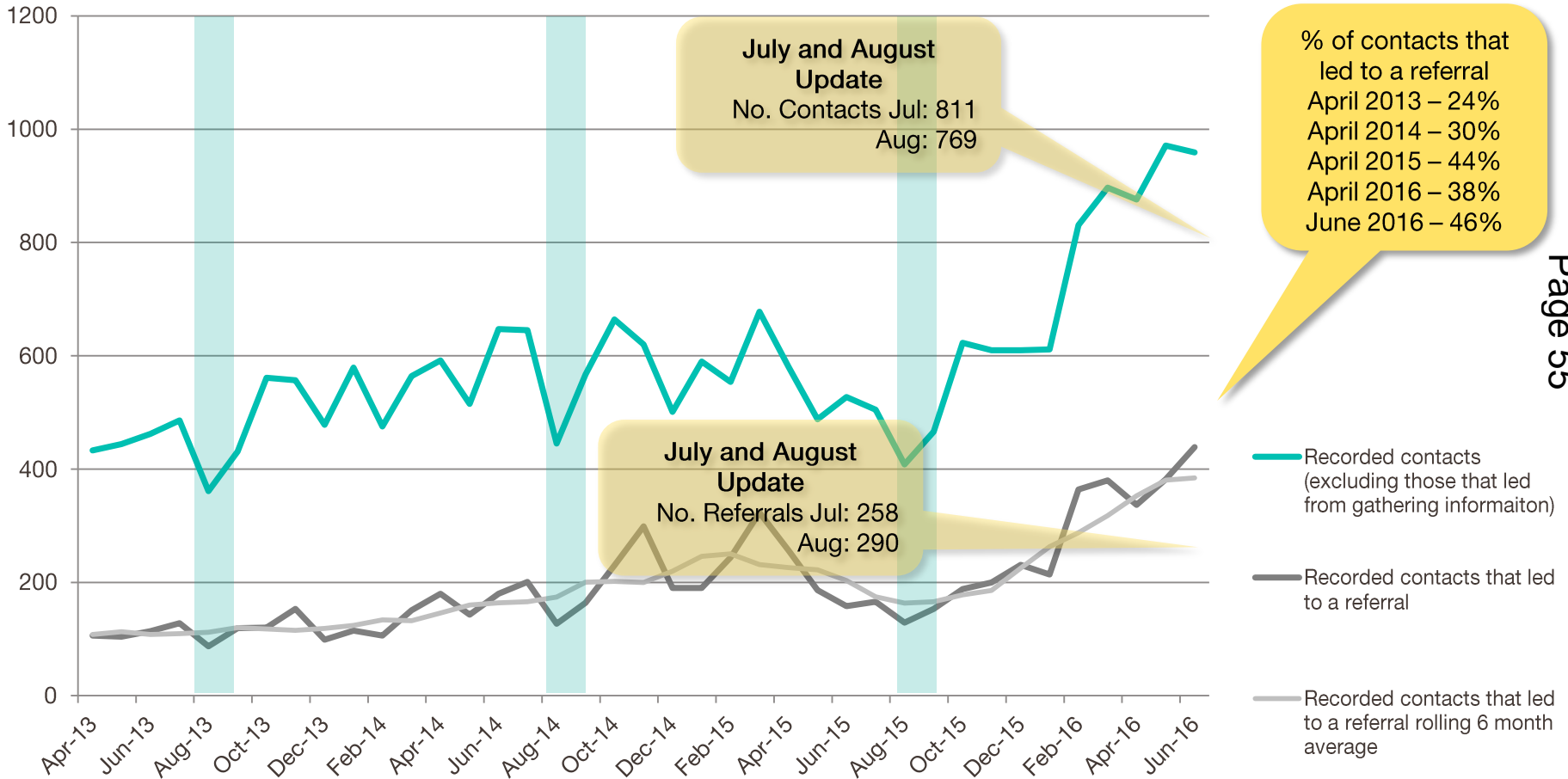
# Current Operating Model



# Contact to Referral

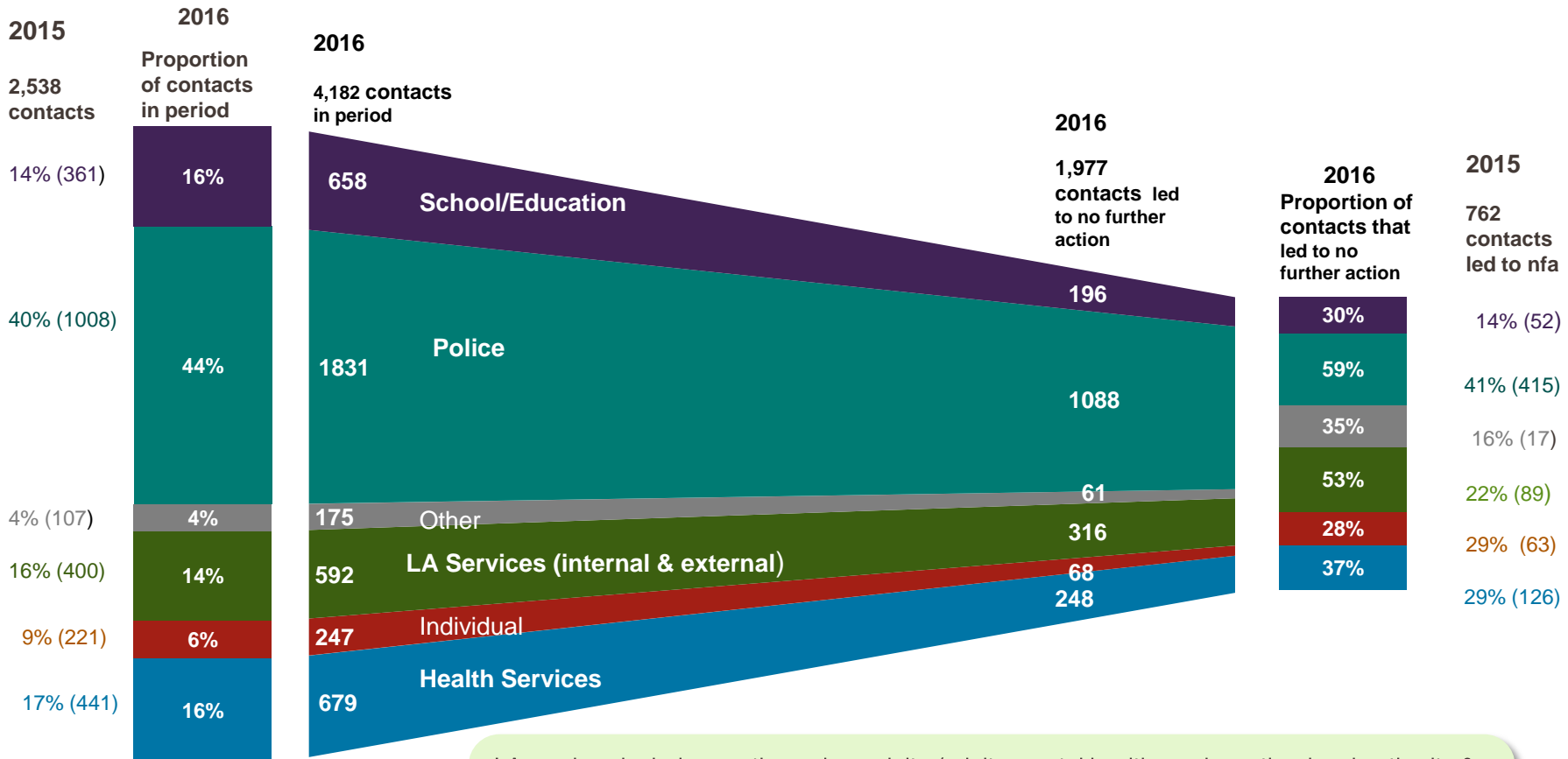
There has been marked increase in the number of recorded contacts since February 2016

Number of recorded children social care contacts and recorded contacts that led to a referral  
 April 2013 to June 2016 (excluding contacts that led from gathering information)



The proportion of contacts leading to no further action has increased, 47% led to no further action between February and June 2016 compared to 30% in 2015

Children social care contacts by source February - June 2016

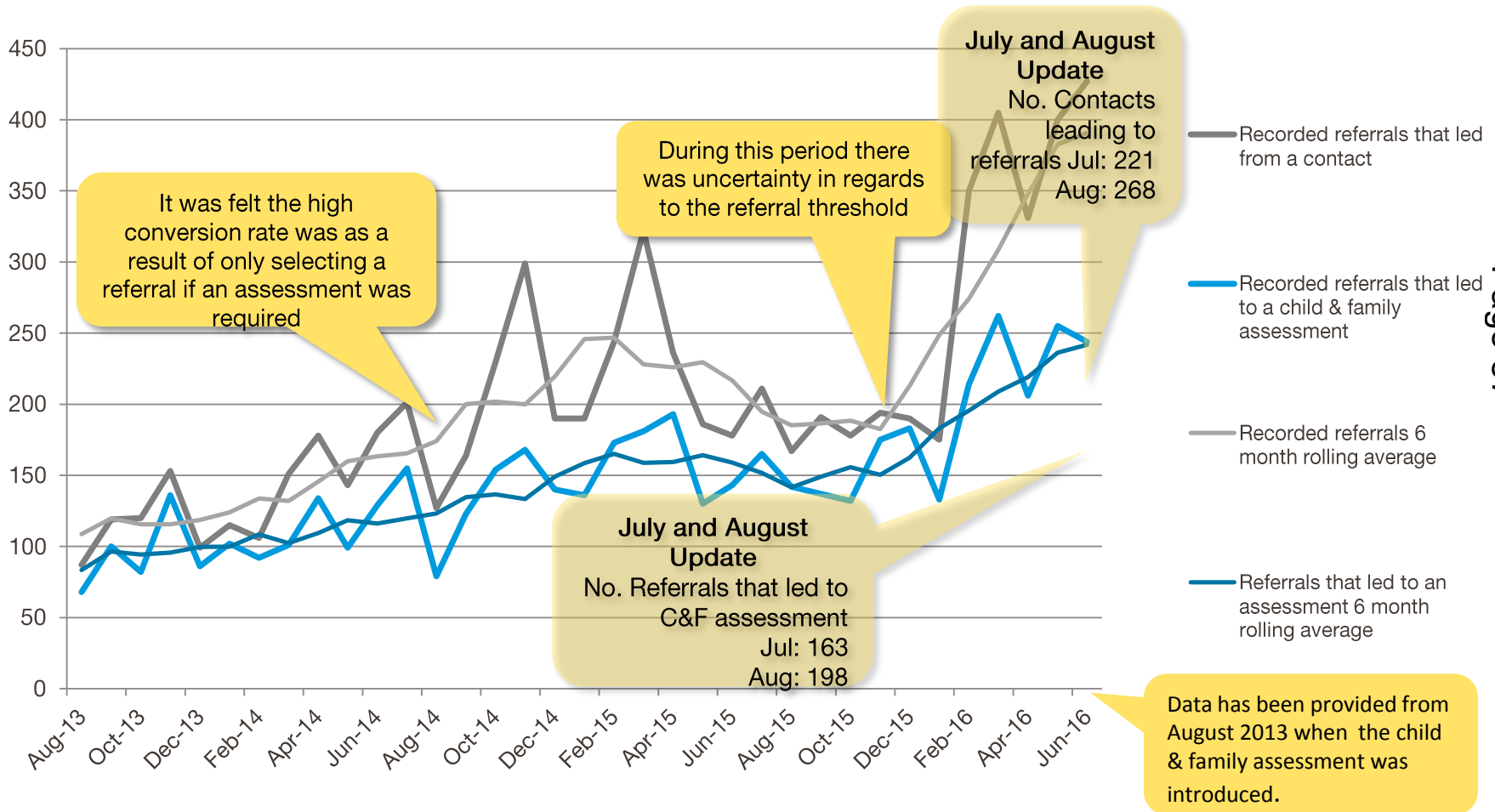


LA services includes youth service, adults /adults mental health service, other local authority & other council departments. It does not include housing, there were 75 contacts from housing or housing association between February – June 2016 of which 50 led to no further action.

Individual includes Haringey employee, self referral, neighbour/friend, relative/house member, MP and member of public.

Whilst the number of recorded referrals has increased since February 2016, the proportion resulting in a child and family assessment being undertaken has started to reduce

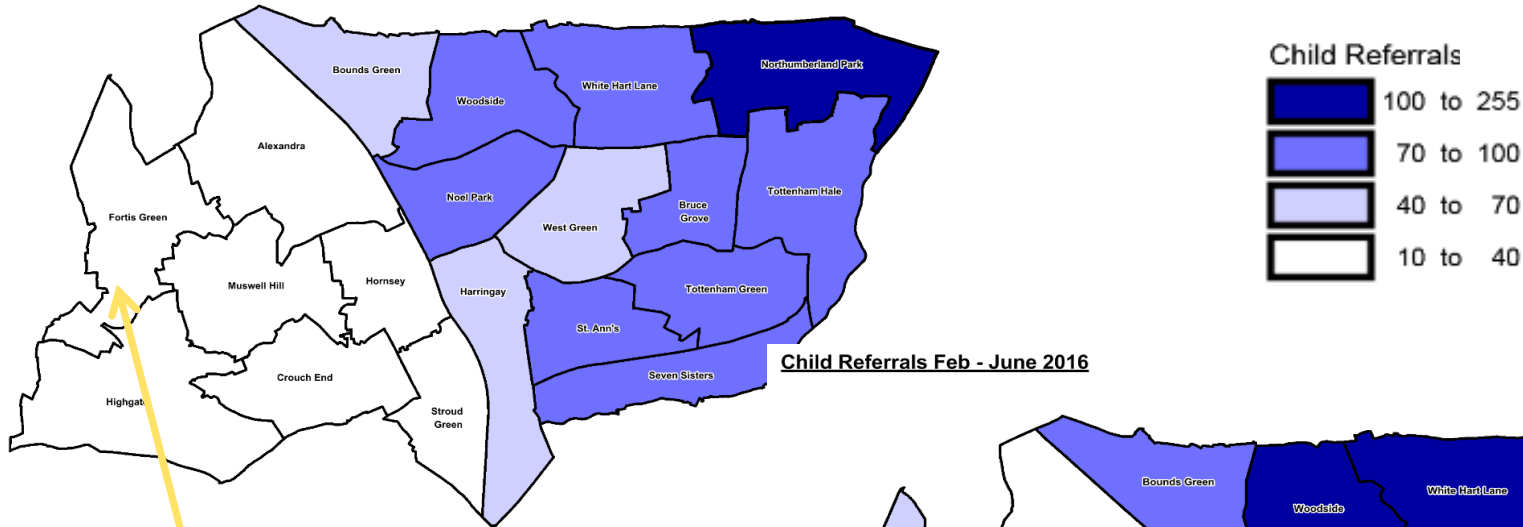
Number of referrals that led to a child and family assessment August 2013 - June 2016



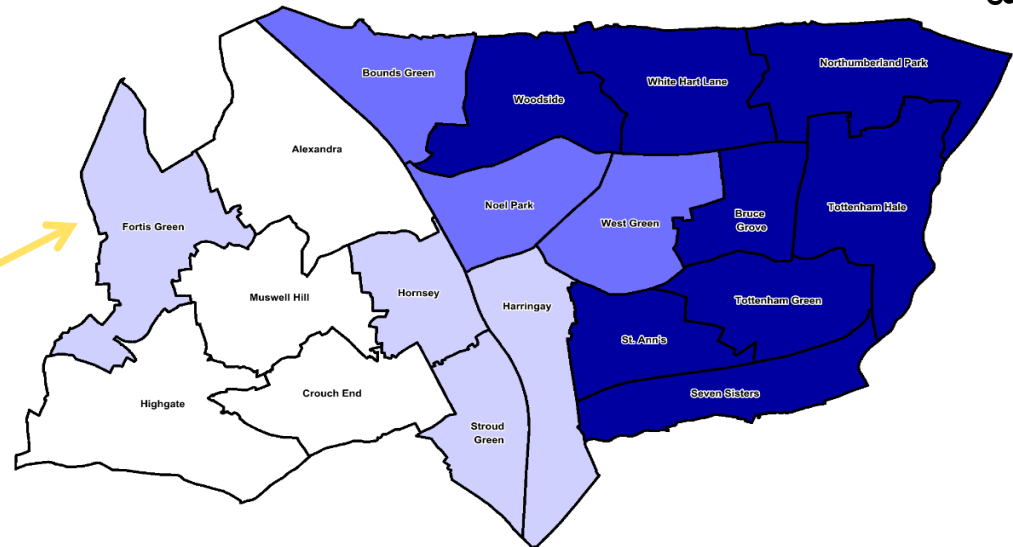
Although the numbers of child referrals has increased in period the proportion of referrals by home address ward remains similar to the profile in 2015

**Child Referrals Feb - June 2015**

**Number of child social care referrals by ward February – June 2015/16**



**Child Referrals Feb - June 2016**

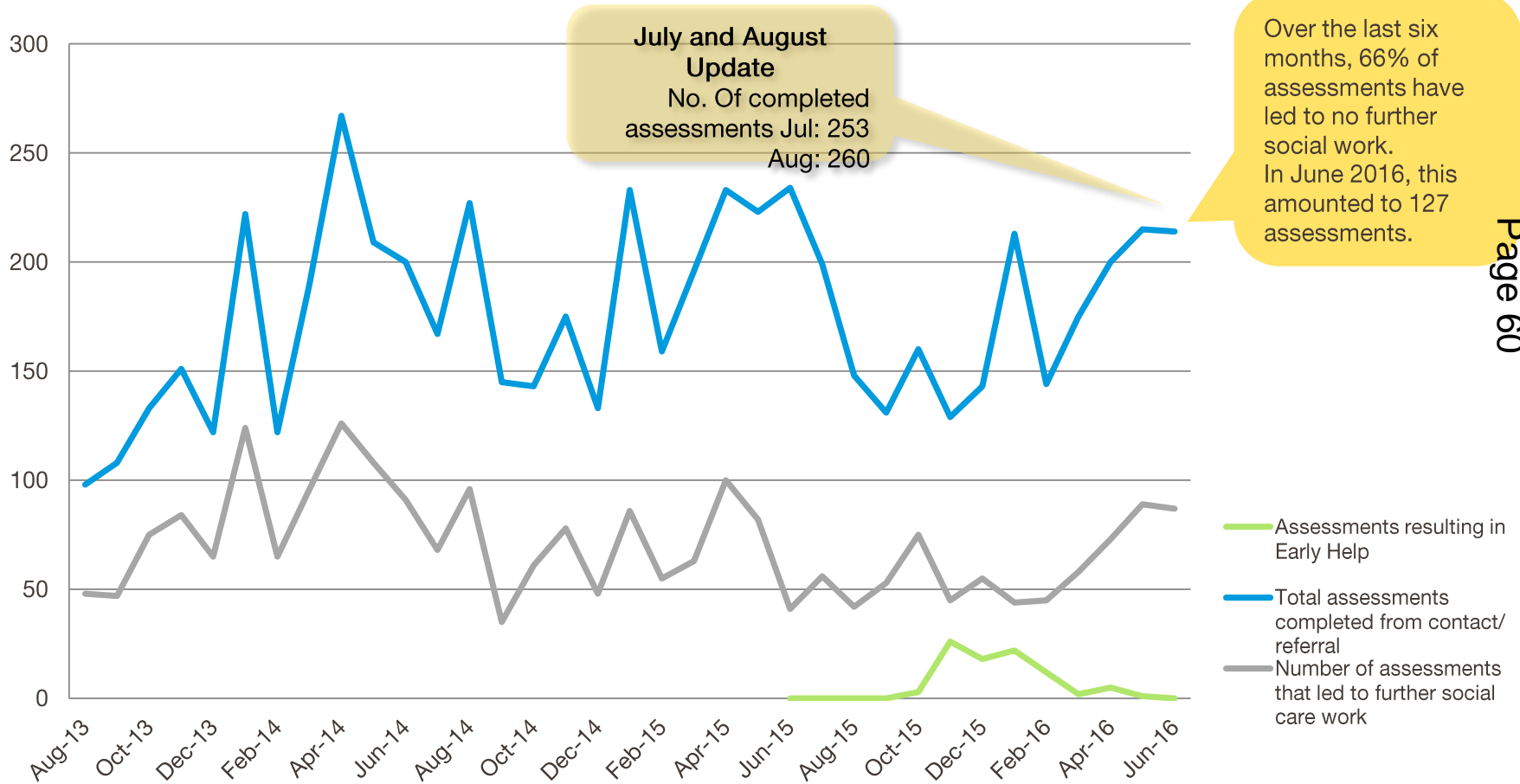


Child social care referrals with a home address in Fortis Green accounts for 2% of referrals between February and June

# Assessments

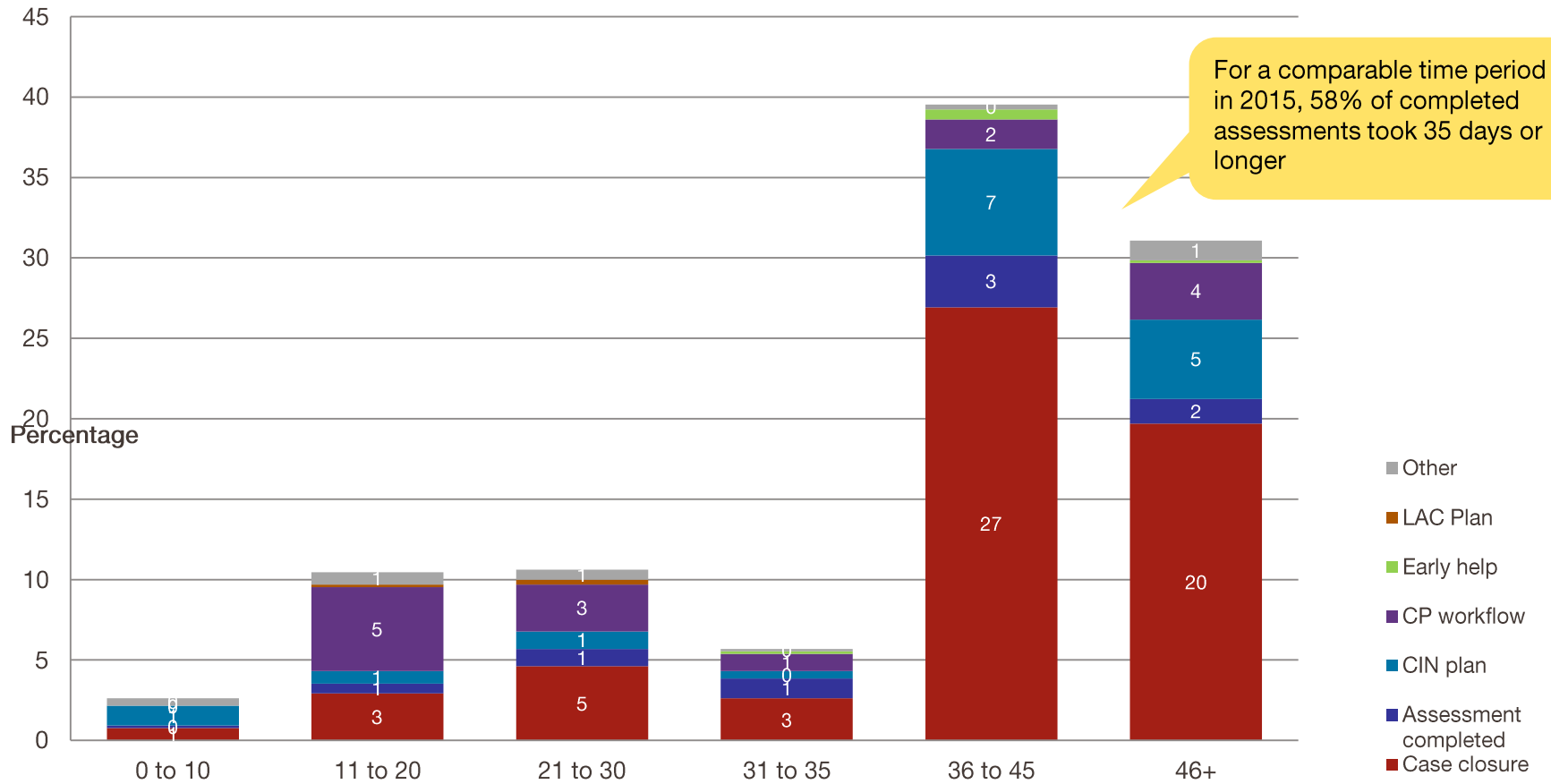
# As seen in the first deep dive, a significant proportion of assessments do not lead to further social care intervention

Child and family assessments completed from contact/referral August 2013 - June 2016



70% of assessments took over 35 days to be completed, including a large number that proceed to case closure

Child and family assessments with a referral as a proceeding step  
April - June 2016

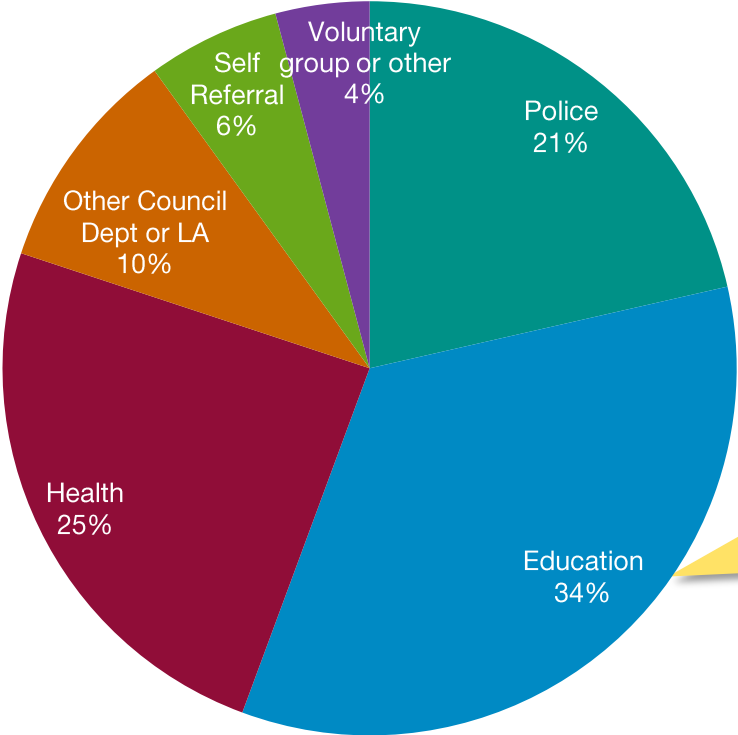


# Early Help

31% of requests for an early help service are a direct result of a step down from children's social care. Excluding these, one third of contacts are from education

Early help requests by contact source excluding social care step downs October 2015- June 2016

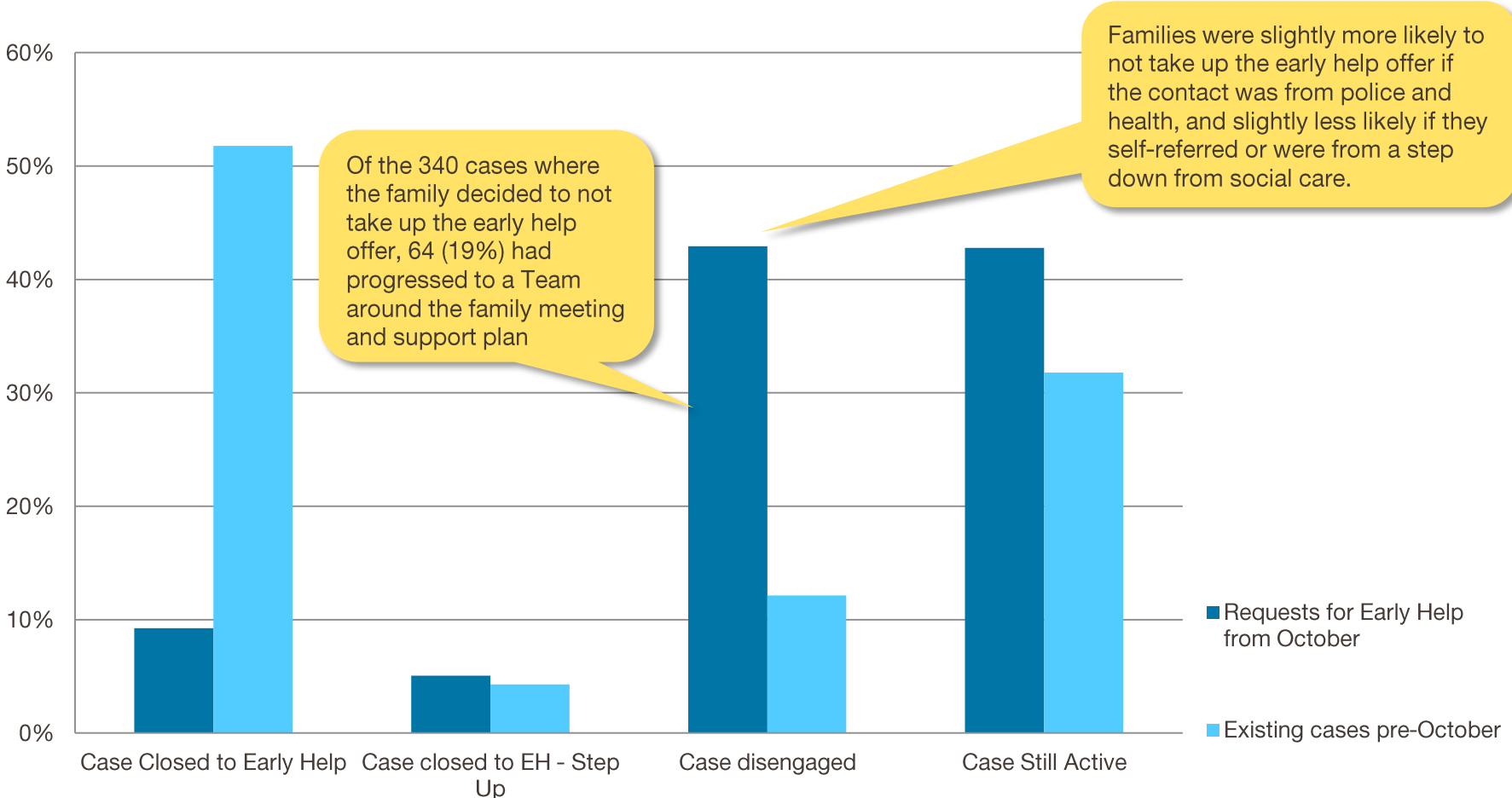
31% of requests for early help were social care step downs.  
Of these:  
42% (103) from referrals  
30% (72) from assessments  
28% (67) from case closures



For comparison, contacts into the SPA between February – June 2016, 44% were from police, 16% were from education & 16% were from health

# A snapshot of early help cases shows over 40% of more recent requests, the family did not take up the early help offer

Snap shot of cases as at end of May 2016



**Report for:** Corporate Parenting Advisory Committee - 3 October 2016

**Title:** Update on the situation and funding of Unaccompanied Asylum Seeking Children (UASC)



**Report authorised by :** Jon Abbey  
Director, Children's Services

**Lead Officer:** Dominic Porter-Moore, Head of Service, Children in Care and Placements, Tel 020 8489 1011

**Ward(s) affected:** N/A

**Report for Key/  
Non Key Decision:** Non key

## **1. Describe the issue under consideration**

This report outlines recent Government developments in caring for and supporting unaccompanied and refugee children and their families across the UK.

The report also reports on the assessment pathway for looked after children with uncertain immigration status

## **2. Background information**

2.1 On 1<sup>st</sup> July 2016 a new Interim National Transfer Protocol for UASC was issued by the Dept for Education, the Home Office and Department for Communities and Local Government.

2.2 The purpose of the interim protocol is to enable the safe transfer of unaccompanied children from one UK local authority (the entry authority from which the unaccompanied child transfers) to another UK local authority (the receiving authority).

2.3 The protocol forms the basis of a voluntary agreement made between local authorities to ensure a fairer distribution of unaccompanied children across all local authorities and all regions across the UK.

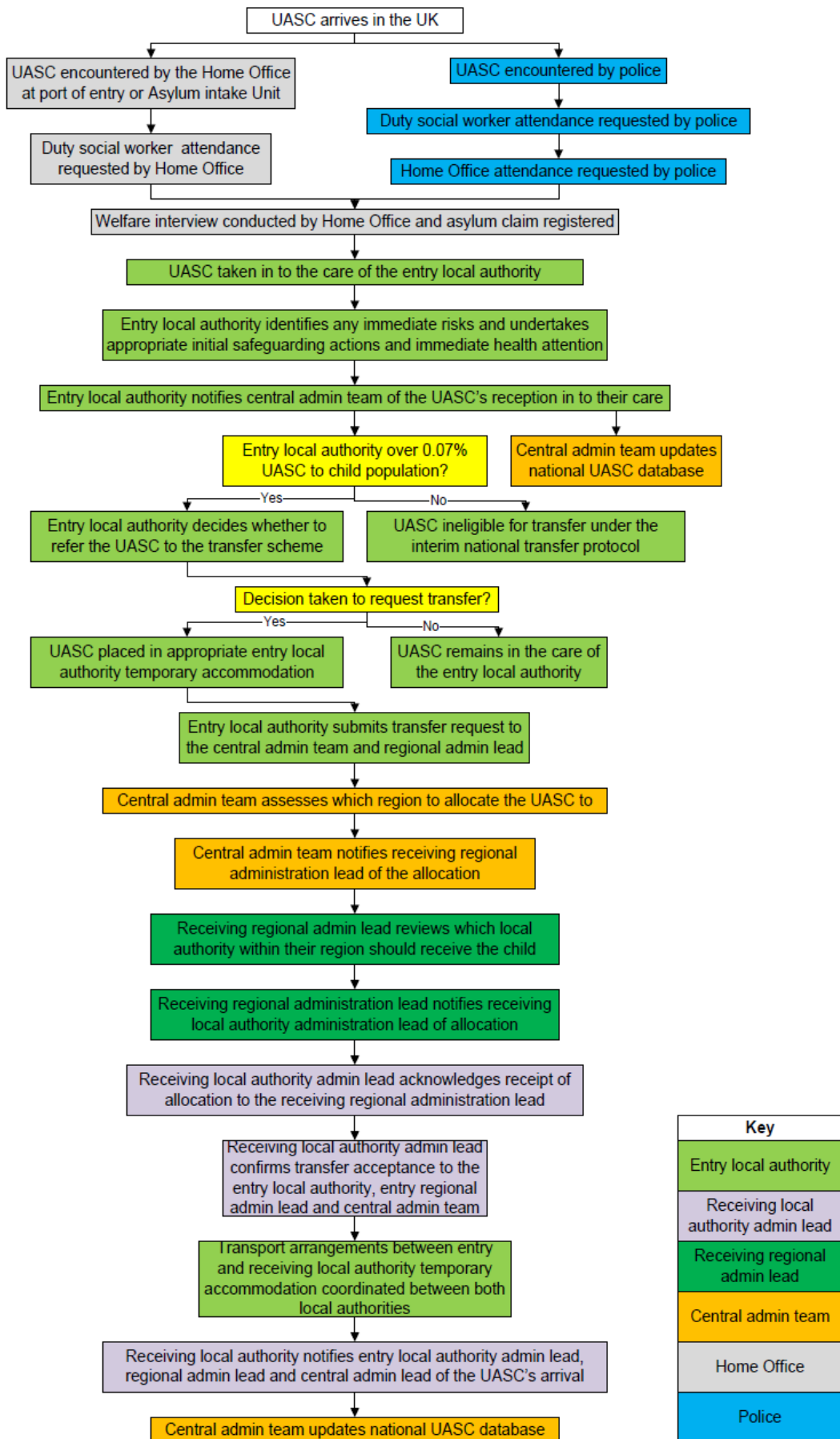
2.4 The calculation on the fair distribution of UASC across the UK was reached through agreement with the Local Government Association and the Association of Directors of Children's Services (ADCS). The formula is a simple and transparent way of checking whether the responsibility for looking after unaccompanied children is distributed fairly across the country. It is based on analysis of the total child population from the 2014 census and the numbers of UASC. The formula is set at 0.07%.of the total child population.

2.5 London boroughs have made a huge contribution in looking after UASC. At 31<sup>st</sup> March 2015 they supported 45% of all UASC in England.

2.6 Currently Haringey has 0.047% UASC to total child population, therefore Haringey has the capacity to take an additional 14 UASC.

2.7 The transfer flow chart identifies the UASC's journey from point of arrival in the UK

### Transfer Flow Chart



Key
Entry local authority
Receiving local authority admin lead
Receiving regional admin lead
Central admin team
Home Office
Police



2.8 Guidance received from the Association of London Directors of Children's Services will apply until the ALDCS review the London arrangements. The ADCS is due to meet on 19<sup>th</sup> September to review how the protocol is working. The following arrangements will remain in place until further notice.

2.8(a) For 16-17 year-olds presenting in the Asylum Intake Unit in Croydon: The London protocol continues to be operational for this group, but that further placements are not made in authorities which are over the 0.07% threshold of UASC to total child population.

2.8(b) For UASCs under 16 presenting in Croydon: these children will feed into the national transfer protocol once Croydon has assurance that these arrangements are ready to take the volume of children (around 22 per month).

2.8 (c) For spontaneous presentations in other boroughs of UASCs of any age: where the authority is under the 0.07% threshold these will become looked after to that borough; where the authority is over 0.07%, these children will feed into the national transfer arrangements.

2.9 In the first instance UASC will be dispersed within the local region ( such as London region) in which the child first presents if there are local authority partners who are under the ceiling of 0.07%.

2.10 The only exception to these arrangements is if it is assessed as not in the UASC best interest to referred to the transfer protocol, for example if a sibling or close relative is also looked after by the receiving local authority.

2.11 On the 8<sup>th</sup> September the Immigration Minister Robert Goodwill MP wrote to all Council Leaders in the UK requesting that all local authorities:

- i) who have not registered for the National Transfer Protocol do so by the 21<sup>st</sup> September 2016. The Immigration Act 2016 gives the government the power to make the scheme mandatory if required
- ii) Local Authorities are also requested to confirm how many more UASC they could accept using the 0.07% threshold.
- iii) That local authorities under the Vulnerable Persons Resettlement Scheme (VPRS) consider taking children and their families as part of the UK government's commitment to receive 20,000 Syrian refugees over the next 5 years.

2.12 In regard to the VPRS it remains unclear what the dispersal and allocation mechanism will be although in a London Councils briefing document dated 13<sup>th</sup>

September up to the end of Q2 2016/17 nine London authorities had taken a total of 144 Syrian refugees.

2.13 London local authorities face challenges such as identifying sufficient private rented accommodation that is both available and affordable for refugee families receiving local housing allowances and the cap on levels of housing allowances and income maintenance benefits especially for larger refugee families.

2.14 The Greater London Authority calculate that London will take 2500 refugees as part of the national commitment to take 20,000 refugees.

### **3. Looked after children (LaC) with uncertain immigration status**

3.1 Expert legal advice has been sought regarding LaC & care leavers in regard to LaC without a settled immigration status. This advice informs the following commentary.

3.2 There is no statutory requirement which says the local authority (LA) must seek to achieve settled immigration status for it's looked after children. However the duties under S23(c) are broad. The local authority duties rest on two tests

- i) how a reasonable parent would act in respect of their child and
- ii) the 'welfare of the child test'.

3.3 The analysis and outcome of the assessment would inform care planning and decision making on resolving a looked after child's immigration status.

### **4. Children and young people who become looked after by a local authority**

4.1 At the earliest opportunity the assessing Social Worker must identify what the citizen status of the LaC is, whether they are UK citizens, European Union or the European Economic Area (EEA) citizens or from other countries outside the EU & EEA.

4.2 The allocated Social Worker will need to get a clear picture from the parents or carers as to their immigration status and the child's immigration status, what applications the family has made or plan to make and confirms that the parents will be including their child in any applications they intend to make whilst the child is in care.

4.3 If a LaC remains in care and there is little likelihood of rehabilitation to the parents or becomes LaC through the provisions of a S31 care order or the parents abandon their child or refuse to co operate then the local authority will need to undertake the two tests of a reasonable parent and the welfare of the child test to determine whether the LA takes steps to secure the LaC with indefinite leave to remain in the UK. The exception to this would be if the permanency plan is for adoption as once a child is adopted the child assumes the citizen status of their parent(s)

4.4 The decision to support and fund a LaC seeking indefinite leave to remain will depend on the needs assessment of the LaC. Once the decision has been taken that

it is in the child's welfare for their immigration status to be regularised then this needs to be done as quickly as possible as the threshold test for granting indefinite leave to remain is lower for children than for care leavers over the age of 18.

4.5 However part of the assessment must be an analysis of whether the LaC can be returned to the Children's Social Care Services or friends & family in their home country.

4.6 Whether or not a child can return to their home country depends on the country, the reasons why the child is in care, the social work assessment and facts of the child's case. There may well be cases where the LA takes the view that it would not fund the application but decisions will need to be based on assessments.

**Report for:** Corporate Parenting Advisory Committee – 3 October 2016

**Item number:**

**Title:** Overview and Scrutiny Work Programme Update

**Report authorised by:**   
Director, Children's Services

**Lead Officer:** Christian Scade, Principal Scrutiny Officer  
020 8489 2933, [christian.scade@haringey.gov.uk](mailto:christian.scade@haringey.gov.uk)

**Ward(s) affected:** N/A

**Report for Key/  
Non Key Decision:** N/A

**1. Describe the issue under consideration**

1.1 This report outlines how the Overview and Scrutiny Committee will review Haringey's corporate parenting responsibilities.

**2. Recommendations**

2.1 That the work planned by the Overview and Scrutiny Committee, in relation to Haringey's corporate parenting responsibilities, be noted.

**3. Background Information**

3.1 On 27 July 2015, the Overview and Scrutiny Committee (OSC) received a report entitled "Learning from the Lessons of Rotherham – Implications for Scrutiny and Safeguarding".

3.2 This report supported OSC to be aware of the lessons from Rotherham in considering its future work programme. As a result, a number of issues were identified for further consideration by scrutiny.

3.3 In addition to work undertaken by the Children and Young People Scrutiny Panel, the Overview and Scrutiny Committee agreed to review how the Council performs its corporate parenting responsibilities.

3.4 Following discussion between Cllr Wright, Chair OSC, and Cllr Weston, Cabinet Member for Children and Families, on the 28<sup>th</sup> November 2016 Haringey's Overview and Scrutiny Committee will consider the following:

- [The roles and responsibilities of Haringey's Corporate Parenting Advisory Committee;](#)

- [“10 questions to ask if you’re scrutinising services for looked after children”](#)  
– a publication produced by the Centre for Public Scrutiny, the Local Government Association and the National Children’s Bureau;
- Areas of work still relevant / outstanding from the [Corporate Parenting Scrutiny Review \( 2011\)](#) – linked to the “10 questions” above (rather than just monitoring previous scrutiny recommendations);
- [Learning from Lessons of Rotherham](#) – Implications for Corporate Parenting;
- *Keep on Caring, Supporting Young People from Care to Independence* Ofsted Report July 2016 :  
<https://www.gov.uk/government/publications/keep-on-caring-supporting-young-people-from-care-to-independence>
- The voice of the child/young person and how this might be strengthened;
- Opportunities for scrutiny involvement moving forwards.

#### **4. Contribution to Strategic Outcomes**

- 4.1 Scrutiny work in this area will contribute to Corporate Plan Priority 1 – *“Enable every child and young person to have the best start in life, with high quality education”*.

#### **5. Statutory Officers Comments**

##### **Finance**

- 5.1 There are no financial implications arising from the recommendations set out in this report. Should any of the work undertaken by Overview and Scrutiny generate recommendations with financial implications these will be highlighted at that time.

##### **Legal**

- 5.2 There are no immediate legal implications arising from the report.

##### **Equality**

- 5.3 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:
- Tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;

- Advance equality of opportunity between people who share those protected characteristics and people who do not;
- Foster good relations between people who share those characteristics and people who do not.

5.4 The Overview and Scrutiny Committee will ensure it addresses these duties by considering them in relation to work on corporate parenting. This will include considering:

- How policy issues impact on different groups within the community, particularly those that share the nine protected characteristics;
- Whether the impact on particular groups is fair and proportionate;
- Whether there is equality of access to services and fair representation of all groups within Haringey;
- Whether any positive opportunities to advance equality of opportunity and/or good relations between people, are being realised.

## **6. Local Government (Access to Information) Act 1985**

6.1 External web links have been provided in this report. Haringey Council is not responsible for the contents or reliability of linked websites and does not necessarily endorse any views expressed within them. Listings should not be taken as an endorsement of any kind. It is your responsibility to check the terms and conditions of any other web sites you may visit. We cannot guarantee that these links will work all of the time and we have no control over the availability of the linked pages.

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## Draft Terms of Reference Haringey Children in Care Operational Group

Date: TUESDAY 20<sup>th</sup> October 2015 (Amended 22.7.2016)

1. Purpose:

To provide a safe and supportive forum to discuss issues of concern regarding Children in Care.

2. Responsibilities:

- a) To evaluate the Children in care pathways and outcomes.
- b) To strengthen partnership working across social care, health and CAMHS .
- c) To problem solve on specific cases and identify learning.
- d) To implement changes as required to our systems/pathways.
- e) **CAMHS transformation project update will be discussed at this meeting**
- f) The Terms of reference will be reviewed annually

3. Standards of Operation

- a) The group will be chaired by The Designated Doctor.
- b) The group will initially meet monthly, Members are requested to send deputies when they are unable to attend.

4. Core Membership

Designated Doctor Haringey, Designated Nurse Haringey, Head of Children in Care Service Haringey, Adoption and Fostering Service manager

Deputy Head of Service Disabilities Team. Deputy Head of Leaving Care Service Service manager Independent Reviewing Officers.

Service manager for First Step, Vulnerable children's commissioner

5. Exceptional reporting from this group to both The Corporate Parenting Committee and The Safeguarding and Assurance Committee will take place.

**Operational Meeting  
Friday 22 July 2016**

## MINUTES

Dr Kim Holt (Chair)	Designated Doctor for Children in Care and Medical Advisor to Haringey <a href="mailto:kim.holt@nhs.net">kim.holt@nhs.net</a>
Lynn Carrington	Designated Nurse - Children in Care <a href="mailto:lynn.carrington@nhs.net">lynn.carrington@nhs.net</a>
Catherine Swaile	Commissioning Manager – Haringey CCG <a href="mailto:catherine.swaile@haringey.gov.uk">catherine.swaile@haringey.gov.uk</a>
Martina Weilandt	First Step <a href="mailto:mweilandt@tavi-port.nhs.uk">mweilandt@tavi-port.nhs.uk</a>
Wendy Lobatto	Service Manager – First Step <a href="mailto:wlobatto@tavi-port.nhs.uk">wlobatto@tavi-port.nhs.uk</a>
Emma Cummergen	DHOS –YAS 16 + Team Manager <a href="mailto:emma.cummergen@haringey.gov.uk">emma.cummergen@haringey.gov.uk</a>
Dominic Porter-Moore	HOS CIC & P <a href="mailto:dominic.porter-moore@haringey.gov.uk">dominic.porter-moore@haringey.gov.uk</a>
Brenda Green	Administrator (Minute Taker) <a href="mailto:brenda.green1@nhs.net">brenda.green1@nhs.net</a>

### APOLOGIES:

Annie Walker	DHOS CiC <a href="mailto:annie.walker@haringey.gov.uk">annie.walker@haringey.gov.uk</a>
Lesley Kettles	SM F&A <a href="mailto:lesley.kettles@haringey.gov.uk">lesley.kettles@haringey.gov.uk</a>
Sunita Khattrra	Senior IRO Haringey Children's and YPS <a href="mailto:sunita.khattrra@haringey.gov.uk">sunita.khattrra@haringey.gov.uk</a>
John Murphy	Team Manager <a href="mailto:john.murphy@haringey.gov.uk">john.murphy@haringey.gov.uk</a>
Jennifer Wakelyn	First Step <a href="mailto:jwakelyn@tavi-port.nhs.uk">jwakelyn@tavi-port.nhs.uk</a>

### 1. Introduction and Apologies

Introductions by those present and apologies noted.  
Minutes of last meeting read.

High Risk List was discussed. There is a list of children of concern discussed weekly in HCYPS.

DP-M explained this list is of children missing from care. There will be overlap between this list and those young people whom we are struggling to engage with. A report is sent to the director and managers. DP-M does not see any problems of those present in the operational meeting having access to this list.

Minutes Agreed.

CAMHS Transformation update

**2. First Step Plus**

The team is trying to engage with those children referred. MW does her best to liaise using links in the network. Children may be placed far outside London which can make the information gathering more difficult. Concerns were raised regard mismatch between children's needs and the provision by the Designated doctor and she cited an example where the placement had been unaware of the full history and needs of a child before he was placed. That placement subsequently broke down. This increases the loss for a child and will escalate the situation. There is a general view that we need to try and be proactive. The benefit of First Step plus is that the workers can follow the young person around the system.

There should be a list of preferred providers for placement into the system. Not all placements have been helpful.

Placement officers need to know what expectations are for each child.

Action to invite Verna Miller Senior Placement and Commission Officer to next meeting.

First Step Plus pilot will continue into next year. Concern was raised about the potential risk of a sudden break in provision, and how that might impact upon children.

**Training plan**

Social Workers will be offered training in emotional development and well being and the routes of access support. Training will be offered to Family Support Workers and LAC nurses and permanent staff as all would benefit, and it would be helpful for the networking of professionals dates to be confirmed. Action First step to confirm training dates.

**3. Not Seen, Not Heard CQC report**

To be discussed at the next meeting.

**4. Notifications of Children Entering Care/Moving Placement**

The number of notifications/placement moves was given.

Action DP-M to explore notification/placement moves and other options and report back.

**5. Terms of Reference**

Wording to be changed at point 5 and confirmed as terms of reference for the group.

**6. AOB**

WL happy that meeting times have been changed and will be able to attend more.

Future Meeting Dates:

Friday 9 September 2016

Friday 14 October 2016

Friday 11 November 2016

Friday 9 December 2016

LC happy about First Step and how it is helpful to LAC team.

**Date of Next Meeting**

**Friday 9 September 2016  
3.30 – 5.00 pm  
Bounds Green Health Centre**

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**Annual Report  
Haringey Universal Children's Services  
Children in Care Service**

**2015/2016**

**Lynn Carrington, Designated Nurse, Children in Care Haringey  
Dr Kim Holt, Designated Doctor, and Medical advisor Children in Care  
Haringey. July 2016**

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**Haringey Universal Children's Services  
Children in Care Service**

**Annual Report  
2015 - 2016**

**1. Introduction**

This annual report provides an overview of the work provided by the Haringey Children in Care (CIC) Health Service from April 2015 – July 2016 in line with the Statutory Guidance on Promoting the Health and Well-being of Looked after Children (DCSF 2015) and NICE guidance 2015.

The team's focus is working together to enable children and young people reach their full potential and enjoy the same opportunities in life as their peers.( see below team values; 2.)

We are commissioned to carry out both initial and review health assessments for Haringey CIC. We feel that this provides continuity to young people and can help improve engagement and the willingness to listen to advice. In terms of health outcomes, we need to identify measures that will inform developments within the team

**1.1 National Statistics**

There were 69,540 looked after children in England as of 31 March 2015, an increase of 1% compared to 31<sup>st</sup> March 2014 and 6% compared to 31<sup>st</sup> March 2011. Nationally the numbers have increased steadily over the past five years (Source: SFR 36/2015: Children looked after in England (including adoption and care leavers) year ending 31 March 2015, issued 30 September 2015 Department of Education).

On 30th June 2016 there were 408 CIC for over 4 weeks on our caseload. A figure around 400-420 has been the average throughout this year, with fluctuations each month, and movement in and out of care, either as children and young people return home, or reach 18 years.

**1.2 Context**

Children in care are more likely to have been exposed to severe neglect and trauma in early years and many children we meet have been exposed to situations and experiences that leave them vulnerable. We have difficulties in obtaining full health information. Older young people in care might have fragmented and incomplete health histories. The reasons for this are sometimes the information is not known by partner agencies; e.g. unaccompanied children, or there are some organisational barriers. e.g. in obtaining information from Barnet and Enfield mental health trust.(BEH)

(An information sharing agreement has since been agreed but as yet we are unable to access

records, The heads of Whittington and BEH IT departments were notified in July 2016 and we are waiting for the issue to be resolved)

The higher rate of emotional and behavioural difficulties, are generally linked to longstanding neglect and emotional deprivation. Young people in care can be targeted due to their vulnerability and are at greater risk of abuse and exploitation. A number of young people from Haringey are now identified as being at risk of sexual exploitation, being involved in gangs, misusing substances or criminal activity.

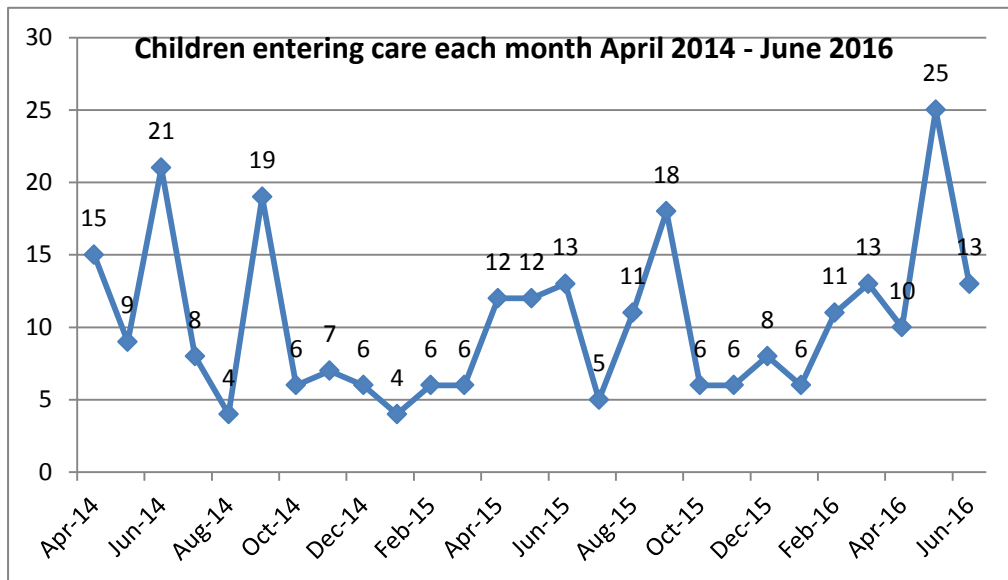
There are a significant number of younger children now presenting with serious and enduring mental health problems and is of real concern to the partners working with this group.

We also have a problem accessing immunisation data as it is not always uploaded via Child Health onto RIO; this is currently being investigated and an action plan put in place.

**1.3 Profile of Haringey Children In Care June 2016, and the geographical and placement distribution.**

New into care

There are 408(Source LBH) children and young people currently on our caseload. The number of children entering care each month varies, and some will return home. But on average there are 11 entering care each month over the last two years.



Of the 408 children in care, around 20 have a Social Worker from the disability team. There are 56 children have an Education and Health Care in total at present. There are currently 30 children who are unaccompanied minors. 24% Children are placed 20 miles or more from Haringey which continues to increase.(Source : Haringey Adoption team annual report 2016). They are living in residential units, with kinship carers, specialist foster carers or are in long term settled placements. The largest proportion of these children is aged 15-17 years. (Source : Haringey Safeguarding Children Board Performance Data Report June 2016)

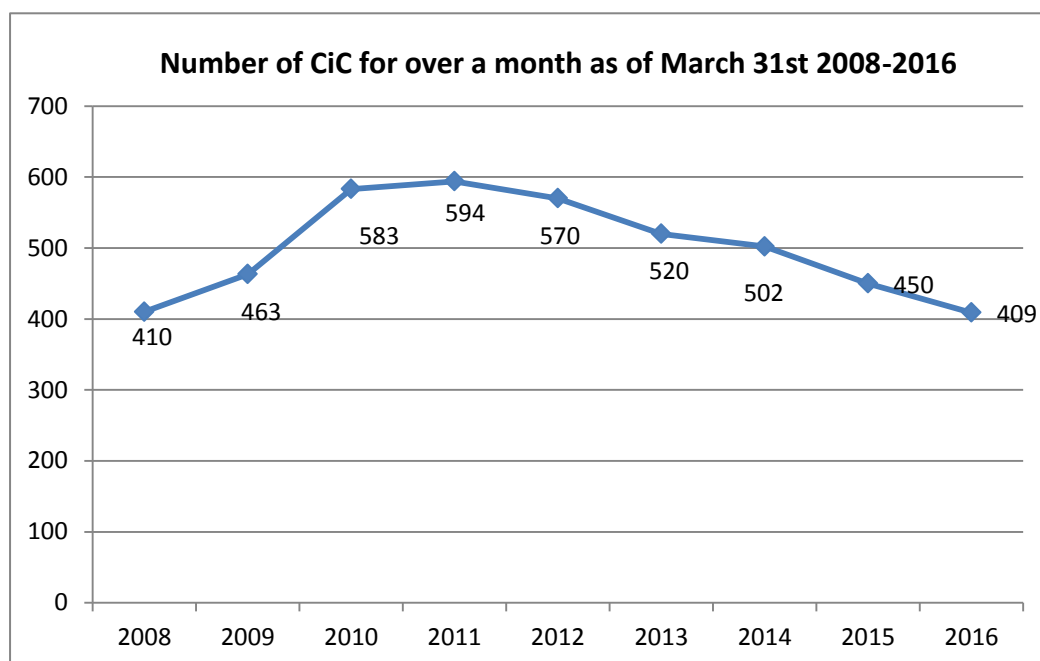
Geographical and placement distribution.

As far as possible the local authority seek to place children and young people as close to Haringey as possible.

We have 200 in borough foster carers at present, with some being Family Link. A recruitment drive has been taking place throughout 2015 and is ongoing, to try and increase the available pool

of carers. The Medical Advisor completed 171 health forms for adults applying to become carers or adopters (from Haringey, NRS and London Consortium). The recruitment strategy was targeted at prospective adopters for older children, sibling groups and black and ethnic minority children. This is important because it enables a child to remain in the same school more often and health monitoring and review is far easier.

52 % are placed with in house foster carer, and 48% with independent fostering agencies. Grandparents Plus put a bid into the Big Lottery Fund, to provide support to connected persons and connected special guardians in relation to getting started, benefit entitlement and family relationships. There has been a reduction in adoption approvals and matches reflective of the London wide situation as more children are placed with family members. This has impacted upon the nature of the work of the medical advisor and this area continues to change following government policy redirections, and legal rulings.



## **2. Children in Care Objectives and Team Values**

The objective of the CIC health service is to ensure that all Haringey children and young people in care are physically, mentally, emotionally and sexually healthy and that they are able to make healthy choices that enable them to enjoy healthy life styles.

Our 5 team values are:

- Always show respect and kindness for all
- Always going the extra mile for our clients
- Always learning and improving
- Always enabling and empowering children and young people to achieve their potential
- Always put the child and YP first, challenging where needed and speaking up for children.

## **3. Care Quality Commission Inspection (CQC)**

In December 2015 Whittington Health underwent a CQC inspection. We highlighted the difficulties CIC have accessing treating mental health services for children in care, particularly where they

have experienced a number of moves. We spoke about the valued partnership working with First Step psychological service. There is currently Child and Adolescent Mental Health Service (CAMHS) transformation work underway, with focus being on improving the mental health support to children in care, First Step Plus, training for all social workers on mental health and improving the support in schools and foster homes.

The CQC inspection report was published on July 8<sup>th</sup> 2016 with no specific recommendations for Haringey CIC team to implement this time. There were comments that we were meeting statutory requirements and that there is a good standard of multi-disciplinary working in Haringey.

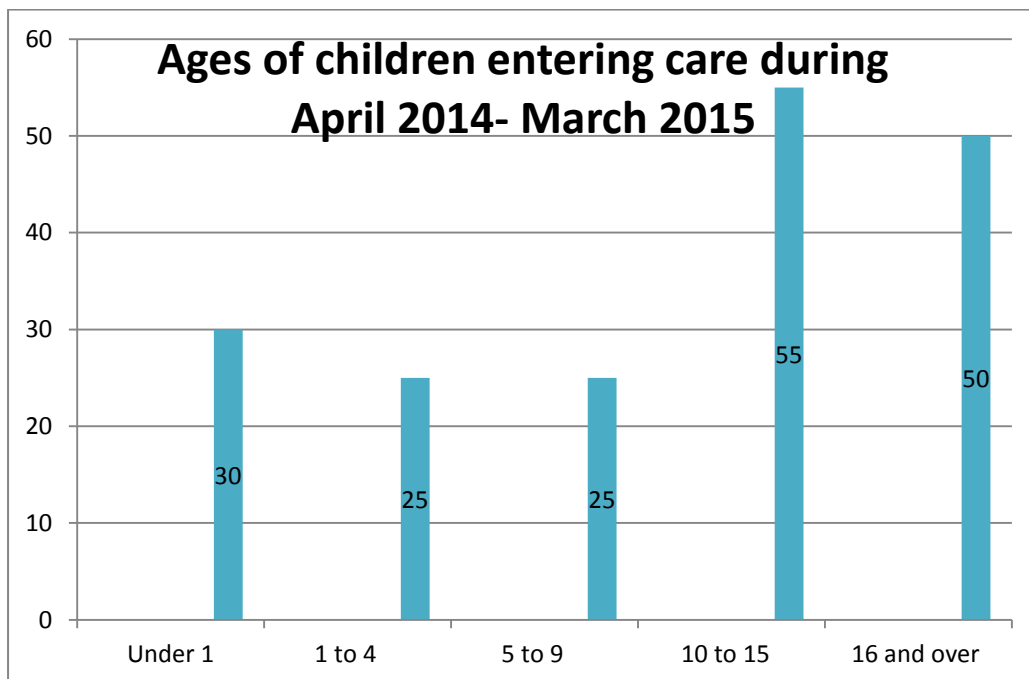
#### **4. London wide Statistics**

##### **Table 1: Children Looked After by Local Authorities, rates per 10,000 children aged under 18 years on 31 March each year**

The number of Haringey Children in Care per 10,000 children has decreased significantly from 104/10.000 in 2010 to 69/10.000 on 31.3.2016. Our statistical neighbours Greenwich, Lewisham and Southwark have also reduced. 2016 figures for those boroughs are not yet published. Islington and Hackney are listed as Whittington Health provides CIC services to these boroughs.

##### **2009 – 2015**

	2010	2011	2012	2013	2014	2015
Haringey	104	107	100	94	87	75
Islington	89	89	91	84	81	90
Hackney	53	48	56	55	56	58
Greenwich	101	99	92	93	85	80
Lewisham	85	77	78	77	77	73
Southwark	95	89	93	95	91	82



Ages of Haringey children entering care during the year April 2014-March 2015

## **5. Referral and update of our clinical record.**

Notification is received from the London Borough of Haringey; this should be within 48 hours of a child becoming looked after. There have been recurring difficulties with the system of notification from the local authority. The Designated Dr and Nurse have escalated to The Vulnerable children's commissioner and Head of CIC at Haringey Council via The Operational meeting in July 2016. Whittington Health have been informed via The Children's Safeguarding Committee and Clinical Commissioning Group (CCG) through The Safeguarding and Assurance meeting. This is still being monitored.

Notifications are received when:

- A child is first taken into care- date is provided by the local authority and child's details.
- A change of address/placement once in care.
- A change of legal status e.g. following a special guardianship order.
- A child is no longer looked after e.g. returns home or adopted.

## **6. How we work and performance**

The team work closely with all the children's Social Workers, family finding social workers and the adoption team. We arrange regular floor walks where we meet Social Workers in person and discuss cases of concern and to remind social workers where assessments are due. We believe that the messages conveyed to the children will help them understand the purpose of health reviews, and improve the uptake of health advice.

First Step psychological service based in Bounds Green Health centre are an additional resource that are invaluable help to the network, in supporting a child's recovery from abuse. First step are able to advise social workers, ourselves and the foster carers, in how to nurture a child's wellbeing.

The Health team offer primarily a clinic based service but we also outreach.

Prior to an appointment, the doctors will read the background chronology provided by the social care team, the health background and any child protection reports. Nurses offer the carers a telephone consultation to record any concerns before the appointments. Assessments whenever possible are at a convenient time for the children and young people. We are keen that for the initial health assessment we aim to meet the 20 day target, and it is far more likely to be clinic based.

All of the assessments are holistic based upon guidance in 'Promoting the Health and Wellbeing of Looked after Children' 2015. The written reports and recommendations contain details of personal history, birth and family histories, growth and development, emotional health, dental and oral health, sexual health and lifestyle.

The views and concerns of children and young people are also sought and documented. We always seek to speak to the children alone where developmentally appropriate. In younger children we use observation of the carer child interaction as a measure of the success of a placement, as well as how the child is functioning.

Both the medical team and nurses, outreach to children in placement where necessary. We have discussed in the team whether Skype reviews might be feasible for some young people who are doing well and there are no concerns raised by the multiagency team. We have now embedded fortnightly clinical meetings to discuss children of concern, system challenges, and integration within the team.

The health team are managing to engage with some of the hardest to reach young people on the caseload. We currently have 8 young people (YP) in care who have refused a health assessment or have been offered several appointments and have not attended. In these cases we discuss in our fortnightly clinical team meetings and will review their history and check with the Social Worker if there are any health or safeguarding concerns, and whether there are other venues apart from a clinic setting where we might be able to have a conversation with the young person about their health.

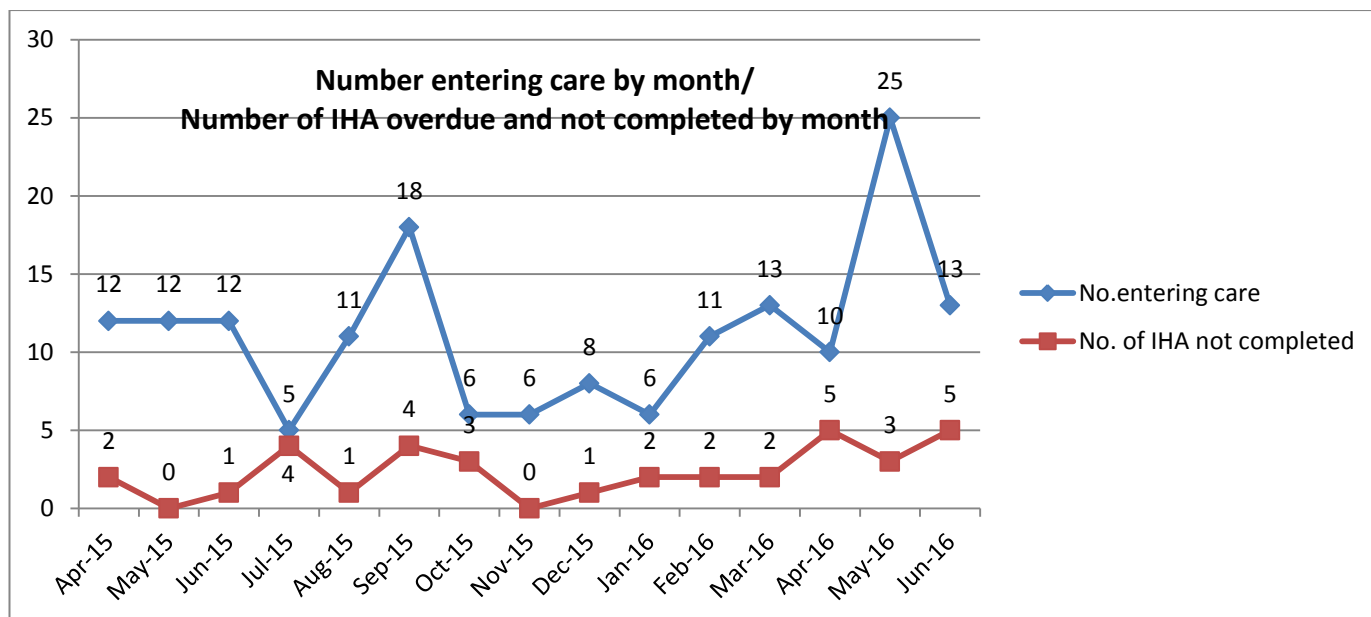
We provide a Care Leavers Summary for the young person after their last health assessment prior to 18 years. We are developing the quality of these reports to ensure they are as informed about their health histories as possible. It is also crucially important that they know and understand how to access health services, and their health records if they need to in later life.

### **6.1. Performance Initial Health Assessments** (IHA's)

117 IHA's were completed year 2015-2016 and 3 assessments from other boroughs, where children have been placed in Haringey. A service level agreement (SLA) is agreed with the placing Clinical Commissioning Group (CCG) and payment received for conducting out of borough assessments.

There are some significant variations that we are unclear about with regard to the reasons, with spikes of as high as 25 per month in May 2016. There are factors outside our control that impact upon the numbers being brought into care. There has been an increase in the referrals and assessments which may relate to the implementation of the new Single point

of Access arrangements (Source: LSCB Performance Data report June 2016). We allocate an appropriate number of medical staff to carry out the initial health assessments, as much as possible, but it is difficult for us to meet the statutory demands required from our service if numbers fluctuate significantly.



**The number of children entering care each month and the Number of CIC whose IHA were overdue and not completed within the timescale.**

The reasons that IHA are not completed in time were due to,

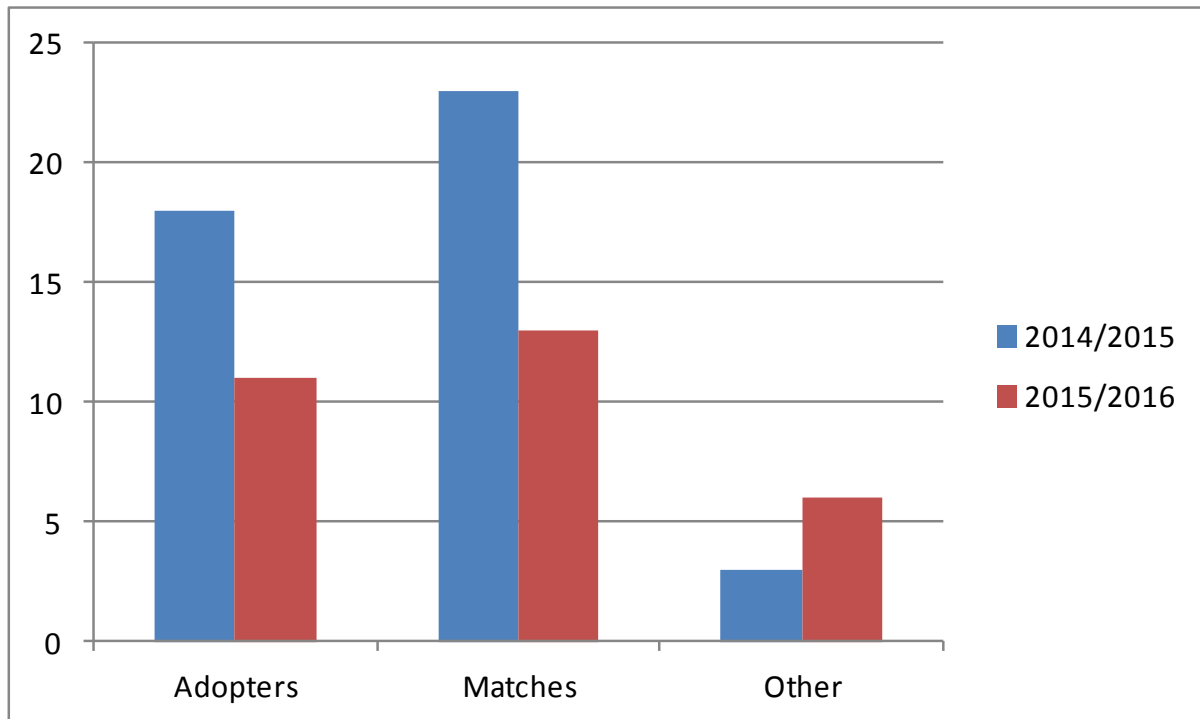
- Not being notified the child has entered care; the most common reason.
- Delay in receiving documentation including consent from SW.
- 2 Children were in hospital 1 child was waiting to be seen by a consultant that knew her from the paediatric team at a special school,
- Child not attending first appointment (Refusal and missing)
- Carers cancelling appointments or young person not attending.

An audit of initial health assessments completed in 2015 identified that the timeliness of the reports was good for the majority of cases. Delayed reports happened where there were either delays in notifications or where children were placed a long distance away, and it is problematical to arrange visits, or with carers that were reluctant to attend appointments. This happens occasionally where children are placed with extended family. The audit will be reviewed this year.

## **6.2 Adoption Work**

As highlighted in the introduction there has been a reduction in the workload related to adoption through 2015. There has been a national reduction in the numbers of children placed for adoption following a landmark case, and children are being placed increasingly with kinship carers under special guardianship.

**COMPARISON OF CASES CONSIDERED BY PANEL 2014-2015 & 2015-2016** SOURCE LONDON BOROUGH OF HARINGEY



The adoption panel has reduced to monthly.

The medical advisor meets any prospective adopters of Haringey children to ensure that they are aware of developmental or learning needs, and will also incorporate information about their emotional health; especially where work has been carried out by First Step. The medical advisor also is responsible for signing off the health reports for the prospective adopters and following through any potential risks to an adopters' health with their GP. This has led to two adopters' approval being deferred pending health issues being addressed or investigated further.

**CASES CONSIDERED BY PANEL FROM APRIL 2015 – MARCH 2016**

MONTH	APPROVAL OF NEW ADOPTERS	MATCH FOR ADOPTION	OTHER CASES
<b>April</b>	0	4	0
<b>May</b>	1	3	0
<b>June</b>	1	0	0

<b>July</b>	No Panel	No Panel	No Panel
<b>August</b>	No Panel	No Panel	No Panel
<b>September</b>	1	0	1
<b>October</b>	No Panel	No Panel	No Panel
<b>November</b>	0	0	2
<b>December</b>	1	1	0
<b>January</b>	3	3	0
<b>February</b>	2	1	2
<b>March</b>	2	2	1
<b>Total</b>	<b>11 (18)</b>	<b>14 (23)</b>	<b>6 (3)</b>

\* **Figures in brackets are for the previous year (April 2014 – March 2015)**

25 Adoption medicals took place (counted in monthly statistics as RHA). Children are seen 3-6 monthly where adoption is the care plan.

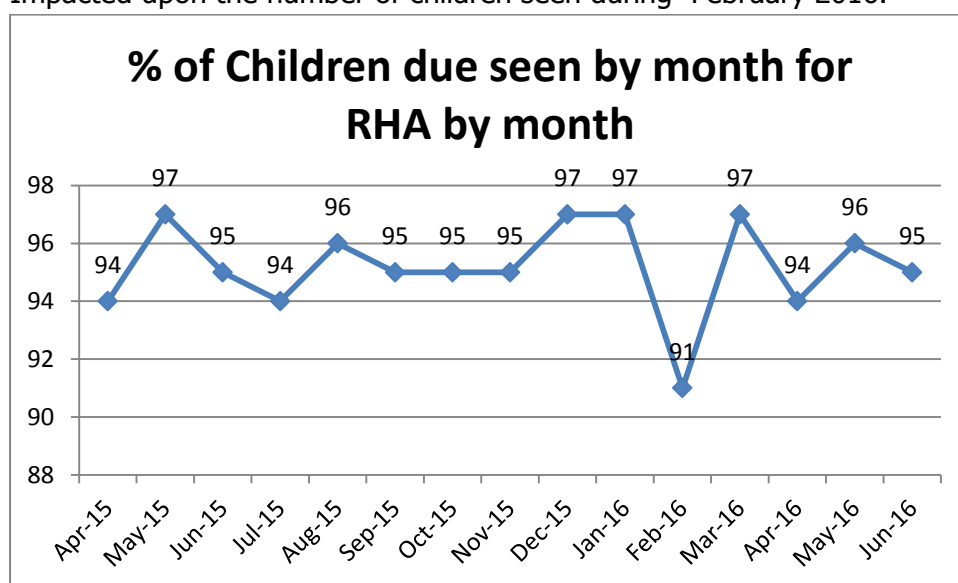
11 meetings took place with prospective adopters.

.

**6.3 Review health assessments (RHA)**

383 RHAs were completed, and 12 out of borough assessments for children placed in Haringey (SLA drawn up with the placing CCG and payment received).

17 RHA's were not completed during the financial year (10 young people refused and the remaining 7 took place during April and May 2016). Unplanned short term staff absence Impacted upon the number of children seen during February 2016.



## **6.4 Immunisation**

We contact GP's prior to the IHA & RHA and ask for a health report and invite GP's to contribute to the health care plan. GP's are also asked for details of the child's immunisations. If they are not up to date the Foster Carers and Social Workers are informed and asked to book appointments at the GP if consent is obtained. A recommendation is made on the health care plan for the child to be immunised. 85% of CIC 12 months on 31.3.2016 were fully immunised.

## **7. Young People Remanded Into Detention**

Since May 2013 statutory requirements relating to young people remanded into detention (who weren't previously looked after) changed and they no longer require a statutory health assessment (Care Planning, Placement and Case Review (England) (Amendment) Regulations 2013). These young people are not seen by our team. During the year, 17 young people that is (7% over the age of 10) were convicted of an offence.

## **8. Voice of the Child and Young person.**

All children are invited to complete a Client Participation Feedback Form after their assessment. The adult accompanying the child is also given the opportunity to give written feedback. The questionnaire asks for feedback about the service.

Comments are then collated monthly and discussed in team meetings. We continue to receive mainly positive feedback and where possible act on carers and children's recommendations. See Appendix 3 for a list of comments received during the year

### What we changed in response to feedback.

We have changed the way we work following the feedback, carrying out home visits when preferred.

In order to shorten the length of time a child needs to be in clinic, we have arranged to speak with the carers beforehand by telephone so that they can update us and raise any particular worries about the child's health and well-being. This enables the specialist nurses to investigate further any issues that will arise as part of the health review. It also prevents unnecessary distress for the child whom may otherwise be exposed to distress from the carer.

We have started working with the Consultation and Participation Officer in Aspire (Haringey's Children in Care Council) in developing a guide about being in care with information on health assessments to ensure that children and young people are part of the decision making process, and they don't feel that things are being done to them, but understand the reasons behind the work.

## **9. Audit**

The following audits were carried out during 2015-2016

### **1 .Initial health assessment audit (see Appendix2)**

Standard 1 of audit.

100% of initial health assessments completed within 4 weeks of a child entering care

Standard 2 of audit.

A detailed chronology and key health information such as immunisations is available at the time of the IHA.

Standard 3 of audit.

That all young people attending an IHA have a developmentally and age appropriate holistic health assessment that is able to accurately identify health, emotional and developmental needs.

## **2. Audit of Review Health Assessments completed by Children in Care Nurses. See appendix 3**

The audit was carried out across Haringey, Islington and Hackney Children in care nursing teams.

The aim of the audit was to assess the Review Health Assessments (RHA) carried out by the specialist nurses for Looked after children/ Children in Care (CiC) to ensure that the health assessments were recorded to an acceptable standard.

### **2. Criteria and Standards**

The following criteria were used when auditing the assessments.

- Has the child/young person consented to the assessment and were they given the opportunity to be seen alone?
- Has the child/young person and carers concerns and comments been sought?
- Is there evidence to show that information has been gathered to inform the assessment from Social worker/GP/other professionals involved with the care?
- Does the health assessment document capture pre-existing health issues, newly identified health issues, a chronology or medical history, details of whether immunisations are up to date, a summary of childhood screening and outstanding health appointments?
- Details of appointments with optician and dentist?
- Developmental or learning needs have been assessed and concerns identified documented?
- Emotional and behavioural needs have been assessed and concerns documented?
- Lifestyle issues discussed and health promotion information given?
- Do the recommendations have clear time scales and an identified person responsible?

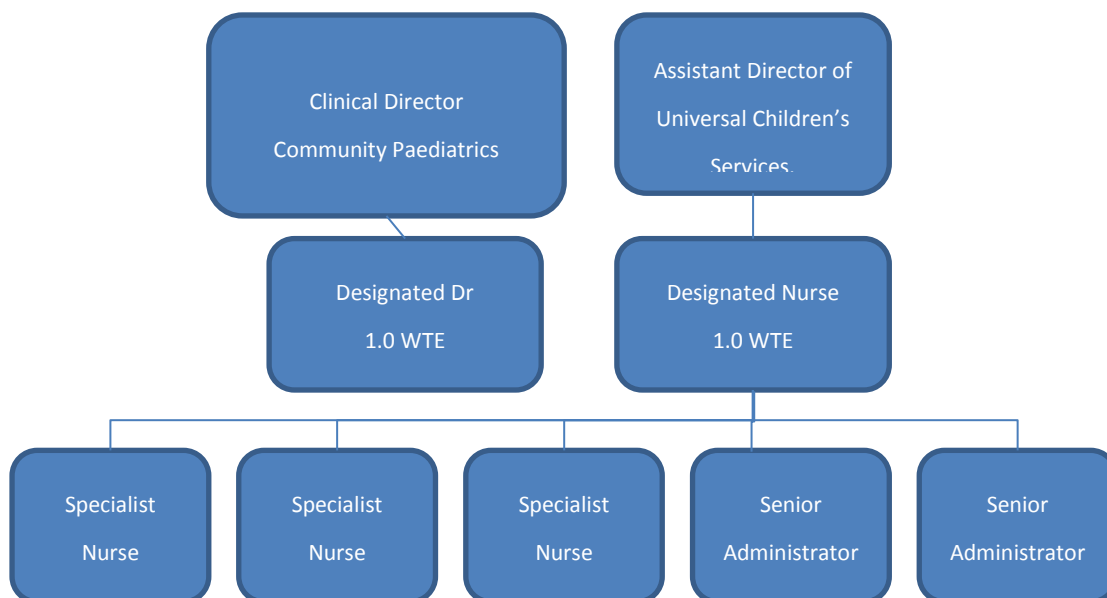
The results demonstrated that not all information was being captured and a new template was required. The Haringey team have been writing their reports using a similar format to the IHA reports since October 2015 using templates developed by the Islington LAC team. A repeat audit has taken place and results due to be presented to the audit committee.

Whittington Health Universal Children Services completed a record keeping audit and CIC records were selected and audited.

**Planned quality improvement work 2016/2017**

1. Improve the service for unaccompanied minors arriving in Haringey and in consultation with Islington and North London sector.
2. Develop our care leaver’s health summaries and improve the transition process.
3. Develop meaningful outcomes for the health assessments.

**10 Organisational Structures, Management and Staffing**



The Designated Doctor and Designated Nurse lead the team that consists of three full time nurses and 2 full time administrators who are managed by the Designated Nurse. Doctors conducting IHAs are supported by a Health Care Practitioner for two sessions per week.

The Designated Dr and Nurse undertake a strategic role on behalf of the CCG and we advise on national key issues that affect Children in Care, raising and sharing issues with the CCG, Social Care partners and the Corporate parenting committee. Our primary contribution during 2015-2016 has been in relation to the gaps in provision in mental health , which is now being addressed by the Camhs transformation projects.

Fortnightly clinical team meetings are embedded in the work of the department. Children are discussed if there are concerns regarding attendance, placement moves, mental health concerns, developmental, complex concerns, or where the care plan is adoption. The nurses also have separate fortnightly team meetings where there is an opportunity for case discussion and supervision.

We are endeavouring to listen to the voice of our children and young people and regularly review feedback from children, young people and their carers on how they found our assessments and on how we can improve them further.

The nurses receive additional clinical supervision monthly and we have the opportunity to discuss cases with a psychologist from The Parent Infant Psychology Service. The nurses receive managerial supervision monthly. Child protection supervision takes place bi-monthly by the Named Nurse for Safeguarding.

The Designated Doctor receives individual clinical supervision, on a monthly basis.

### **11 Designated Roles and the Role of the Medical advisor**

#### **2015-2016 strategic developments.**

Developing the shared care agreement with Barnet and Enfield Mental Health Trust to enable us to access mental health history at the point children enter care and at each health review.

Implementation of the recommendations from the IHA audit; April 2015.  
as follows,

- a) Contact GP for up to date immunisation data pre assessment
  - b) Audit of immunisations to inform the need for change regards Child Health system
  - c) Access TO BEHMT RIO to access mental health history
  - d) Monitor timeliness of notifications and notify partners where there are ongoing system issues, and escalating again the concerns in April 2016.
  - e) Access SDQ at the time of the IHA
  - f) Improve induction training with regard to emotional health of infants and sexual health
  - g) Action plan on obtaining immunisation data via Child Health
- Participate in the Camhs review and engage in the Camhs transformation work- the Camhs transformation work related to Children in care is embedded in our operational meeting.
  - Chair the monthly operational meeting. (see terms of reference attached).
  - Develop the flexibility in the medical workforce.
  - Ensure that all young people have an IHA report even if they refuse to attend by collating key background health information especially from mental health history.
  - Attending Care Leaver's Health seminar. We have listened to the concerns raised by care leavers with regards to health, and plan to start a drop-in session with the leaving care team for young people.
  - Develop and improve the Care Leavers Summary for the young person after their last health assessment prior to 18 years.
  - Developing links with First Step plus a pilot service that works with young people who have had more than three placement moves in a year.
  - The Operational Group meeting was reconstituted in 2015 and is chaired by the Designated Doctor. It provides a safe space to raise systemic challenges and brainstorm ways forward. The aim is to improve collaboration across the agencies in relation to CIC. See terms of reference appendix 4
  - Attending the Whittington Health Safeguarding Children's meeting and committee (Designated Doctor and Nurse)
  - Conducting audits as described and supervising trainees. (Designated Doctor & Nurse)
  - Attending Child Sexual Exploitation Sub Group (Designated Nurse)

- Attending Corporate Parenting board meetings and meet with Aspire (Designated Nurse and doctor from autumn 2016)
- Attend Health operation meetings with the CCG.(Designated Doctor and Nurse)
- Attend Haringey Clinical Commissioning Group (HCCG) Safeguarding Children Assurance meetings (Designated Dr and Nurse)
- The Designated Nurse attends the quarterly London Designated LAC nurse meetings and ensures good practice is shared and embedded within our service
- Designated doctor is a member of the National network for Designated health professionals.
- Designated doctor meets with other colleagues from NCL to review our practice and share knowledge and peer support.

### **12 Training and workshops**

- Provision of training; The specialist nurses have provided training on health and development needs of children in care, risky behaviour and sexual health, to social workers and foster carers. The nurses are also promoting child development in foster care through play to foster carers within Haringey.
- We have provided training to student School Nurses and student Health Visitors at South Bank University as part of their safeguarding module.
- The designated doctor provides onsite clinical supervision to the paediatric trainees working within the department.
- Trainees are enabled as far as possible to observe clinical team meetings and adoption panels.
  
- Receipt of training and team updates. Peer supervision and training took place across the teams following last year's audit of RHAs.
  
- Presentation from Haringey LADO. August 2015.
- A workshop with some special guardian was organised which was incredibly informative. November 2015
- We attended as a team a workshop organised by First step where they had been working with an art collaborative to support young people in care express themselves and describe their care experience.
- Designated doctor attended research outcomes on special guardianship seminar. University of London.
- Designated doctor attended insight day; The Child refugees, exploring the welfare needs of unaccompanied asylum seeking children. May 2016
- Designated doctor and nurse attended the Camhs transformation day for professionals July 2016

### **13 Risk Management, Incidents and Complaints**

#### Complaints during 2015-2016

No complaints were received.

#### Datix

The team have completed 2 Datix forms following incidents. Lessons learned from serious incidents reported in Whittington Health have been shared with the team. The Datix related to low or minor harm.

The Serious Case Review for Child O was published in 2015.

Teenager O was a Haringey child in care, who died in January 2014. There was a history of frequent severe self harm and we were unaware of her history. A key issue for us is access to a young person's background health history, and hence the development of the shared care agreement with BEHMT (see above). Numerous attempts were made to arrange Child O initial health assessment which she repeatedly refused. As a result of this case and another similar, we reviewed our practice. Primarily the main change is that on notification of a young person in care we will allocate a slot for a paediatrician to review the medical and social history as known at that time. We will liaise with the social work team regards whether a professionals meeting is required in order to discuss safeguarding a young person. We discuss any young person, who refuses a health assessment or does not attend, in our fortnightly clinical meeting. We are very aware that this group are the highest risk group of young people, and we are also discussing in the operational meeting with the LBH other options for engagement. We notify local health teams when a young person moves placement; this highlights the need for timely notifications.

Access to mental health history is an area we continue to press for improvements. Paediatricians collate all known health information in an initial report even when we haven't been able to meet the young person, and ensure all local health professionals are sent updates. The quality of these reports is dependent upon the detail that we are able to access, hence the importance of a functioning shared care agreement.

### **14. Achievements**

- Improvements in coverage so that only 8- 10 children have not been seen in any one year, and constantly reviewing this group to find different ways to try and engage this group, in a health conversation.
- Chairing the operational group and receiving positive engagement from partner agencies.
- Participating actively in Haringey's Camhs transformation work in relation to children in care. We will all be participating in the training seminars being set up for all social work teams in the autumn of 2016.
- Since October 2015 the newly revised RHA template and report summarises the early history and includes family history and healthcare plan summarises the physical and emotional health of the child.
- Systematically obtaining feedback from our health assessments and implementing any suggested change for improvement.
- Ensuring that all young people receive an IHA report even when they are refusing to attend.

### **15. Summary**

The report details the work of the CIC health team and highlights our aspirations to further develop joint working with children and young people and all partner agencies. We participated in the CAMHS transformation project to ensure the needs of Children in Care were on the agenda and there is now a positive action plan to attempt to improve the

emotional health with First step plus service, and a comprehensive training plan for social workers.

We have campaigned nationally for Children In Care to ensure their voice is heard, by participating actively in National networks. We are carrying out more home visits and listened to concerns raised by the Care Leavers Association and are working on improvements to the care leavers summaries. The increase in the number of CIC in recent months is a challenge that we work hard to meet by being flexible and discussing priorities. We have also embraced the need to review children from other health authorities placing children in Haringey and a demand to carry out their assessments.

## **16. Plans for 2016-2017 - Our Key Priorities**

### **1. Hear the Child's Voice**

- Ensuring children or YP are seen promptly, with quality holistic assessments
- Ensure all children and young people are seen alone to hear their views.
- We plan to hold a weekly drop-in service for young people with any questions or concerns about their health.
- Develop our relationship with Aspire and the young person participation officer to improve the timelines of feedback; feedback in real time.

### **2. Working with Partner Agencies**

- Develop meaningful health outcomes
- To support the child in understanding their journey from birth family through care; to improve the quality of their care leavers discharge
- Remain active participants in the Camhs transformation work where it relates to Children in care
- Attend Corporate parenting group and relevant CCG meetings to ensure that we are informed and able to advocate for Children in care, where necessary.

### **3. Improving the quality of assessments for unaccompanied minors / refugees**

- Unaccompanied minors have overwhelming health needs. It is imperative that we work in partnership to listen to the young person's individual story and understand Post Traumatic Stress Disorder. Services for these young people are currently fragmented, and a quality improvement piece of work in collaboration with Islington will try to bring together the necessary health components for service improvement.

### **4. Audits for 2016/2017**

- Audit of the timeliness of health assessment reports being sent out
- Audit of the SDQ incorporation into the IHA as per NICE guidance 2015.
- Repeat audit of the IHA audit to ensure change has happened.

## **Appendix 1**

### **Case study**

**An example of a health assessment of a young unaccompanied minor.**

**Children in Care Team Health Team  
Bounds Green Health Centre  
Gordon Road  
Bounds Green  
London  
N11 2PA  
Tel No: 020 3074 2800  
Email: [whh-tr.CIC-Central@nhs.net](mailto:whh-tr.CIC-Central@nhs.net)**

**Initial Health Assessment completed on: 15<sup>th</sup> June 2016**

**Completed by: Dr xxxxxxxxST5 Paediatric Registrar to Dr Holt  
For Children in Care**

<b>Name: xxxxxx</b> <b>NHS Number: xxxxxxxx</b>	<b>DOB:</b> <b>Age: 17years</b>
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Seen by Dr in clinic with foster carer and a translator.

**Background**

M has been in foster care for three months. She initially arrived in the UK from Albania together with her mother xxx. However, her mother then left her and she was taken into care. M's twin brother is also residing in England; he is with a foster carer in Enfield. M and her brother go to the same school.

**General Health**

M says that she cannot remember having any hospital admissions in Albania and has had no long term health problems although she does suffer from hay fever. She tells me that she had an immunization in Albania where she had an allergic reaction to, although she does not know what this was. Since being in the UK, she has had her HPV vaccine and she did not have a reaction to this.

M saw a dentist two weeks ago and there are no problems with her oral health. M saw an optician as well recently and has no problems with her eyes, she does not wear glasses.

**Mental Health**

For the first three months after M's mother left, she found it very difficult to eat and felt sick when she did. She tells me that this is now better and she is regaining her appetite. She is currently fasting in daylight hours for Ramadan.

She says that she has difficulties falling asleep at night, as she has lots of thoughts going around her head. Sometimes she will only fall asleep at 2 o'clock and wake up at 6 o'clock. She reports that she has nightmares including dreaming that her mum is dead. She tells me that she 'does not like to open up' to people about her emotions.

M tells me that previously in Albania she wanted to commit suicide by drowning, but her mother was telling her that things would get better so she changed her mind. She says that she has not self-harmed by cutting.

She still has very difficult emotions to deal with. She thinks about hurting herself, but has not done so. She says that she have not told anyone about this so far, she has not told her brother and she told me that she is secretly worried that he will leave like her mother did. She feels unable to tell anybody at school about the thoughts in her head; she feels they might tease her about it.

We spoke about some things that happened in her past in Albania. She tells me that a group of men wanted to traffic her but were not able to do this because her mother stopped them. She says that they tried to sell her virginity for 10,000 Euros, but instead she offered to work for them for free in a restaurant and by doing this she was able to stop them from selling her.

I asked her if they have made her to perform any sexual acts that she did not want to do but she says that they did not and that she is still a virgin.

These same men were violent to her, they hit her and at one point broke her nose and broke her arm. She was taken to hospital in Albania with her broken arm but she did not tell the truth to the doctor there. She says that these same men made her convert to Christianity although she is a Muslim. She does not have contact with these men anymore and she says that they do not know that she is in the UK. However, due to all of these events in the past, she still does not feel safe. She does not trust boys now and she says that she cannot be in a relationship.

### **Education**

M attends xxx College as does her twin brother. She wants to be a police officer when she leaves school. She has made several friends at school, one of whom speaks Albanian. She says that she has not suffered any bullying.

M feels unable to tell any of her friends about her foster care situation - when her friends saw her with her foster carer, she told them it was her mother. I asked her who she would speak to if she is having any troubles at home or at school, and says that she would speak to her foster carer. I emphasised to her that I felt it will be a good idea for her to speak to a psychologist as she has gone through some extremely traumatic experiences in her past. She has agreed for me to make this referral.

### **Foster carer's report**

The foster carer tells me that she has found M crying on a few occasions but she did not want to tell her why she was crying. She was very tearful on the day of the Home Office interview but appeared to be much more cheerful afterwards.

The foster carer says that the placement is going very well and she has absolutely no problems with M. She says that she is a 'lovely girl' and her English is improving a lot. She says that M clearly 'does not want to open up to her' but she wants to be able to help her. She does not report any difficult behaviour at all.

### **Examination**

On examination, M weighs 59.4 kg and her height is 163 cm, she was wearing clean clothes and looked well cared for. She presented as polite and pleasant. She made eye contact with the interpreter while talking, but did not make much eye contact with me throughout the interview - especially when talking about the traumatic experiences of her past. It appeared for much of the interview that she was holding back tears.

On physical examination her heart sounds were normal, her chest was clear and her abdomen was soft and non-tender.

### **Summary and Recommendations**

M is a 17 year old young woman who has arrived in the UK unaccompanied via Albania. She has experienced trauma in the journey and expresses distress at being separated from her family.



## **Background**

Statutory guidance March 2015 states that the local authority that looks after a child in care must arrange for them to have a health assessment and to have an individual health plan, which forms part of the child's overall care plan.<sup>1</sup> The Initial health assessment provides an opportunity to take stock and clarify the background history and the health of the children at a key transition point.

This initial health plan should be completed within 28 days of coming into care, and should be ready for the first child care review, and be conducted by a registered doctor.

At the point of entry into care notification to the health provider needs to be arranged, and needs to be within 5 days; and subsequently within 5 days of any change of placement. The guidance makes a strong point that notifications need to be in a timely way if up to date health assessments are going to be feasible.

Around 50 % of Children in Care are likely to have a diagnosable mental health disorder, and a greater proportion of looked-after children have special educational needs, than the general population. (estimate around two thirds).

Delays in identifying and meeting children's needs could have far reaching effects on all aspects of their lives, including their chances of reaching their educational potential, and ability to live healthy and fulfilling lives as an adult. Children and young people may have experienced neglect of their physical and emotional health needs prior to coming into care which is why a timely and high quality health assessment at the point of entry into care is so important.

The NHS contributes to meeting the health needs of looked-after children at three levels:

1. The Health and Social Care Act 2012 and statutory guidance places a legal duty on CCGs to work with local authorities to commission services for Children in Care for whom they are responsible.
2. Provider organisations tasked with provision of the health services provide the health services.
3. Finally the NHS through individual practitioners provides coordinated care for each child.

Staff working with looked-after children in the NHS should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different. They should in particular:

- ensure looked-after children get access to universal services as well as targeted and specialist services where necessary – we do this by keeping Gps, health visitors and school nurses informed of health plans.
- promote a culture that takes account of the views of looked-after children, according to their age and understanding, in identifying and meeting their physical, emotional and mental

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[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413368/Promoting\\_the\\_health\\_and\\_well-being\\_of\\_looked-after\\_children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf)

health needs We try to do this by building a relationship with young people as they attend for health assessments, and additionally with the Aspire group in Haringey to receive feedback. We are also regularly asking for feedback from clinic, as much as we can.

NICE standards for Children in Care services are set out here below;

<b>Statement 1</b>	Looked-after children and young people experience warm, nurturing care.
<b>Statement 2</b>	Looked-after children and young people receive care from services and professionals that work collaboratively.
<b>Statement 3</b>	Looked-after children and young people live in stable placements that take account of their needs and preferences.
<b>Statement 4</b>	Looked-after children and young people have ongoing opportunities to explore and make sense of their identity and relationships
<b>Statement 5</b>	Looked-after children and young people receive specialist and dedicated services within agreed timescales
<b>Statement 6</b>	Looked-after children and young people who move across local authority or health boundaries continue to receive the services they need
<b>Statement 7</b>	Looked-after children and young people are supported to fulfill their potential
<b>Statement 8</b>	Care leavers move to independence at their own pace

These overarching aspirations rely on multiagency working together, where health has an important part to play in providing information and support to what is ideally, an integrated care management plan.

**This audit focuses on statements 5, and 7.**

**Standard 1 of audit.**

**100% of initial health assessments completed within 4 weeks of a child entering care**

**Standard 2 of audit.**

**A detailed chronology and key health information such as immunisations is available at the time of the IHA.**

**Standard 3 of audit.**

**That all young people attending an IHA have a developmentally and age appropriate holistic health assessment that is able to accurately identify health, emotional and developmental needs.**

Our standards are set out within our operational policy. March 2015.

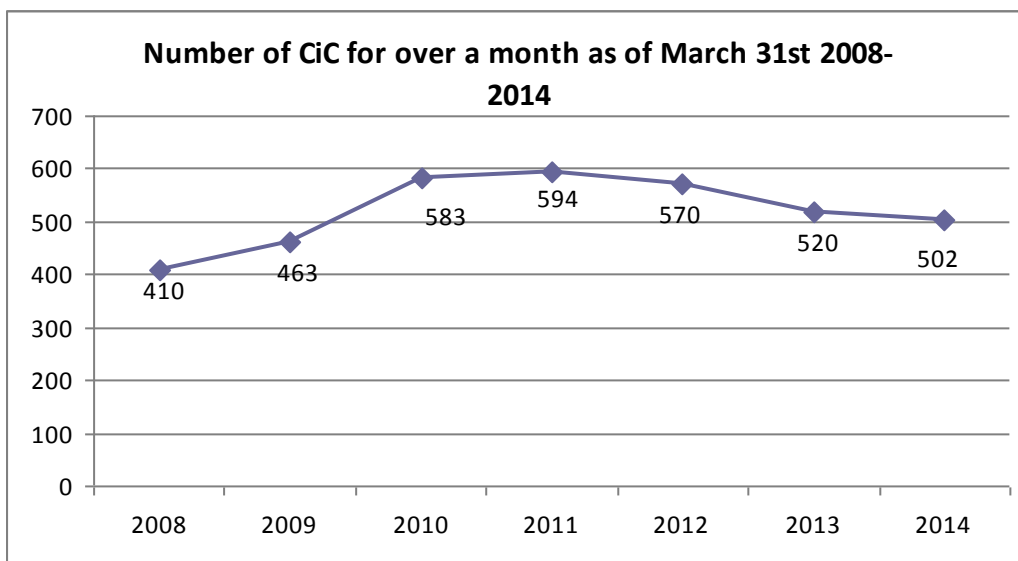
A sample of 40 initial health assessments was randomly chosen to look at the following features;

1. Age range of the sample
2. Timeliness of the IHA from when they entered care.
3. Reasons for any significant delays, including notification delays.
4. The narrative quality detailing the background reasons that children become looked after.
5. Whether immunisation details were available to the assessing clinician at the time of the IHA.
6. Whether weight and BMI was recorded and the results.
7. In age appropriate cases were lifestyle issues, sexual health, drug and alcohol use discussed?
8. Was there adequate recording of developmental concerns or educational progress at the time of the IHA.
9. Was there an age and developmentally appropriate assessment of the child's emotional well being, given that mental health is such an important part of the assessment.
10. Other general comments highlighted during the audit.

The sample was taken from a 3 month period April to July 2014.

**Background context re the Haringey children in care service.**

The numbers of children in care has fluctuated over the past few years to a high of nearly 600 and to just below 500, in 2014; numbers have continued to gradually drop. Currently they hover around 450.



The service at the time of the audit was part of the Women’s, Children and Families directorate of Whittington NHS Health.

The Children in Care Team was managed by the Assistant Director for Women, Children and Families.

During the period of the audit in 2014 The Haringey CiC team consisted of:

1.0 WTE Designated Doctor part of the Community Paediatric team

Paediatric Registrars carry out initial health assessments, under the supervision of the Designated Doctor.

1.0 WTE Designated Nurse

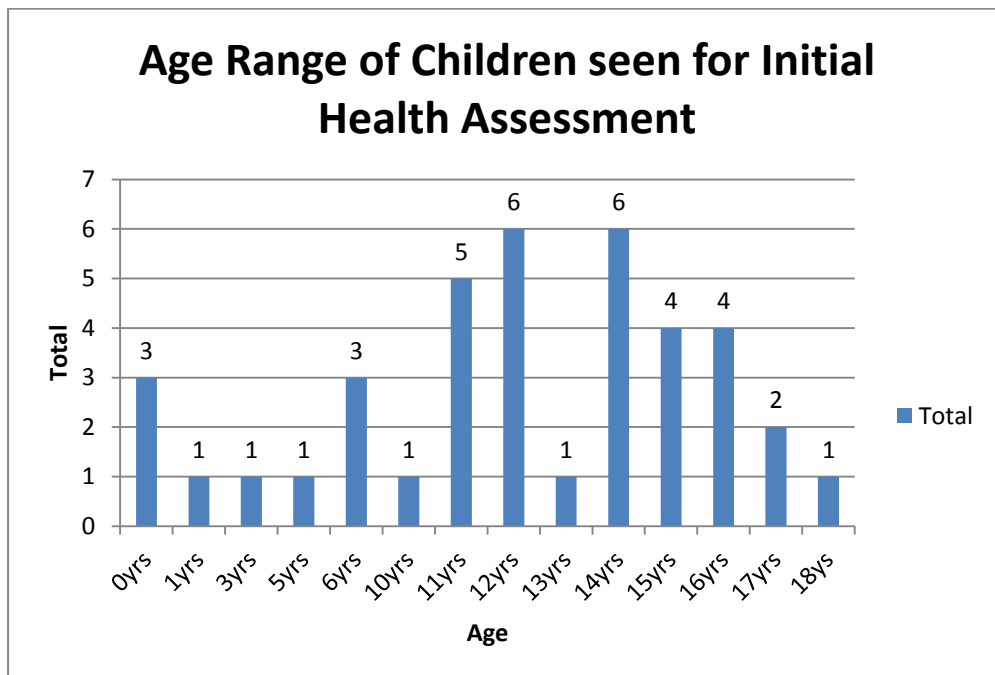
3.0 WTE Specialist Nurses

2.0 WTE Administrators

**Audit results.**

40 records were evaluated. Two children returned home before being seen, and so **38 case records were looked at.**

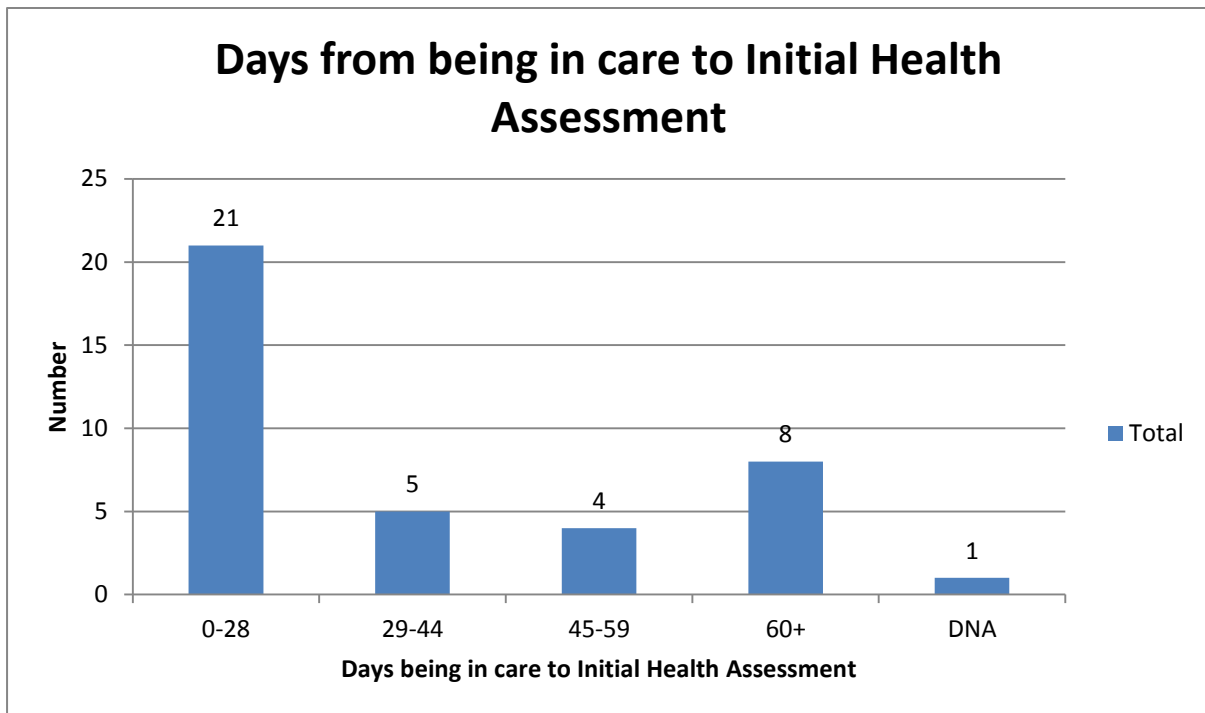
The age range of the children seen were from new born to aged 17 years.



**Standard 1.**

**100% of initial health assessments completed within 4 weeks of a child entering care**

The timeliness of the IHA ranged from zero to 7 months.



**The majority of children booked for an IHA therefore, 34/38 were separate appointments to the child protection assessment.**

There were four children whose Initial health assessments were carried out alongside child protection medicals and two where they were completed from the notes taken at the time of the child protection medicals.

**21/38 were within 28 days of coming into care that is 55%**

**17/38 were overdue from the time they came into care to having the health assessment.**

**26/38 were seen within 5 weeks that is 68%**

**More severe delays of over 45 days took place in 12 ( 9.8 %) children.**

**45-60 days in 4 cases**

**60-75 days in 4 cases**

**And the longest outliers were 97 days, 108, and two siblings at 210 days.**

**Overdue Health assessments source**

First response, 2/17 (108)

Safeguarding and support 6/17 (210)

NRPF/ YP in care teams 4/17

Court team 3/17

Disabled children's team, 1/17

Home safe team 1/17 (97)

**The longest outliers occurred in the Home safe team, ( 97), First response , 108, and Safeguarding and support 210. So delays happen across all parts of HCYPs.**

**Outliers analysis of the delays.**

- **The 97 days case**, the CIC team have **still not** received a notification that the child is in care. The child is known to the Home Safe team. This delay was picked up via the monthly reporting system from the local authority where we cross check all names, and it came to light that the child had not been notified to us. This report is now cross checked monthly by Designated nurse, and so she should be able to pick up similar cases, in the future. This is a back-up system.
- **The 108 days delay**, arose from a child known to First response where the child had been taken into care under a section 20 agreement. The mother was in prison and the children living with grandmother. There were difficulties for us in obtaining consent, because mother was in prison, as we do this as part of our process before a child is given an appointment.

We offered one appointment which the child was not brought to. The second appointment we had to cancel because of an issue related to annual leave of a doctor which we were unaware of. This led to late cancellation of the clinic.

The child was brought to the third appointment.

- **The children, who were not seen for an IHA until 210 days**, were known to Safeguarding and support.
- They entered care before our new process of notifying the social workers of the need for an Initial health assessment had been set up, and our system of chasing the information required.
- The children were looked after from 11.11.2013 and notification arrived with CIC on 17 April 2014 **It took 22 weeks and 3 days before the notification came through, that is 157 days.**
- **The children were placed with kinship carers out of borough** and it was difficult to contact them and arrange the appointment. There was a reluctance to attend promptly as is sometimes the case with kinship carers (maternal aunt), because they are not professional foster carers, and will not understand the statutory expectations in all cases. There were also some concerns regards obtaining consent in this particular case, but the main delay was the notification alongside a reluctance to attend.

**Four cases where delays lay between 60 and 75 days**

Two of these cases were referred to safeguarding and Support. One was from Young people in care team, and one from First response.

In all four cases notification was timely but there was delay in the background paperwork being received. This is sent by the child's social worker.

Summary

<b>done</b>	<b>Notification</b>	<b>Paperwork</b>		<b>IHA</b>
Case 1	5 days	52 days		71days
Case 2	3 days	60 days		63 days
Case 3	5 days	11 days	Home visit	65 days
Case 4	6 days	14 days	43 days DNA	Seen 69 days

Case 3 This young person was unable to be seen in Haringey , and it takes longer to identify a time when a doctor might be available to carry out a home visit. Seen at 65 days.

Case 4 notification 6 days from entering care, paperwork 14 days and child booked initially at 43 days, but was not brought; rebooked for 69 days. This was a CIC team issue, we are unsure but we think due to lack of available staff.

**Three cases where delays were 45-60 days.**

Summary

Case 1	7 days	11 days	hospital	45 days
Case 2	6 days	28 days		49 days
Case 3	6 days	43 days		57 days

Case 1 disabled Children's team notification 7 days paperwork 11 days discharged from hospital at 45 days. Seen at 45 days

We could have tried to see the child in hospital before discharge, but a decision was made to await discharge and then be able to provide a care plan that was up to date to the placement.

In all of these cases once the paperwork was sent through we saw in a timely way.

**Standard 2 of audit.**

**A detailed chronology and key health information such as immunisations is available at the time of the IHA.**

Immunisations

**In 15 cases full immunisation details were available on RIO.**

Of the 39 records examined in **23/38 there was no information or incomplete information** on our RIO system regards the immunisations received.

6 of these children were unaccompanied minors or asylum seekers.  
A number of other children had been born in other countries and the immunisation record was therefore incomplete on RIO

Eg African girl living in a private fostering arrangement until care

Aged 12 and half Bangladeshi- with early history unavailable.

Another child had moved addresses a number of times, making tracking of the immunisations problematic.

In one of these cases, the details of the immunisations had not been put into the report, which could create confusion amongst other health professionals.

What do we try to do?

The CIC health team will always request the red book of pre -school children to ensure that we copy any immunisations that have been done when we see the children. However because of the nature of children in care there are times when the red book is unavailable. We now always contact the GP prior to the Initial health assessment to try and obtain health updates and immunisations. We recommend in the IHA report that all immunisations are listed and dated so that there is clarity for any health professionals subsequently seeing a child.

**Standard 3 of audit.**

**That all young people attending an IHA have a developmentally and age appropriate holistic health assessment that is able to accurately identify health, emotional and developmental needs.**

Each report was read with regard to whether a narrative had been written describing the young person's experience prior to coming into care.

**Of the 38 reports looked at there were clear narratives in 34 of the children explaining the background history in some detail.** This is a good basis for understanding the child's health and developmental needs.

Of the 4 reports where there were gaps, *three of these had been written from the information available at the time of the child protection report*, which was understandably patchy, and 1 was an unaccompanied minor where there was both incomplete information, as the young person had recently arrived in the UK, but also a reluctance of the young person themselves to share his history.

Of the child protection cases where the detailed narrative had gaps;

1. Child was aged 22 months, and there was some history provided by a carer, who reported that he was not the main carer, and therefore the detail regards the history was lacking. The background chronology from social care was unavailable at that time as they were still

getting to know the child. There were records on RIO as the child was born in 2012, but this detail was not included in the report.

2. Sibling aged 5 years 8 months; there was little background available at the time of the child protection medical. RIO record had no progress notes between 2009 and the referral for child protection.

3. Sibling aged 3 years at the time of the medical there were a couple of slots on RIO with information about eczema that had not been incorporated into the background history and were relevant to the detailing of neglect, and important

#### Unaccompanied minor case where narrative was sparse

This young man, aged 15 years, had reportedly travelled to this country from Albania, and was reluctant to talk about the journey. He may have been traumatised by his experience, or be fearful of sharing information with professionals, and lacked trust and confidence. His responses had to be relayed via an interpreter, and that could also potentially create some concerns regards who would then be aware of the story, and where it would go, and any ramifications for himself. Generally his reluctance to speak is understandable.

#### Initial health assessments and understanding a child's emotional state.

In the vast majority of cases, there was reference within the report of the emotional state, or mental health concerns, and where anything was available reference to a psychological or Camhs report. Generally the doctors stated their own impressions of whether a child was demonstrating worrying behaviours that indicated distress or in an older child exhibited anxiety or depression or suicidal ideation.

However the doctors confidence in describing the emotional state of babies was less evident, and in two babies in particular no reference of their emotional state was made at all, and this could be an area for further development.

In several of the young people there were serious concerns, e.g. self harming but there was some difficulty in accessing Camhs reports, where that young person had been known to Haringey Camhs.

All children and YP entering care in Haringey are screened with an SDQ which is returned to the First Step service who will offer consultation and a focussed assessment in those young people where they have not had any previous or on-going Camhs involvement who score above a previously agreed threshold. The new guidance stipulates that the SDQ should be available for the initial health assessment. As soon as the SDQ is received by First Step it is emailed across to us and we can access; this, however currently we understand that there is a 25 % non-return rate and this needs to be challenged and addressed.

In several of the Initial health assessments, reference is made to First step screening reports, which are thorough, evidenced from chronology and which can be very helpful in making sense of where a young person is emotionally. A key difficulty for the Children in Care health team is with regards to those young people who fail to attend, or who are reluctant to engage even if the doctor visits them in their placement. These are probably our highest risk group in terms of their mental well-being, and so being able to access any background Camhs information for this group is crucially important.

### Non attenders

There were four initial non-attenders out of the 38 , and three of those children were seen by a doctor eventually.

In all four an initial report was sent out collated from the background information that was available at that time, in order to have something available for the wider network to inform a health plan.

One young man was 17 years old and attended the IHA for his baby, and was seen by the doctor at the same time. That was an opportunistic appointment.

One teenage girl has been very hard to meet with, to establish a multiagency plan for and she has been in and out of care since 2014. She was 14 years old at the time of the audit and to date she still has not had an IHA, for that particular episode of care. A report was written based upon what had been gleaned at a previous consultation. However despite a number of attempts to establish a professionals meeting to try and develop a multiagency care plan, to date we initially failed. We have now managed to see her following prompting of her social worker, and the IHA was completed on 130415. (4 months after this current placement).

These figures are encouraging but there are always one or two very hard to engage with young people where we fail to be able to actively contribute to their health plan, and where we remain very concerned about their well-being. We maintain an open door policy for this group, so if they change their minds they can be seen by a doctor or a CIC nurse. We are also exploring the option of trying to attend the Initial review of their case, after coming into care.

### Age appropriate health assessment identifying health developmental and educational needs.

All the initial health assessments are primarily carried out by junior doctors under supervision by the Designated Doctor Children in Care. Generally the standard of the health assessments is high, but the trainees vary in their prior experience and training particularly in mental health or sexual health. We are exploring better ways to talk about sensitive issues about sexual health or feelings and relationships, which is a difficult area when you meet a young person for the first time, especially when they may be feeling particularly anxious and unsettled.

The cases where the initial health assessment was completed at the same time as the child protection report sexual health, drug misuse, and mental health concerns were not documented. Additionally in one young unaccompanied minor the doctor did not discuss sexual health or drug misuse.

The communication skills for discussing such issues are a focus of some of the work that the Children in Care team wish to do over the next months and year, and we will need to find ways to enable the trainees as they rotate through to be able to acquire these skills quickly.

The recording of whether a young person has special educational needs is not always clear

### Weight and BMI

The weight and BMI were recorded in most of the children who attended the appointments. In children over 2 years BMI was recorded in 18 of the children, so there were a number where BMI had not been calculated and thought about at the time of the report.

Referral on for assessment will follow the NICE guideline for obesity in children.<sup>2</sup>

### **Summary and action plan.**

#### **An Initial health assessment is an opportunity to capture where a child is in their journey, a detailed narrative and is a real opportunity to contribute towards their care plan in a helpful way.**

The audit of initial health assessments has highlighted unacceptable variation in the timeliness of when children are seen. The variability in the timing relates to whether information has been received from social care in a timely way regards the background, but also down to practical issues related to consent and children being brought to appointments. When children are with kinship carers, they can at times feel that the appointment is unnecessary.

Young people who are adolescents when coming into care can be wary and unwilling to be seen, or it may just not be a priority for them. However in this sample we saw all of the young people eventually, which is significant progress over previous years.

Immediate action;

1. We have implemented a system whereby as soon as a child enters care we email the social worker and we seek background information from GP, social work and camhs.
- 2. We follow up any delays with paperwork via emails to the social worker and team manager and we will escalate if needed.**
3. We monitor the timeliness of notifications and have had at times to raise a concern about delays in the system. This normally means that the issue is addressed.
4. We are now also seeking more pro-actively information from the GP prior to the IHA.

*What we need to think about doing;*

1. Ensuring that we have access to the SDQ before the IHA.
2. Linking up with the virtual school regards ensuring the health plan is integrated into the education and health care plan.
3. Developing skills in the doctors carrying out IHAs regards tackling difficult issues such as sexuality, drug misuse and mental health concerns.
4. Developing flexibility in the workforce so that we can be more flexible regards timing and venue for initial health assessments.

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<sup>2</sup> <http://www.nice.org.uk/guidance/cg189/chapter/1-recommendations#/identification-and-classification-of-overweight-and-obesity>

5. It would save us a lot of time if a way could be found for the Immunisations to be uploaded onto RIO in a timely and accurate way. Working with Child health to improve our records of immunisations.
6. Developing clinical skills regards noting the emotional health and well being of infants, as the early development of attachment is the foundation for healthy growth and development.

Possible future audits;

1. Audit of the health information shared with foster carers at placement.
2. Audit of the health plan being available for the first LAC review.

Social workers are expected to carry out the following;

- ensure the child has a copy of the care plan and the health plan
- support foster carers, or the appropriate person in the children's home where a child is placed, to promote the child's physical and emotional health on a day-to-day basis. That should include providing them with information on the child's state of health, including a copy of the child's latest health plan<sup>3</sup>

4. Audit of whether the health care plan is integrated with the education and health care plan in schools.

The looked-after child's EHC plan works in harmony with their care plan to tell a coherent and comprehensive story about how the child's health needs in relation to accessing education are being met. Health and education professionals should consider how to co-ordinate assessments and reviews of the child's care plan and EHC plan to ensure that, taken together, they meet the child's needs without duplicating information unnecessarily.

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<sup>3</sup> Where the child is 'competent' in line with Fraser Guidelines, their consent should be obtained. NSPCC factsheet on Gillick competency and Fraser Guidelines.

Appendix 3

Whittington Health   
Haringey Children Community Health Services

**Audit of Review Health Assessments completed by Children in Care/Looked after  
Children nurses in Whittington Health.  
March 2015**

**Aim of the audit:** The aim of the audit is to assess the Review Health Assessments (RHA) carried out by the specialist nurses for Looked after children/ Children in Care (CiC). This is to ensure that the health assessments are recorded to an acceptable standard.

**Standard:** The national standard for the health assessments is:  
That a RHA is provided bi-annually for children under the age of 5 years and annually for children and young people over the age of 5.

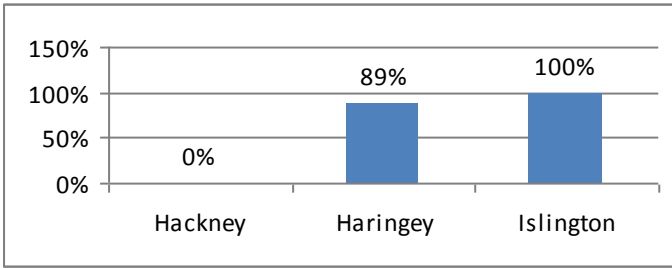
**Background**

The 23 RHA's audited were carried out by nurses. The teams consist of a Designated Nurse and Specialist Nurses.

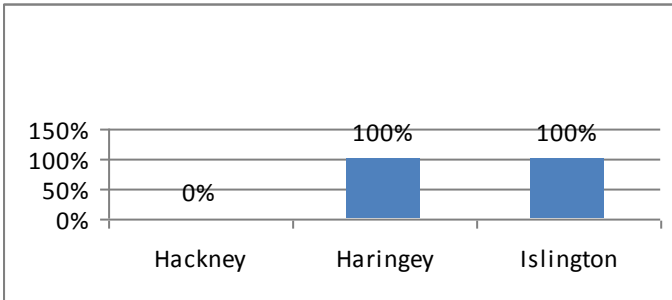
**Findings:**

All the reports were typed, the date seen recorded, and the name of the nurse who completed the assessment was documented. Not all of the reports had the nurse's signature or listed the nurse's qualifications.

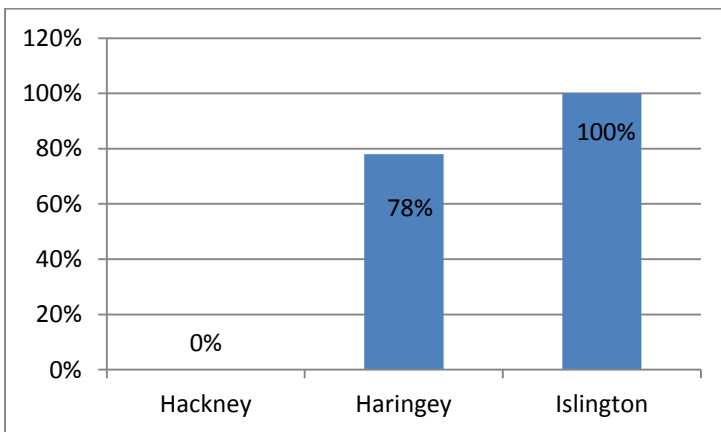
**1. Reports with a recorded NHS Number.**



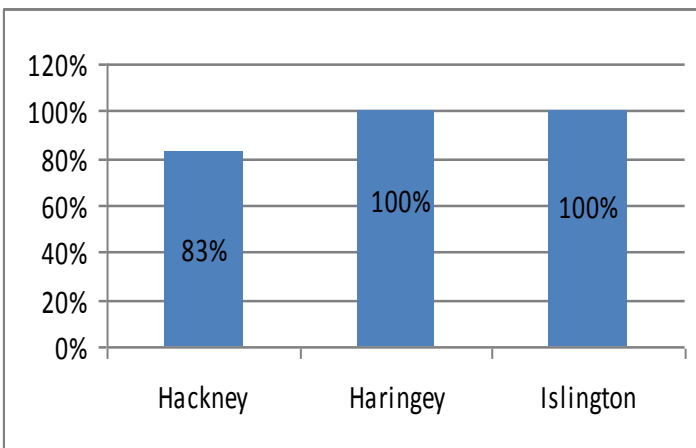
**2. Reports with the date child entered care**



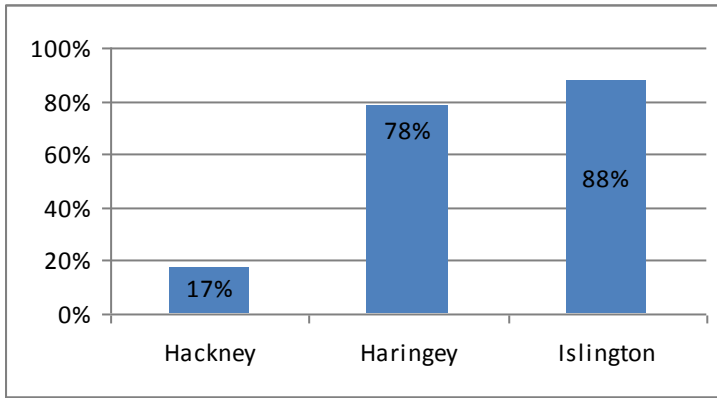
**3. Recorded qualification of Nurse.**



**4. Pre-existing health issues**



**5. Any newly identified health issues.**

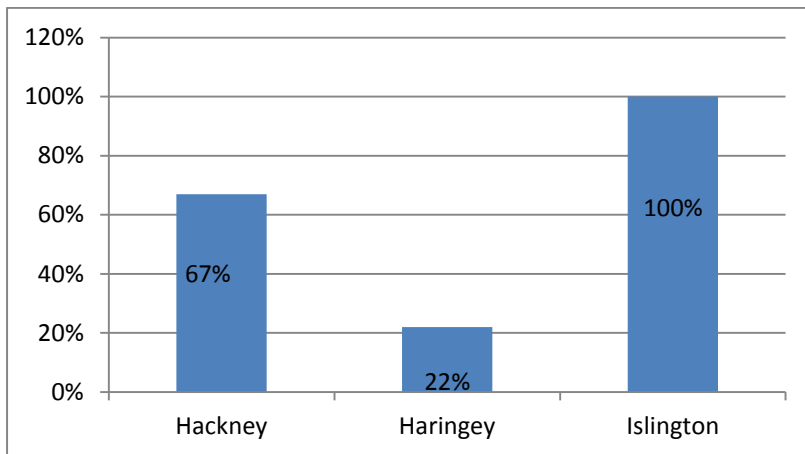


**6. Recommendation with clear time scales and identified responsible person**

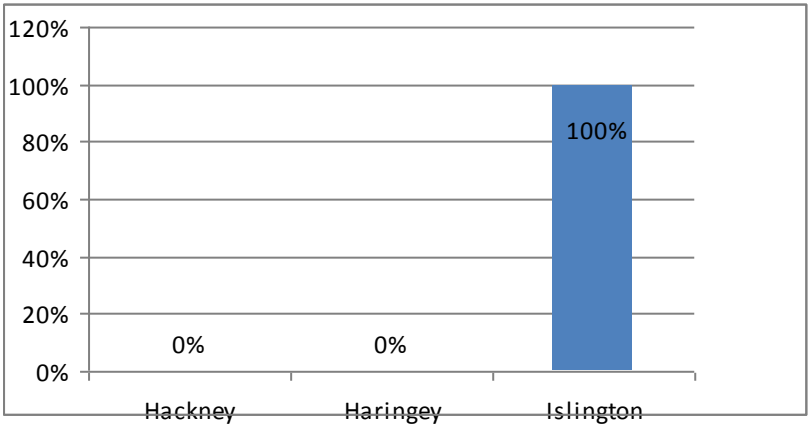
There was evidence that when a health need was identified there was a recommendation for a referral to an appropriate service.

**7. There was evidence that when a health need was identified there was a recommendation for a referral to an appropriate service.**

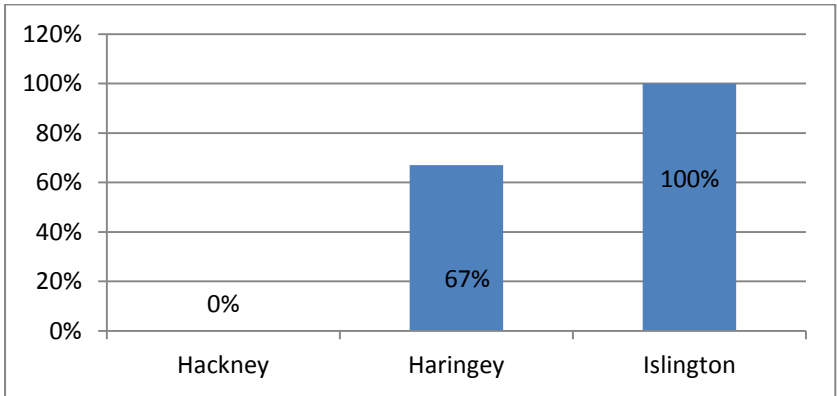
**8. A chronology or medical history including identified risk factors**



**9. % with an up to date immunisation summary.**

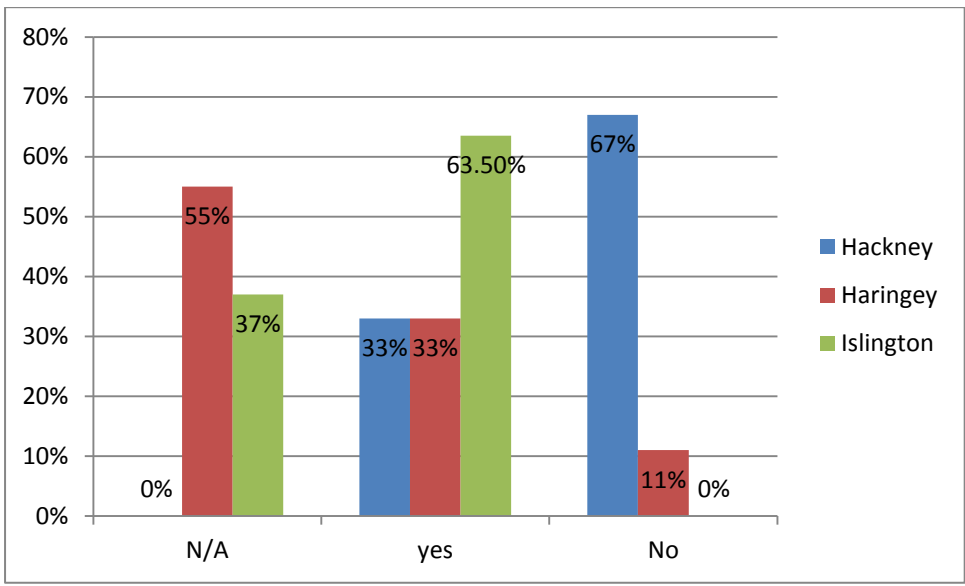


**10. Summary of Child Health Screening.**

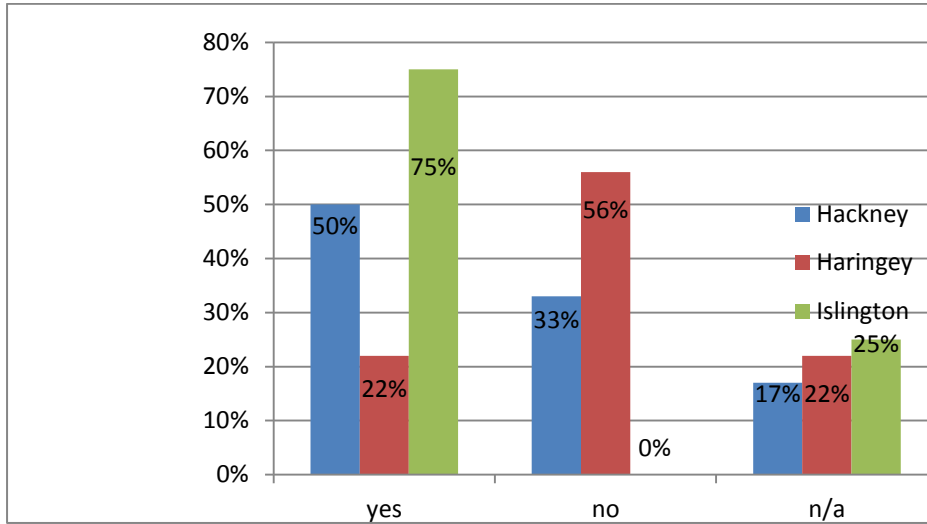


**11 .Consent from child or young person.**

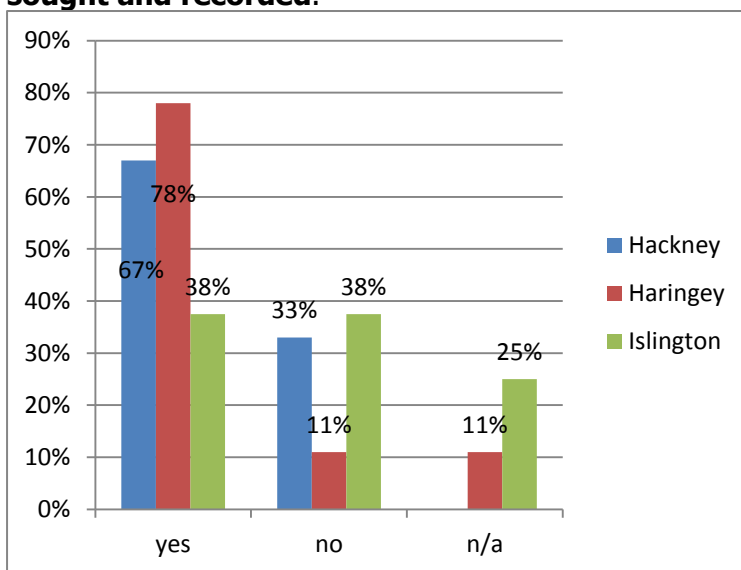
Reports documenting that the child had consented to the Health Assessment.



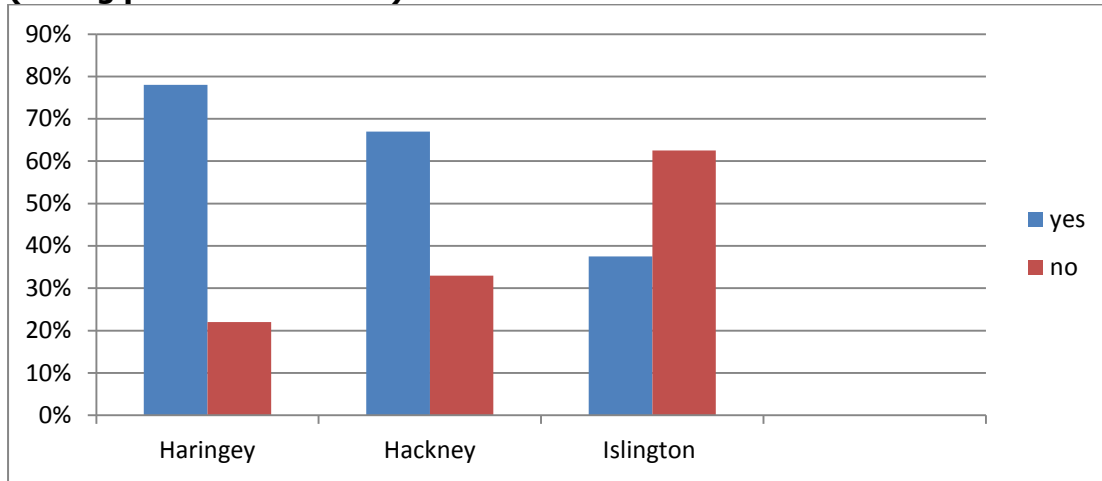
**12 Evidence that the child or young person was offered the opportunity to be seen alone.**



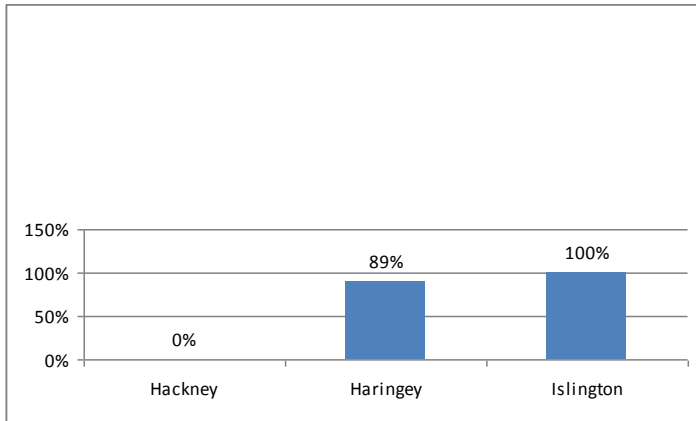
**13 Evidence that the child's or young person's concerns/comments have been sought and recorded.**



**14 Evidence that carers concern/comments have been sought and recorded. (Young person seen alone)**

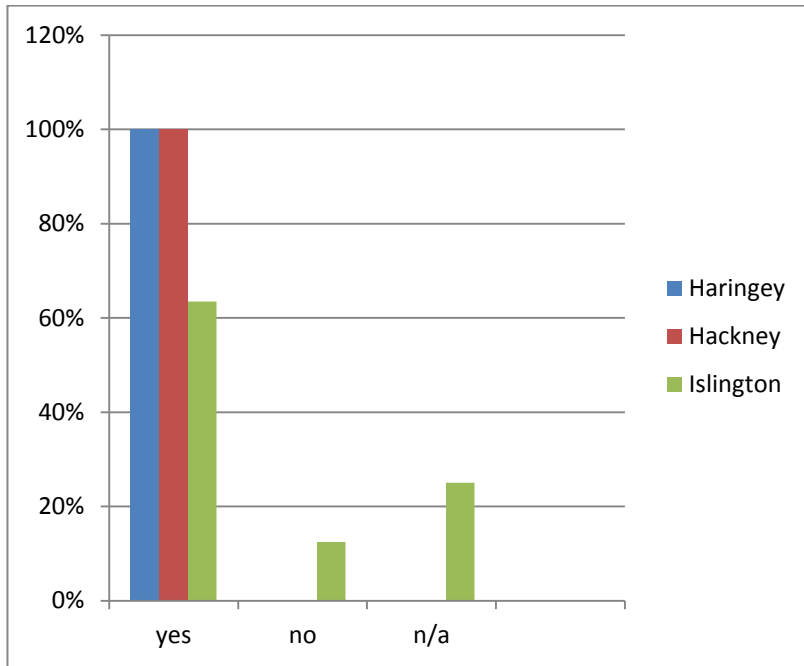


**15. Evidence that information has been gathered to inform the assessment from the placing Social Worker other health professionals providing care e.g. (CAMHS, Therapies, Hospital Services, GP).**



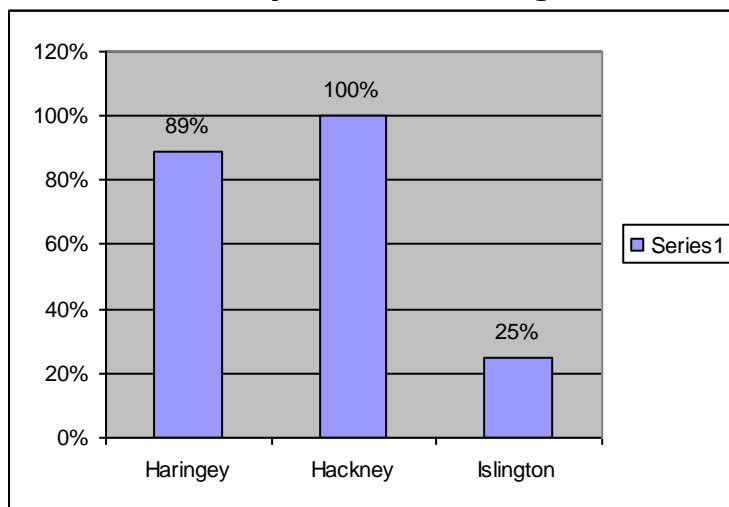
**16. 100% of children were registered with GP**

**17. Percentage of children or young people not registered with a Dentist or did not have access to dental treatment.**

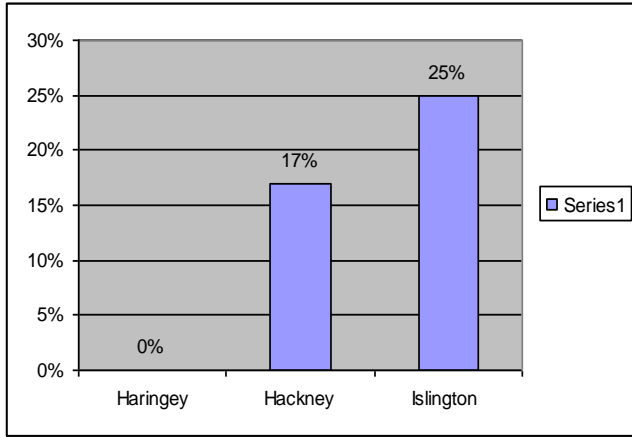


**18 .Date of most recent Dental check or if the subject has refused the intervention.**

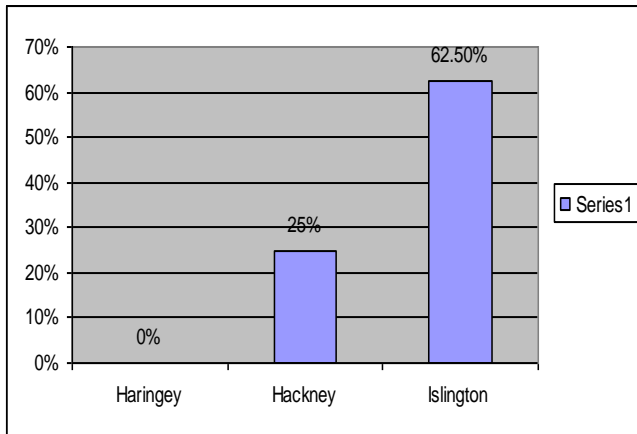
**2 Babies not seen by dentist due to age**



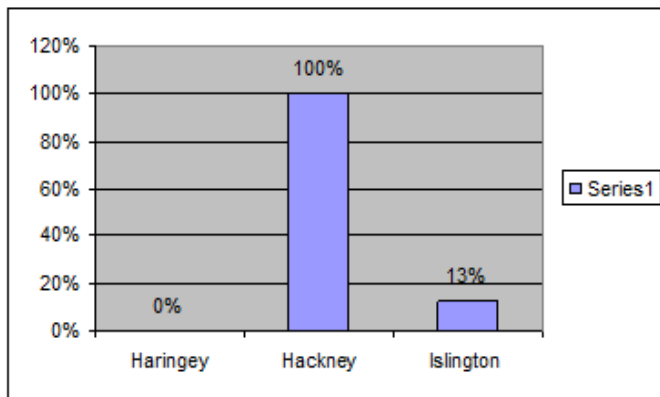
**19. Percentage of children or young person who had not been seen by an optician.**



**20. Number of reports that did not have dates of the vision test**



**21. Number of reports where the Recommendations did not indicate clear time scales.**



**22 .All reports documented that developmental or learning needs have been assessed and identified concerns were documented.**

**23. All reports documented that emotional, behavioural needs have been assessed and any identified concerns documented.**

**24. All reports documented that lifestyle issues were discussed and health promotion information given.**

**25. The Recommendations had a responsible person identified. Timescales need to include a date.**

### **Conclusion and Recommendations.**

All three teams document The Health Assessments on different templates. Hackney use a template. Islington complete a written report. Haringey complete the BAAF Form.

The audit tool has highlighted gaps, due to the difference in how assessments are being recorded. Consistency needs to be ensured across the 3 teams.

The document "Promoting the health and well-being of looked-after children" (March 2015) states that

"To ensure the child's health plan is of high quality, the health assessment should use relevant information drawn together beforehand and fast-tracked by all involved to the health professional undertaking the assessment. This will include information in the GP-held record and also, if not in that, the additional information held:

- by children's social services and derived from an assessment undertaken in accordance with *Working Together to Safeguard Children*. This includes the child's personal and family history if known
- by community dental services and family dentists
- on the Child Health Information System (CHIS), especially immunisation status to date
- on any parent-held or child-held record, or school health record
- within any database in local hospital emergency departments or within other local hospital record systems, especially where the child is known to have been in contact with services.
- on any contact with child and adolescent mental health services (CAMHS)
- on any contact with a Youth Offending Team (YOT) where appropriate.

The health assessment should:

- be integrated with any other assessments and plans such as the child's Core Assessment or an Education, Health and Care Plan where the child has special educational needs
- involve birth families as far as possible, so that an accurate picture of the child's physical, emotional and mental health can be built up.
- involve a named health professional to coordinate the health assessment and the actions set out in the health plan developed from that assessment.

The health practitioner carrying out the assessment has a duty of clinical

care to the child. That includes making the necessary referrals for investigation and treatment of conditions identified at the assessment. Even if the placement is brief, the practitioner should follow up concerns and if the child returns home, every effort should be made to continue to implement the health plan.

The review of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months after the child's fifth birthday. The child's social worker and IRO have a role to play in monitoring the implementation of the health plan, as part of the child's wider care plan.

We recommend that the Children in care nurses/Looked after children nurses in Whittington Health use a template to write a report following the health assessment. The report should include headings that the nurse should populate to ensure information that was highlighted in the audit is captured.

**Lynn Carrington**  
**Helen Halloran**  
**10.4.2015**

**Draft Terms of Reference Haringey Children in Care Operational Group**

Date: TUESDAY 20<sup>TH</sup> October 2015 (Amended 22.7.2016)

1. Purpose:

To provide a safe and supportive forum to discuss issues of concern regarding Children in Care.

2. Responsibilities:

- a) To evaluate the Children in care pathways and outcomes.
- b) To strengthen partnership working across social care, health and CAMHS .
- c) To problem solve on specific cases and identify learning.
- d) To implement changes as required to our systems/pathways.
- e) The Terms of reference will be reviewed annually

3. Standards of Operation

- a) The group will be chaired by The Designated Doctor.
- b) The group will initially meet monthly, Members are requested to send deputies when they are unable to attend.

4. Core Membership

Designated Doctor Haringey, Designated Nurse Haringey, Head of Children in Care Service Haringey, Adoption and Fostering Service manager, Deputy Head of Service Disabilities Team. Deputy Head of Leaving Care Service, Service manager Independent Reviewing Officers. Service manager for First Step, Vulnerable children's commissioner

5. Exceptional reporting from this group to both The Corporate Parenting Committee and The Safeguarding and Assurance Committee will take place.

accompanying them to assessments April 2015-March 2016

(Comments in red discussed with team and where possible acted upon)

More frequent visits, HA in its present form is satisfactory. Continue to employ good nursing staff. Have it in Tottenham

Thanks I have attended the clinic before and the staff have always been helpful/professional. Very useful and happy with the assessment. I don't think there can be an improvement. Very good

Very good nothing we can think of. Well done It is very good. No pleased with HA

The conversations before the appointment were very helpful in reducing the length of time discussing things e.g.: adult discussion in front of x which he finds anxiety provoking. Very positive warm response from xxx The health assessment reassured me that the child was fine. It is better

I have attended the clinic before and the staff have always been helpful/professional. Very useful and happy with the assessment Happy as things are. thank you

Closer to home more convenient some stations don't have step free access Prefer home visit Involve the parent Young people struggle with the many appointments he has to attend find it difficult. Raises anxiety levels Need to look at another way to access information needed Like to have spoken to the nurse alone Distance is always an issue but

XXXX was patient and good. No as everything was covered and explained in great detail XXXX was made to feel comfortable and made to feel relaxed enough to answer questions The xx was very smart professional

It is very good. No pleased with HA Very good nothing I can think of Happy as things are. Not really thank you

Details into our diet were excellent. I find the assessment very good. It is 100% fine Being friendly and co-operative excellent communication manner good support

I find the assessment very good. It is 100% fine Being friendly and co-operative excellent communication manner good support. I am happy how the health assessment is carried out. Its fine Very helpful and informative Positive staff and manner

No complaint Nothing thank you We feel yearly visits is the right level Health worker put us and our foster child at ease and should continue this way Well assessed covered all areas Keep up

No con Overall Inform Comf atmo Excellent

Very good

Everything was done well and very  
Everyone very professional  
Made us feel comfortable  
Updates knowledge

STAFF WERE VERY PROFESSIONAL  
AND LISTENED TO THE YOUNG PERSON  
I THINK YOU ARE DOING VERY GOOD  
JOB I WAS PLEASE.  
XXX WAS PROFESSIONAL AND XX  
DISPLAYED WARMTH AND EMPATHY.

Very good for the child  
understanding of health  
xxxx was really easy to t  
Assessment was conduc  
efficiently  
Very pleased with every  
xxx did with xxxx  
The health assessment v  
The boy to talk abo  
the es and I could

**DRAWING**  
**WRITING A POEM.**  
**PLAYING WITH TOYS.**  
**PLAYING IN THE TENT.**  
**IT'S NOT SCHOOL**  
**BALL**

Everything.  
When I got weighed.  
Playing, talking, and  
measuring.  
I would love to stay  
here.  
Talking about stuff.  
Me as a teacher

**I LIKED PLAYING WITH THE LOOM BANDS.**  
**WHEN I WAS PLAYING IT WAS FUN.**  
**BALL GAMES**

I just wanted to thank you for the meeting with xxx yesterday. They both talked a lot about how helpful they found your input and both said that you clearly knew xxx well and talked about her with care and passion. They were encouraged by your description of her and felt that they had received a good amount of information from your reports.

Playing with finger  
crayons.  
Playing with the  
house and playing  
catch with the ball.  
I like you xxxx  
I like checking  
height/weight/BMI  
I It's fine

Useful Found the  
information useful  
It is comfortable think  
the xx deserves a 10  
Assessment was good.  
I think it was very useful  
and I like coming here.

**WHAT DID YOU LIKE?**

Just do what  
you need to

I am very happy about the service I have been offered. Many thanks  
I dunno  
Very helpfull found it easier to be able to talk. Great advice given very helpful. Its good

Writing a poem.  
Playing with toys.  
Playing in the tent.  
It's not school  
Ball  
Writing and

**WHEN I GOT MY HEIGHT DONE  
FAVOURITE PART WAS FOOTBALL  
EATING BISCUITS  
VERY FUN  
YOU CAN'T MAKE IT ANY BETTER  
HAD XXXX FOR YEARS**

I dunno  
Very helpful found it easier to be able to talk. Great advice given very helpful. Its good

Perfectly fine no improvement needed.  
I enjoyed it.  
You don't because it is brilliant.  
It was good to have all my sisters' appointments at the same time.

I am very happy about the service I have been offered  
many thanks

Checking my height  
I liked all of it.  
Playing with the Lego  
like it when we played.  
I liked making a chatter box  
toys  
Perfectly fine no improvement needed

**USEFUL FOUND THE INFORMATION  
USEFUL  
IT IS COMFORTABLE  
THINK THE XX DESERVES A 10  
ASSESSMENT WAS GOOD.**

Measuring, weighing room  
Playing on my DS and xxx  
promising to take me to McDonalds  
Playing with the toys  
Everything  
When they were asking me questions

It is fine the way it is  
It was fun and fine too  
I got the opportunity to talk about my health and how I feel about my health Thank you

**WHAT DIDN'T YOU LIKE?**

Writing and drawing  
Checking my height  
I liked all of it.  
Playing with the Lego  
like it when we played.  
I liked making a chatter box  
toys

You can't really make it better because all the questions were asked quickly  
It was really good  
When I was playing with XXX with the crocodile  
LOL  
Talking to XXX

## WHAT COULD MAKE IT BETTER ?

When xxx  
wouldn't share  
the toys  
When she  
talked about  
my private  
parts  
Going to the  
toilet it stinks  
Too Hot

When we needed  
to go home

I wasn't told where it was specifically

Nothing I didn't  
like.  
Didn't like writing  
on the board.  
Room too small  
Getting on the bed  
Reading books

**DO IT IN  
SCHOOL**

**I didn't like telling my  
business.**  
**I didn't like listening to  
the adults.**  
**I didn't like the talking  
part I really didn't enjoy  
it as it is boring.**  
**Throwing the ball**

**Hot chocolate for children and  
biscuits.**  
**A snack and food please.**

Offer a wider variety  
of slots.

**Make it a bit  
quicker  
I don't know  
I'm not sure  
Not having it in  
the half term.**

Unfortunately the assessment had to be  
arranged during the young person's college  
time as there was limited availability at the  
centre. It would have been ideal if there were  
a wider variety of time/day slots available to  
allow for School College commitments. The  
communication from the health centre and  
confirmation of the appointment was excellent.

Try and talk  
about new things  
and not about  
whats in the 4  
girls booklet  
because I'm aware  
of it and have  
heard it before

If child could have  
xxxx again as he  
is used to her and  
feels confident.  
If it was nearer to  
home.  
Larger rooms  
Cup of tea.

**Copy my picture  
and put it on  
display.**

**Shorter time length**