Whittington Health NHS

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

2015/2016

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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 31st March 2014 and 6% compared to 31st 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

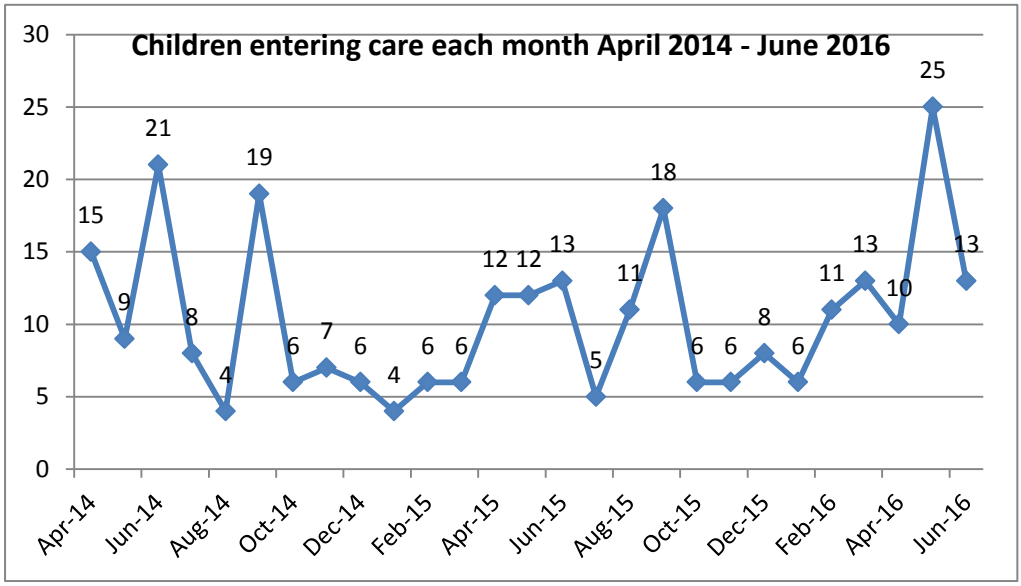
Children in care are more likely to have been exposed to severe neglect and trauma in early years and many children we meet have been exposed to situations and experiences that leave them vulnerable. We have difficulties in obtaining full health information. Older young people in care might have fragmented 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)

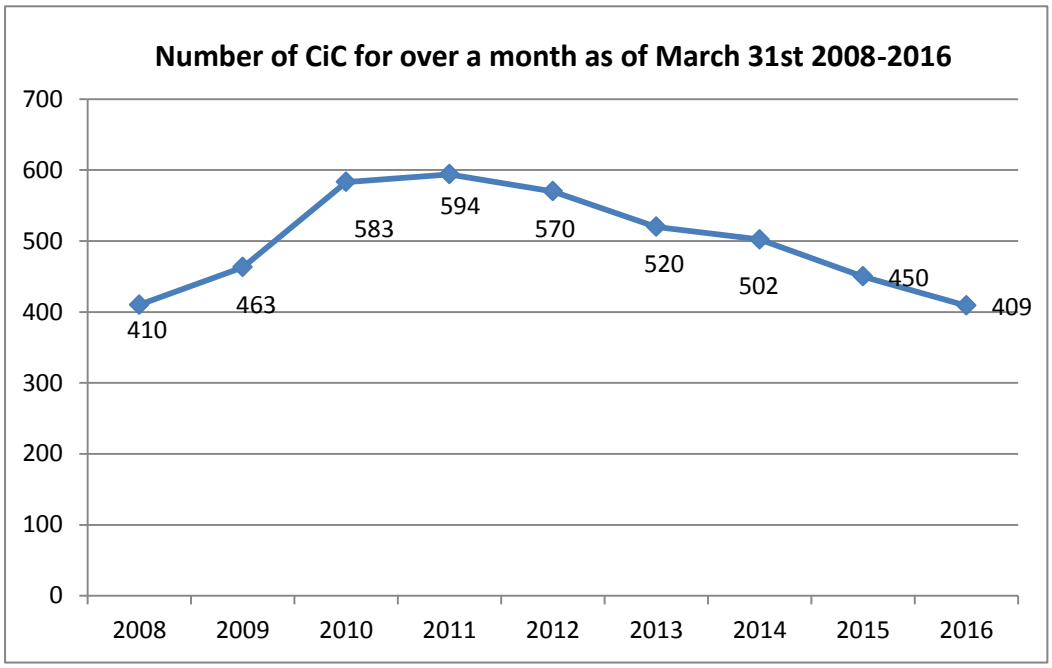
Geographical and placement distribution.

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 8th 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.

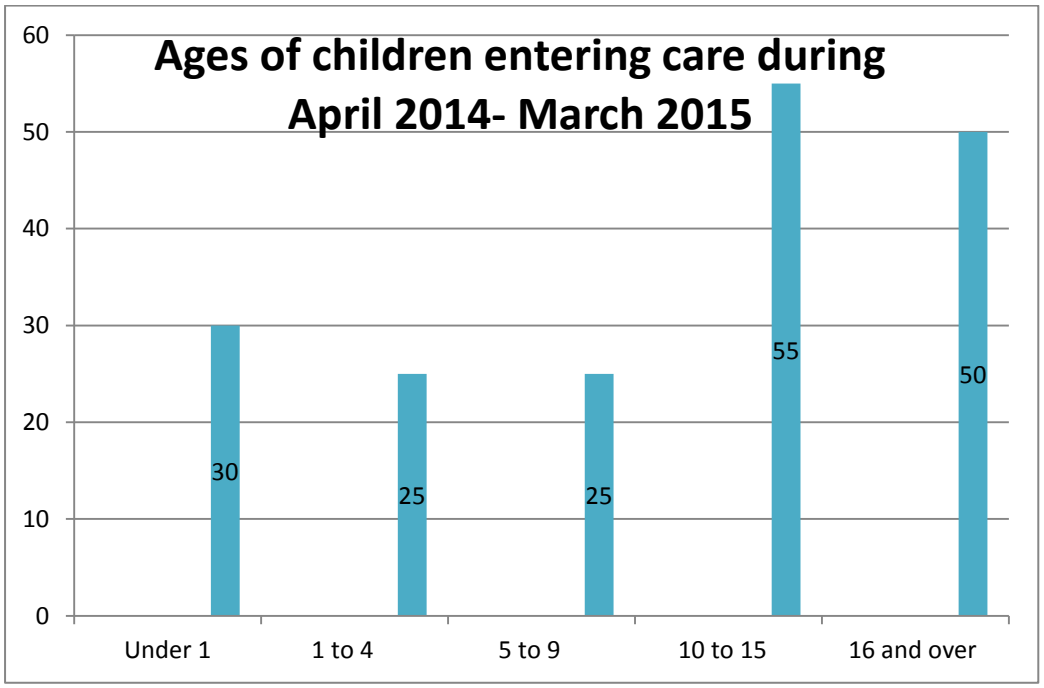
4. London wide Statistics

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.

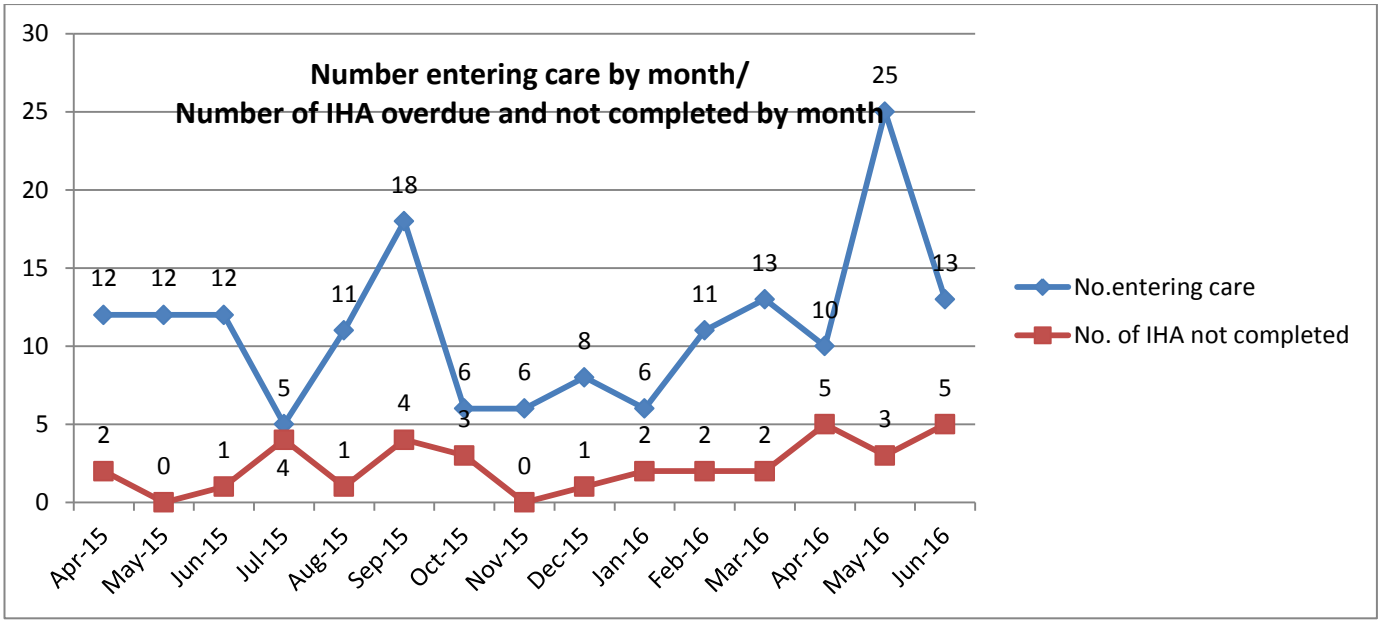
We provide a Care Leavers Summary for the young person after their last health assessment prior to 18 years. We are developing the quality of these reports to ensure they are as informed about their health histories as possible. It is also crucially important that they know and understand how to access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

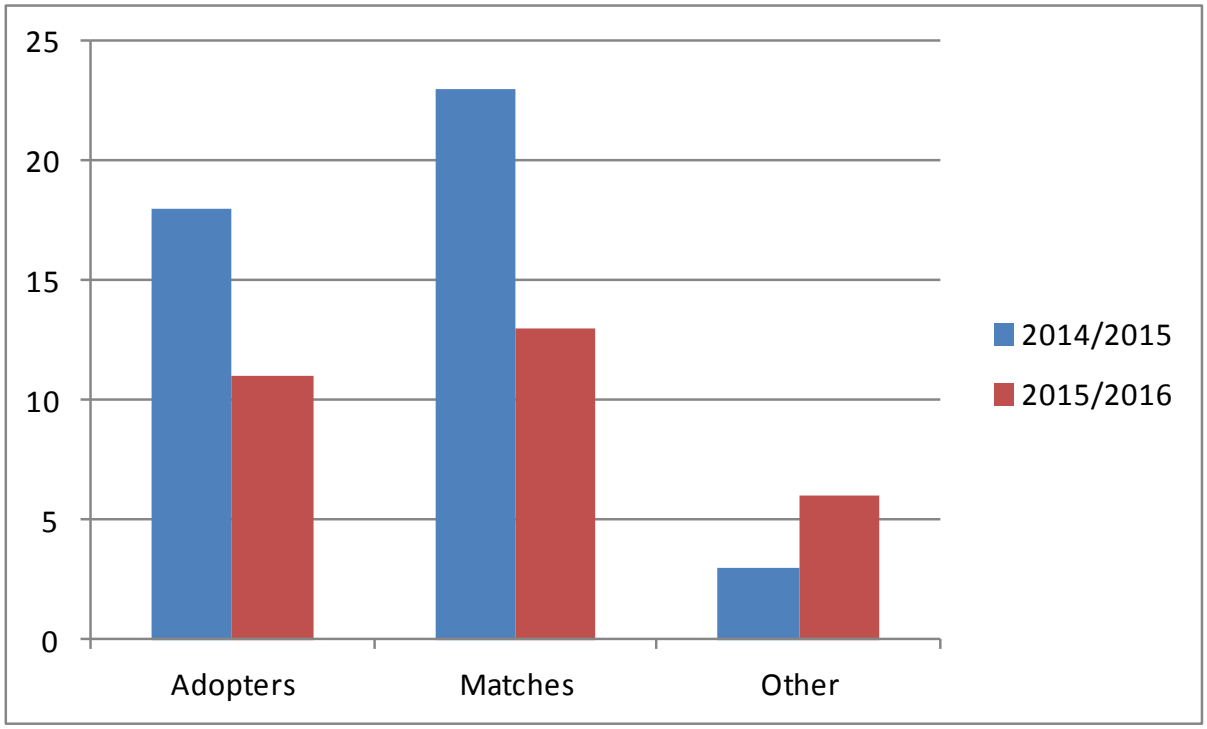
- Not being notified the child has entered care; the most common reason.
- Delay in receiving documentation including consent from SW.
- 2 Children were in hospital 1 child was waiting to be seen by a consultant that knew her from the paediatric team at a special school,
- Child not attending first appointment (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
April	0	4	0
May	1	3	0
June	1	0	0

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

* **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.

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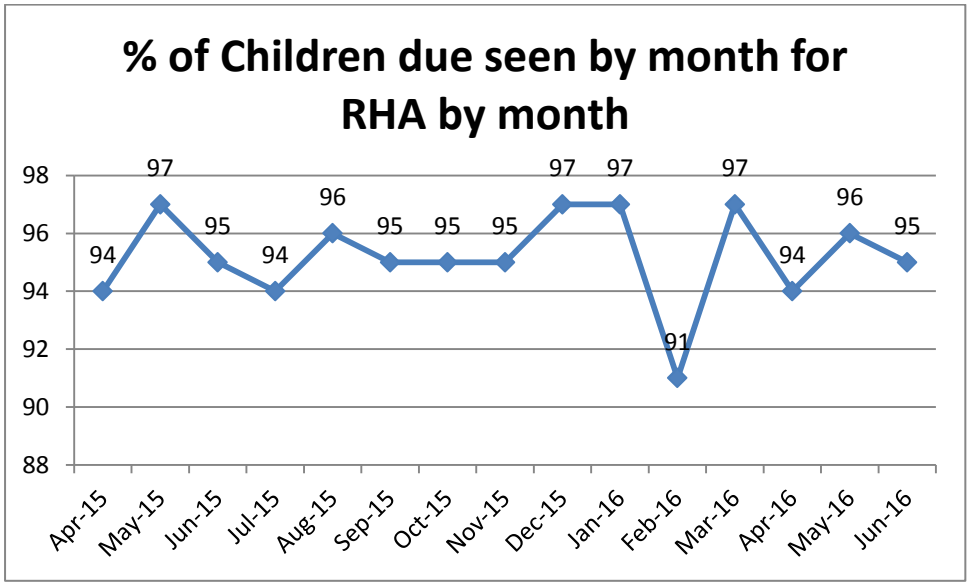
6.3 Review health assessments (RHA)

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.



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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?

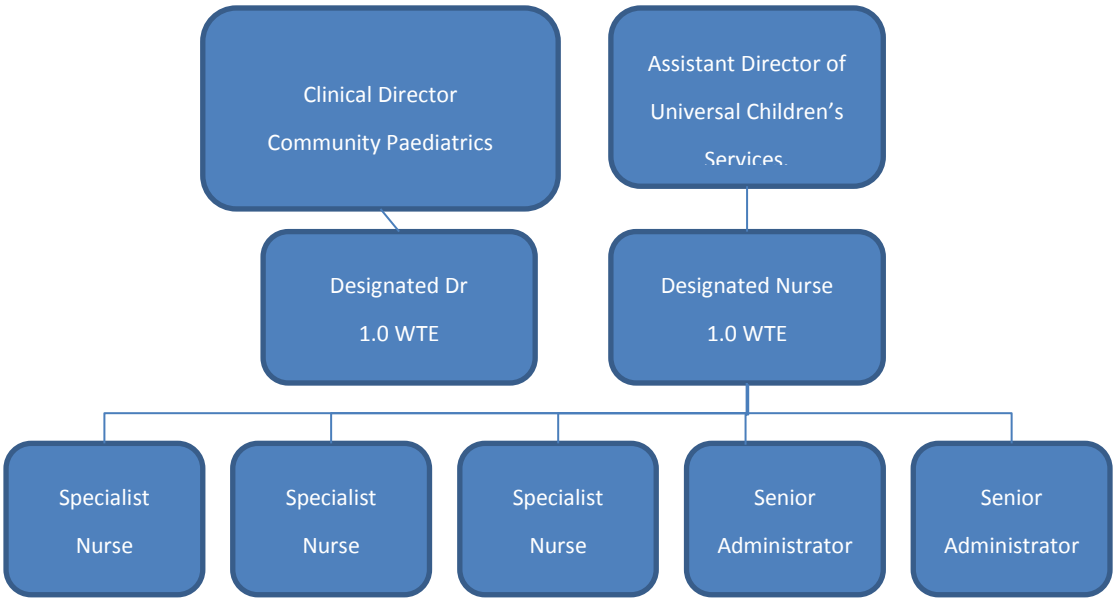
The results demonstrated that not all information was being captured and a new template was required. The Haringey team have been writing their reports using a similar format to the IHA reports since October 2015 using templates developed by the Islington LAC team. A repeat audit has taken place and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

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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
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Initial Health Assessment completed on: 15th June 2016

Completed by: Dr xxxxxxxST5 Paediatric Registrar to Dr Holt
For Children in Care

Name: xxxxxx **NHS Number: xxxxxxxx**	**DOB:** **Age: 17years**

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 was 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.

I am glad to hear that the foster placement appears to be going well and that M's English is improving. I feel that due to her traumatic experiences in the past, she would really benefit with input from psychological support and she has also agreed to this. It is also extremely important that she is allowed to see her brother as much as possible as he is a very significant person for her. Now that her mother is absent from her life, the professionals involved in her care should make an effort to allow M and her brother to see each other outside of school.

Plan
1. CAMHS referral- arranged.
2. Support to allow M to see her brother regularly
3. Has been referred to Dr E (vaccination clinic at Great Ormond St) due to possible history of previous allergic reaction to a vaccination.
4. In light of the risks of asymptomatic infection to be referred to infectious diseases clinic for screening, and consideration of sexual health screen, in light of the possible sexual exploitation history.
5. Review 2017 before her 18th birthday, by our service.

cc:
- ☐ **Social Worker**
- ☐ **GP**
- ☐ **First step psychological service**

- ☐ **Recommendations to carer**

Signature **Date:**
Dr xxx- ST5 Paediatric Registrar to Dr Holt
Checked by Dr Kim Holt **–Designated Doctor For Children in Care**

CHILDREN LOOKED AFTER

This case shows the degree emotionally laden interviews that we experience on a regular basis, and the need to be culturally sensitive and informed as well as not to forget the basic tasks that we need to complete during the one consultation.

Appendix 2
Audit of the Initial Health Assessments Children in Care Haringey (16.4.2015)

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. [1] 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

[1] 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;

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

<u>This audit focuses on statements 5, and 7.</u>

<u>Standard 1 of audit.</u>

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

<u>Standard 2 of audit.</u>

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

<u>Standard 3 of audit.</u>

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.

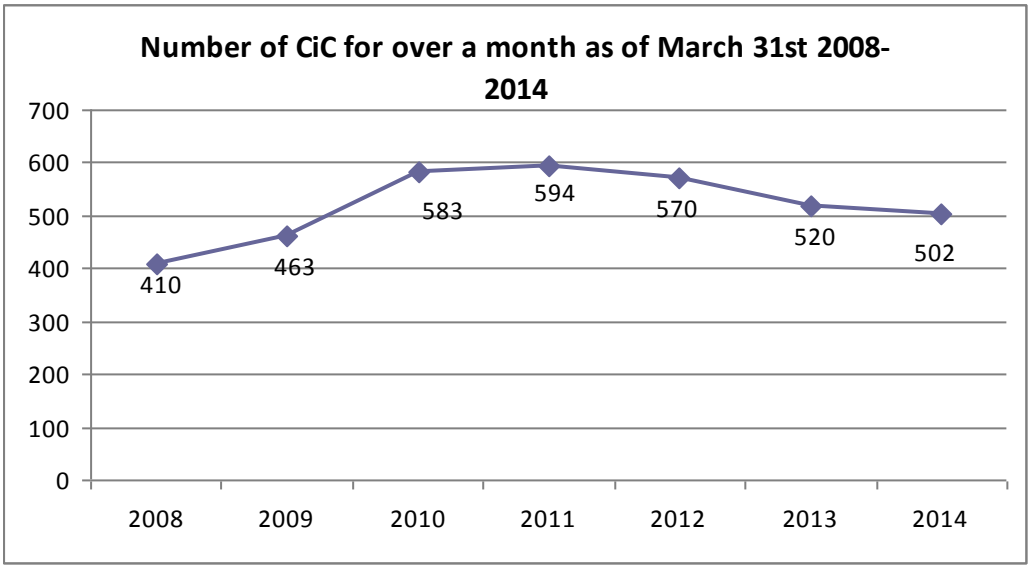
A sample of 40 initial health assessments was randomly chosen to look at the following features;

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.

<u>During the period of the audit in 2014 The Haringey CiC team consisted of:</u>

1.0 WTE Designated Doctor part of the Community Paediatric team

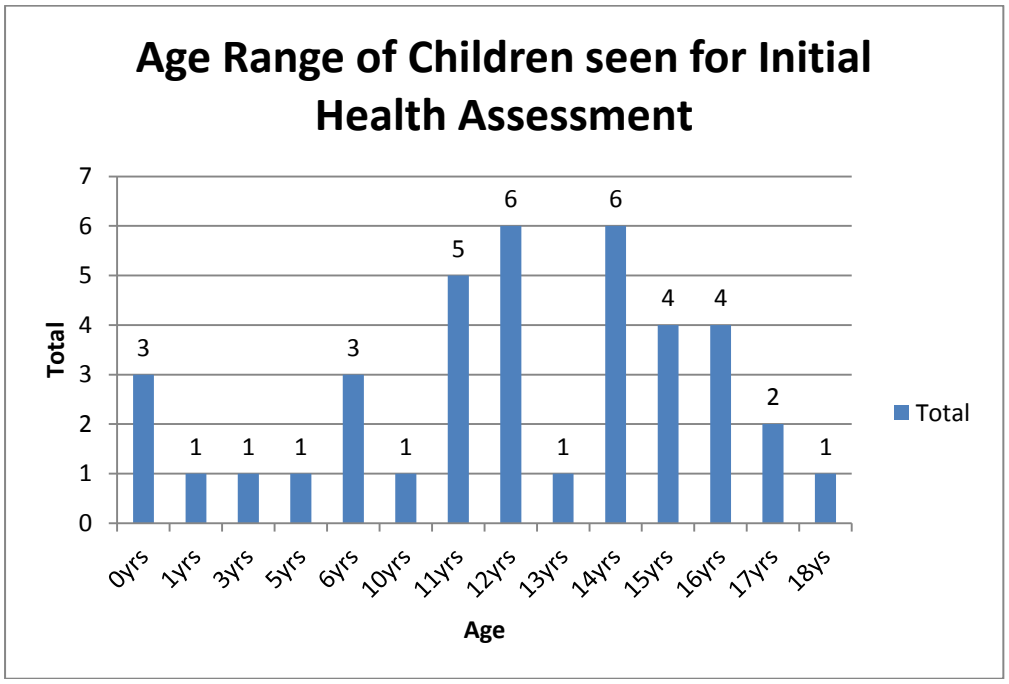
Paediatric Registrars carry out initial health assessments, under the supervision of the Designated Doctor.

1.0 WTE Designated Nurse
3.0 WTE Specialist Nurses
2.0 WTE Administrators

<u>Audit results.</u>

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

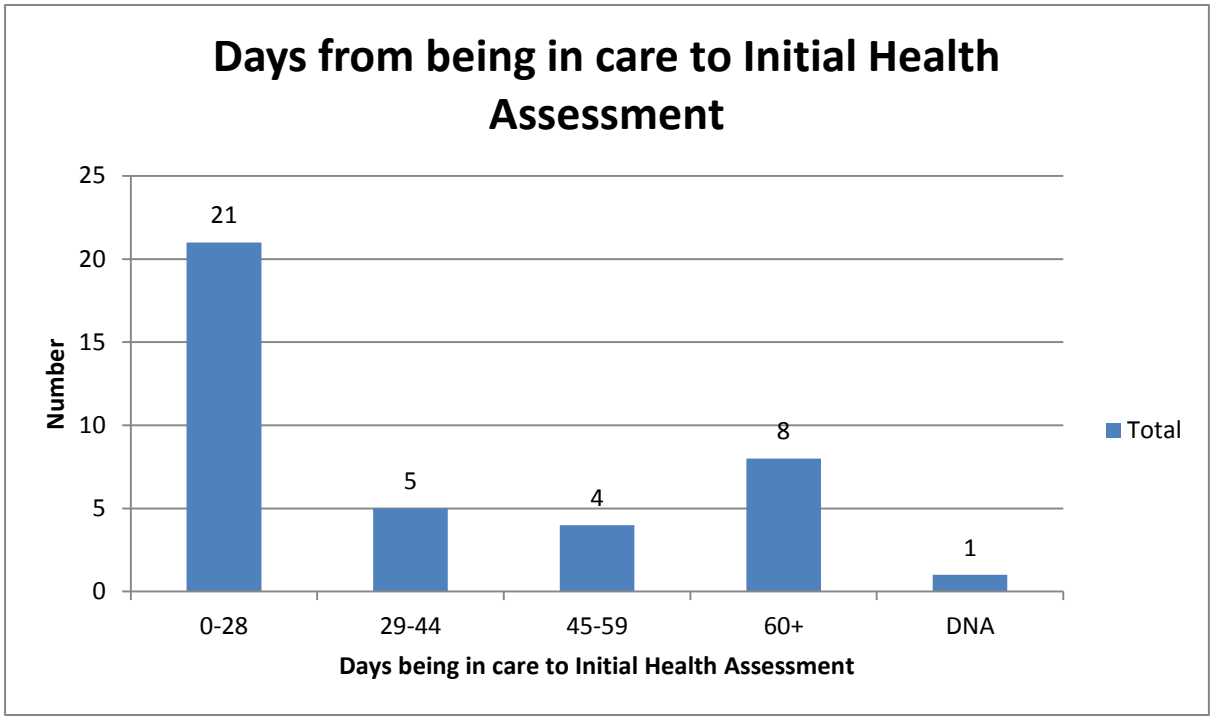
The age range of the children seen were from new born to aged 17 years.



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.

<u>Outliers analysis of the delays.</u>

- **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

	Notification	**Paperwork**		**IHA done**
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.[2]

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.

[2] 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 [3]

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.

[3] 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 NHS

Haringey Children Community Health Services

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

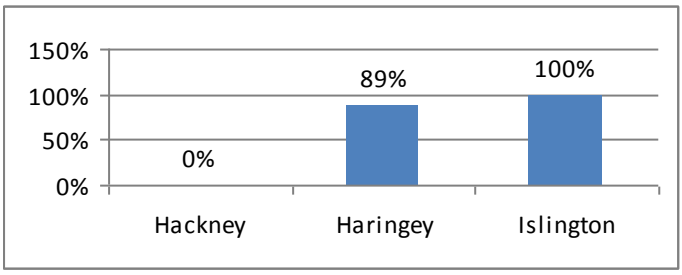
Aim of the audit: The aim of the audit is to assess the Review Health Assessments (RHA) carried out by the specialist nurses for Looked after children/ Children in Care (CiC). This is to ensure that the health assessments are recorded to an acceptable standard.

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.

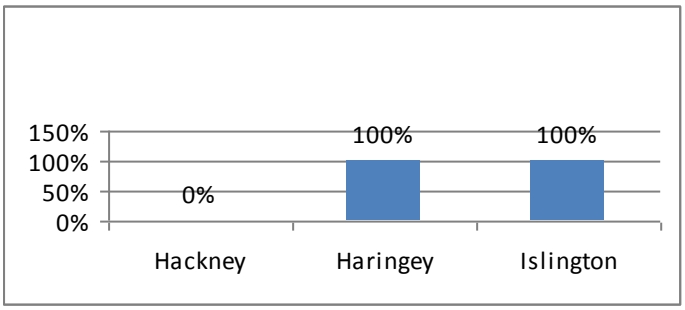
Background
The 23 RHA's audited were carried out by nurses. The teams consist of a Designated Nurse and Specialist Nurses.

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.

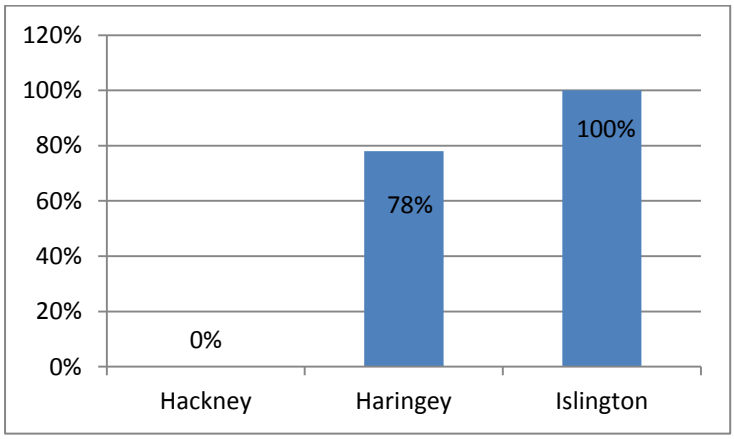
1. **Reports with a recorded NHS Number**.



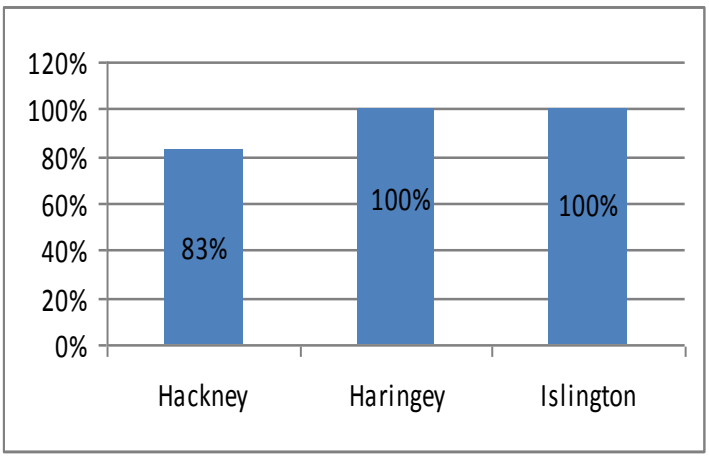
2. Reports with the date child entered care



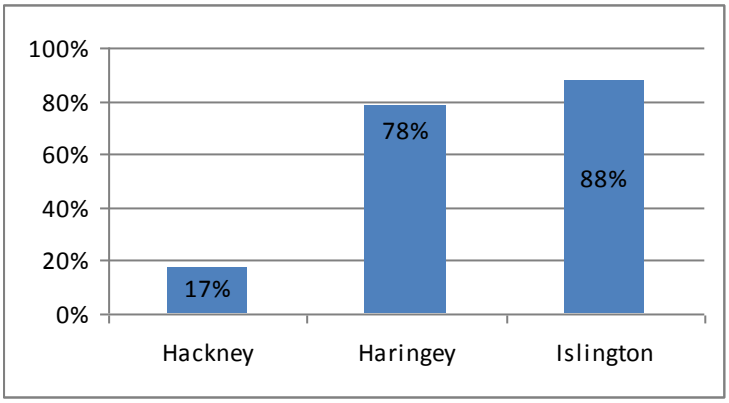
3. Recorded qualification of Nurse.



4. Pre-existing health issues



5. Any newly identified health issues.



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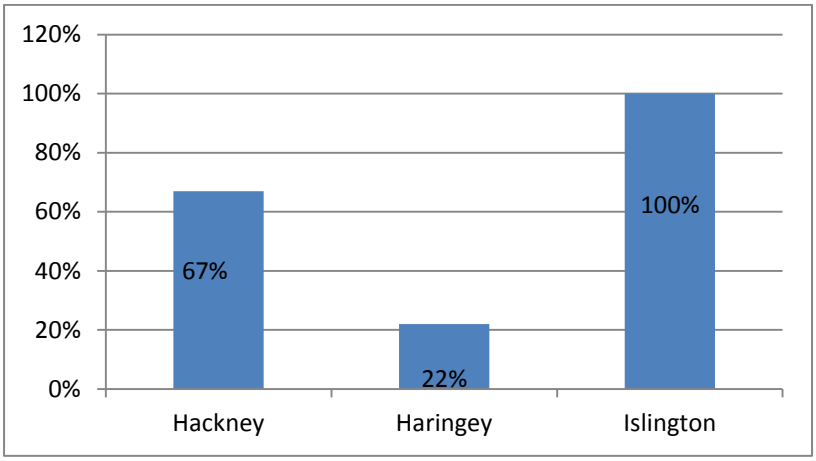
6. Recommendation with clear time scales and identified responsible person

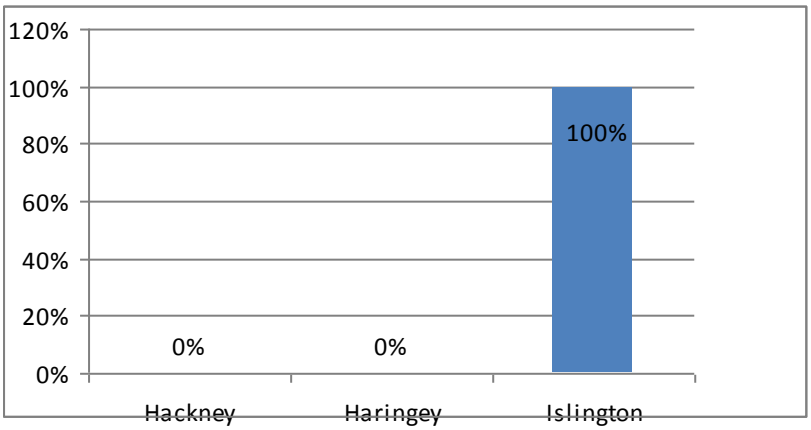
There was evidence that when a health need was identified there was a recommendation for a referral to an appropriate service.

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

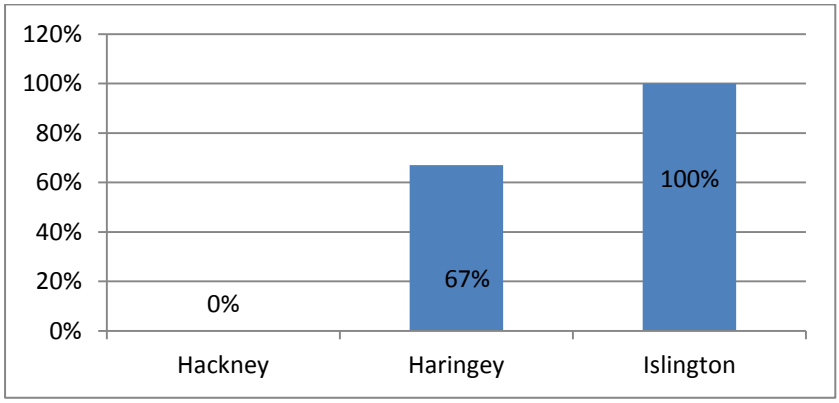
8. A chronology or medical history including identified risk factors



9. % with an up to date immunisation summary.

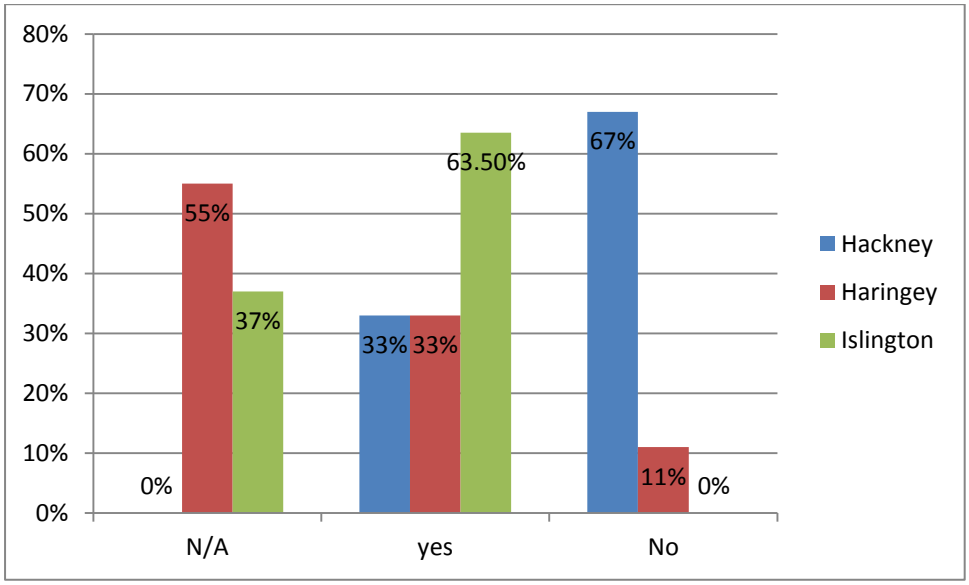


10. Summary of Child Health Screening.

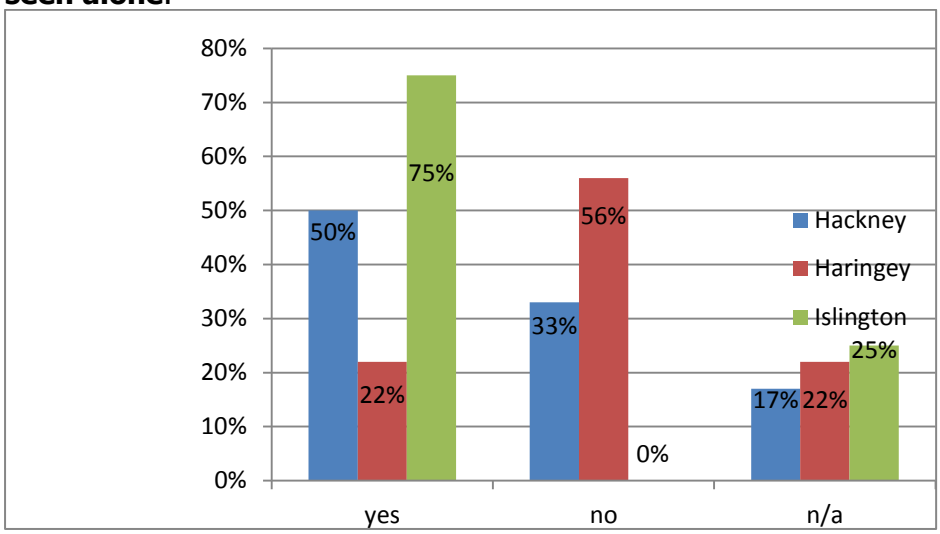


11 .Consent from child or young person.

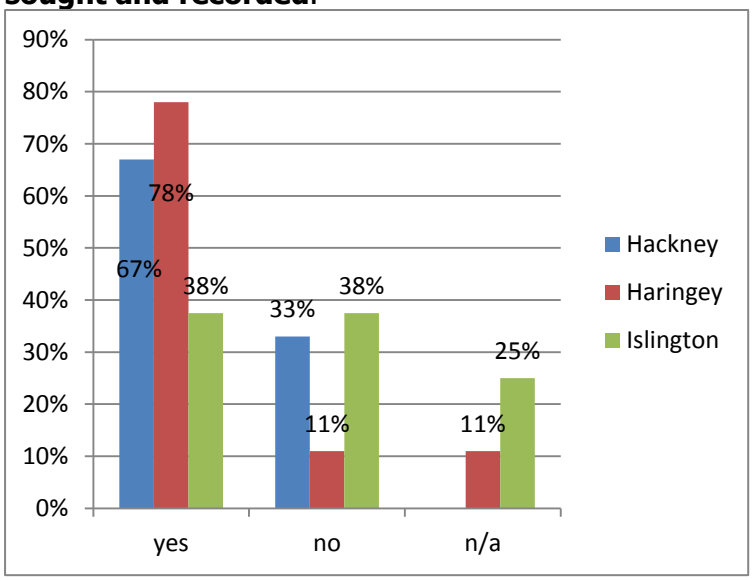
Reports documenting that the child had consented to the Health Assessment.



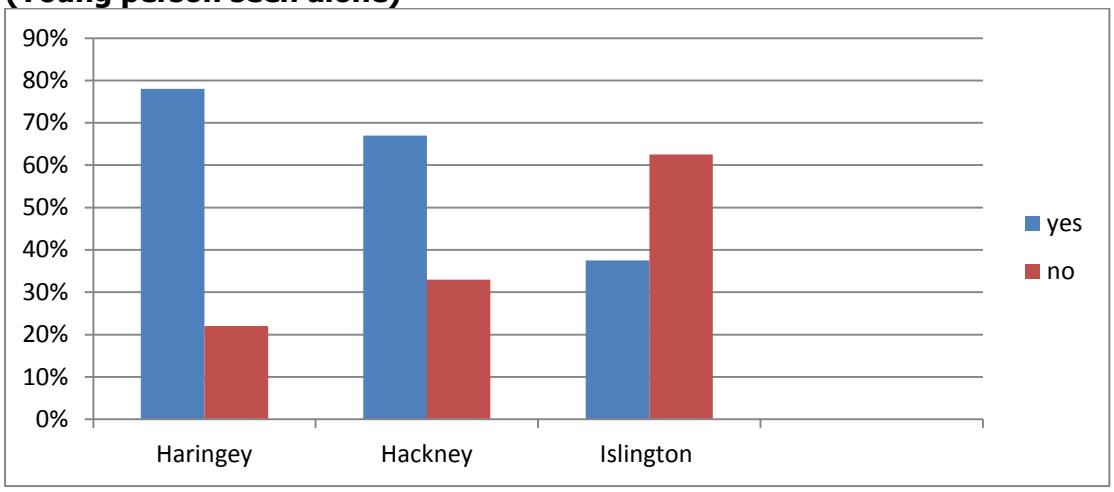
12 Evidence that the child or young person was offered the opportunity to be seen alone.



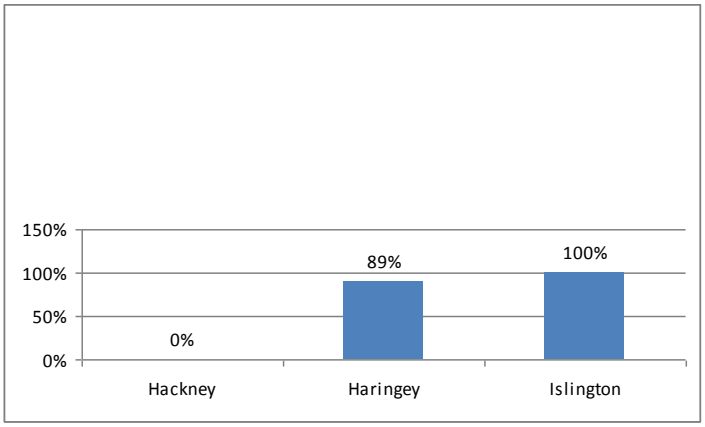
13 Evidence that the child's or young person's concerns/comments have been sought and recorded.



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

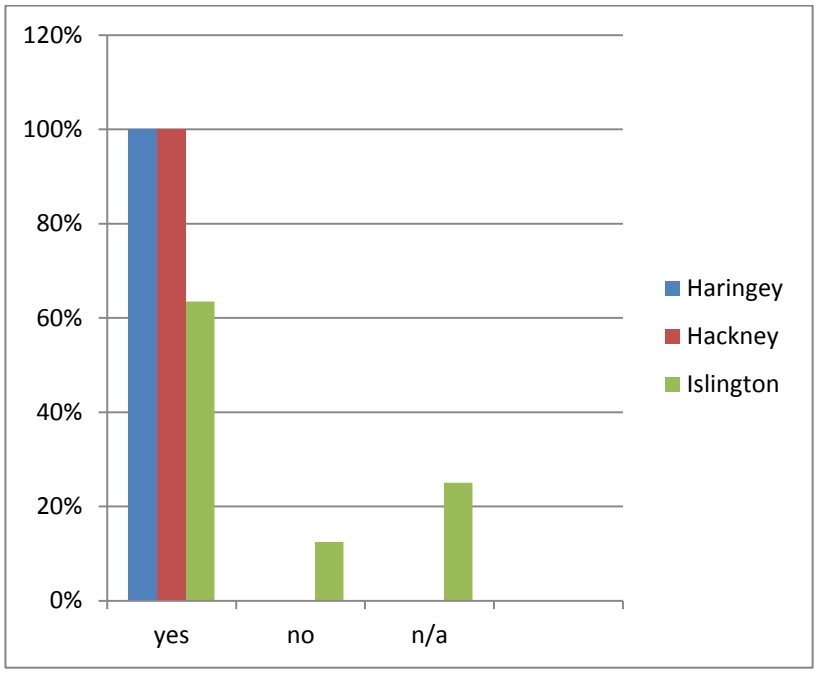


15.Evidence that information has been gathered to inform the assessment from the placing Social Worker other health professionals providing care e.g. (CAMHS, Therapies, Hospital Services, GP).



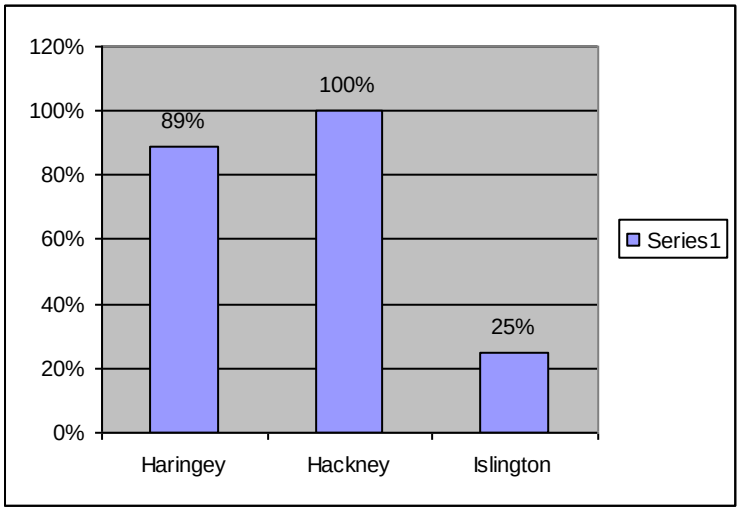
16. 100% of children were registered with GP

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



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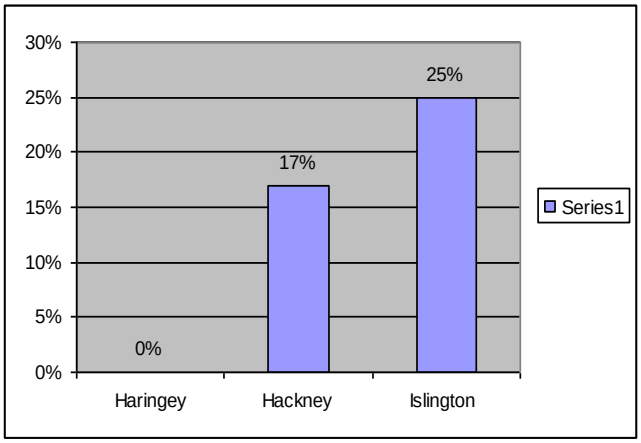
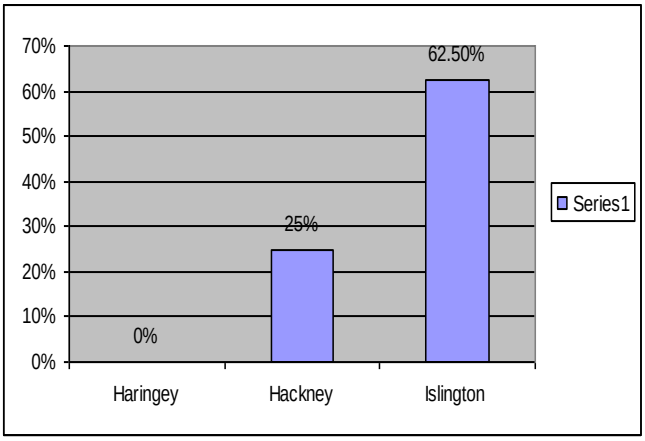
19. Percentage of children or young person who had <u>not</u> been seen by an optician.



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



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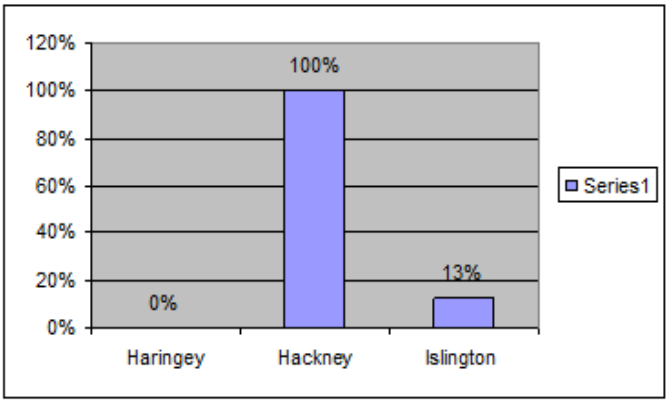
21. Number of reports where the Recommendations did not indicate clear time scales.



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.

<u>Conclusion and Recommendations.</u>

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

Appendix 4

Draft Terms of Reference Haringey Children in Care Operational Group

Date: TUESDAY 20TH 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.

Appendix 5 **Comments and feedback from Children, Young People and those**

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 bu

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 wa very smi professio

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

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

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

Health assessment well done. Health assessment was thorough and ful. A few things feedback

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 Overal Inform Comfo atmos Excellent

xxx

is fine

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 [illegible]sessment
The bo[illegible]to talk abo
ther[illegible]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.

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.

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

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

WHAT DIDN'T YOU LIKE?

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

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

Offer a wider variety of slots.

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

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