NHS
Corby Clinical Commissioning Group

NHS
Nene Clinical Commissioning Group

Promoting the health and wellbeing of children in care in Northamptonshire

Annual Report 2014-2015

June 2015

Contents

Executive Summary

This report describes how health commissioners and providers have worked together, in partnership with the local authority, to meet the health needs of Northamptonshire's looked after children (LAC) between 1 April 2014 to 31 March 2015. It reports on the achievements, progress and challenges encountered. It sets out the current work and priorities for the coming reporting year.

The focus for the reporting period has been to deliver improved partnership working for looked after children and to demonstrate that services and outcomes for our looked after children has taken on board the findings from recent inspections.

There was major organisational and systems change within the service structure in 2012/13. The annual report for the previous reporting year outlined the significant progress that had been made in achieving statutory timescales for delivery of initial health assessments. This report describes how progress has been sustained and built upon. The 'Be Healthy' subgroup which is overseen by the Corporate parenting board (with representation from health commissioners, providers, local authority adoption and care service teams, Independent Reviewing Officer (IRO), education) has driven improvements through its action plan which captures the priorities which have been set following key events.

- An Ofsted (the Office for Standards in Education, Children's Services and Skills) inspection took place in July 2013. The findings indicated the need for work to improve the timeliness of initial and review health assessments, to improve the provision of Children and Adolescent Mental Health Services (CAMHS) services particularly for children who self-harm and to simplify referral routes and processes to access CAMHS services. The overall findings for safeguarding and looked after children service provision across the partnership were judged inadequate.

- There has been a Northamptonshire Improvement Board (NIB) in the county following on the 2013 inspection. An Adoption Improvement Board (AIB) has also been established as a task and finish group alongside the Northamptonshire Safeguarding Children Board (NSCB) and its Quality Assurance and Audit sub-group. The in-depth action plans, audit findings from these groups and the scrutiny provided by both the Executive Support Groups to the Corporate Parenting Board and NSCB continues to play a pivotal role in driving improvement against our priorities.

- Issues of delays in notification to health from the local authority when children become looked after and the obtaining of consent in a timely manner have not only improved but continue to show a month on month improvement. There has been co-location of the teams from the local authority and the health providers. There are regular reports to the 'Be Healthy' sub group with extraordinary reporting so that underlying factors are addressed with escalation to the aforementioned groups if required.

- In March 2015, the Care Quality Commission (CQC) carried out an inspection of health services for looked after children under section 48 of the Health and Social Care Act 2008. This inspection focussed on evaluating the experiences and outcomes for services which contribute to safeguarding and looked after children services. Though the written report is awaited, the partnership has taken on board the verbal feedback given and has put a framework in place to improve and assure the quality of the health assessments undertaken, ensure the action plans are specific, measurable, achievable, realistic and time limited (SMART) and that the voice of the child and young person is reflected in the assessments.

- Since the 1 February, 2015, NHS Nene and NHS Corby Clinical Commissioning Groups have appointed a community paediatrician to the role of the Designated Doctor for looked after children. This role had previously been undertaken by the Designated Doctor for safeguarding. The separation of these two roles has had the added benefit of stronger working and improved capacity and output across both designated safeguarding roles. There continues to be close oversight from the Deputy Director of Safeguarding and lead commissioners in the CCGs.

- There is also partnership work in progress to establish closer working with the professionals working within the adoption medical service. The aim is to work towards a seamless health care plan which follows the child regardless of the type of placement arrangement deemed suitable (adoption, long term fostering, special guardianship, or a return to parents). This work is taking place alongside quality improvement work, process mapping and peer review processes.

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1. Introduction

Looked after children and young people share many of the health risks and challenges of their peers, but often to a greater degree. There are issues of discord within birth families, frequent changes of home and school with higher risk of access to the support and advice of a consistent trusted adult. Children often enter the care system with a worse level of health than their peers, in part due to the combined effects of the impact of poverty, poor parenting, chaotic lifestyles, abuse and neglect. The impact on the child's emotional health and psychological wellbeing cannot be overstated. Longer term outcomes for looked after children have been consistently reported to fall behind that of their peers.

Looked after children can be accommodated in a number of different types of placement. Some children continue to live, or return to the care of their parents, while subject to a care order. Nationally, around 70% of looked after children are in foster care (placed with local authority or independent agency foster carers), or in a connected person (family or friends) placements. These are all vetted. Some young people live in supported accommodation or move to independent living. Other arrangements are put in place for children with more complex needs. A small number of children live in secure settings.

Regardless of the legal status and placement, all looked after children should have access to the same universal, targeted and specialist health services and receive the same quality of services as do children living with their parents.

2. Statutory framework, legislation and guidance

2.1 'Promoting the health and wellbeing of looked after children – March 2015'

This statutory guidance issued jointly by the Department of Education and health. It is issued to local authorities, clinical commissioning groups, providers and NHS England. It replaces the guidance issued in 2009 which has been updated to reflect reforms to the National Health Service following the Health and Social Care Act in 2012. It also takes account of other reforms such as the changes to the special educational needs legislative framework and the cross government mental health strategy, which emphasises that mental health is as important as physical health.

It is issued under sections 10 and 11 of the Children Act 2004 and under section 7 of the Local Authority Social Services Act 1970.

2.2 Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework, 2015

This has been jointly reissued by The Royal College of Nursing, Royal College of Paediatrics and Child Health and the Royal College of General Practitioners.

This document sets out the specific knowledge, skills and competencies which professionals working in dedicated roles for looked after children at specialist, designated and named level should possess as distinct from individuals whose focus may be centred on child protection and safeguarding.

2.3 Children Act (1989)

Under the Children Act 1989, a child is defined as being 'looked after' by the local authority if he or she is in their care or is provided with accommodation for a continuous period of more than 24 hours by the authority (section 22). These fall into four main groups:

- Children who are accommodated under a voluntary agreement with their parents (section 20)
- Children who are subject to a care order (section 31) or interim care order (section 38)
- Children who are the subject of emergency orders (section 44 and 46); and
- Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21)

2.4 Adoption and Children Act (2002)

The Adoption and Children Act (2002) contains key provisions which align adoption law with the relevant provisions of the Children Act 1989. This act determines that agencies must ensure that the child's welfare is the paramount consideration in all decisions relating to adoption.

2.5 Children and Families Act 2014

This bill makes changes to improve the timeliness of processes agencies have in place to ensure children are adopted quicker. It ensures that due regard is given to the greater protection of vulnerable children including those with additional needs.

2.6 Care Standards Act 2014

This act lays out the basis for the reform of the regulatory system for care services in England and Wales. This encompasses care services provided in children's homes, care by fostering agencies and voluntary adoption agencies amongst others. Local authorities are required to meet the same standards as independent sector providers.

2.7 The Children and Young Person's Act 2008

This act strengthens the legislative framework to enable children and young people to receive high quality care and support. Amongst other provisions the amendments to the Children Act 1989 require local authorities to take steps that secure sufficient suitable accommodation within their area and improve care planning by strengthening the role of the Independent Reviewing Officer (IRO). This relates to services for children leaving care.

2.8 Others

- *The Children and Adoption Act 2006 and associated regulations*
- *Care Matters: Time for change (2007)*

The British Association of Adoption and Fostering also issues relevant guidance and updates.

The Local Authority has a responsibility to ensure that initial and review health assessments are carried out and that health care plans are made, reviewed and delivered.

- Each child or young person should have a holistic health assessment on entering care. The Initial assessment should be undertaken by a registered medical practitioner and review health assessments may be carried out by an appropriately qualified registered nurse or midwife.

- The Initial health assessment should result in a health care plan by the time of the first review (four weeks or 20 working days after becoming looked after).

- Children up to 5 years of age should have twice yearly health assessments that takes into account their developmental checks.

- Children above the age of 5 years should have annual review assessments.

- Particular attention is to be paid to the children and young people's emotional wellbeing and mental health with links to the Strengths and Difficulties questionnaire (SDQ). This is a validated and widely used questionnaire which can be completed by carers, young people and school staff to provide a picture of the emotional wellbeing and social and behavioural functioning. It is a requirement that the SDQ is completed for all young people in care between the ages of 4 and 16 years, and that is to be used to inform their health care plans.

3. Local partnerships and forums to support looked after children in Northamptonshire and to promote their health needs.

- Corporate Parenting Board
- Northamptonshire Safeguarding Children Board
- Executive Support Group to the Corporate Parenting Board
- 'Be Healthy' Sub group of the Corporate Parenting Board
- Adoption Improvement Board

The pace of improvement in the services to looked after children has also been driven by the Improvement Board.

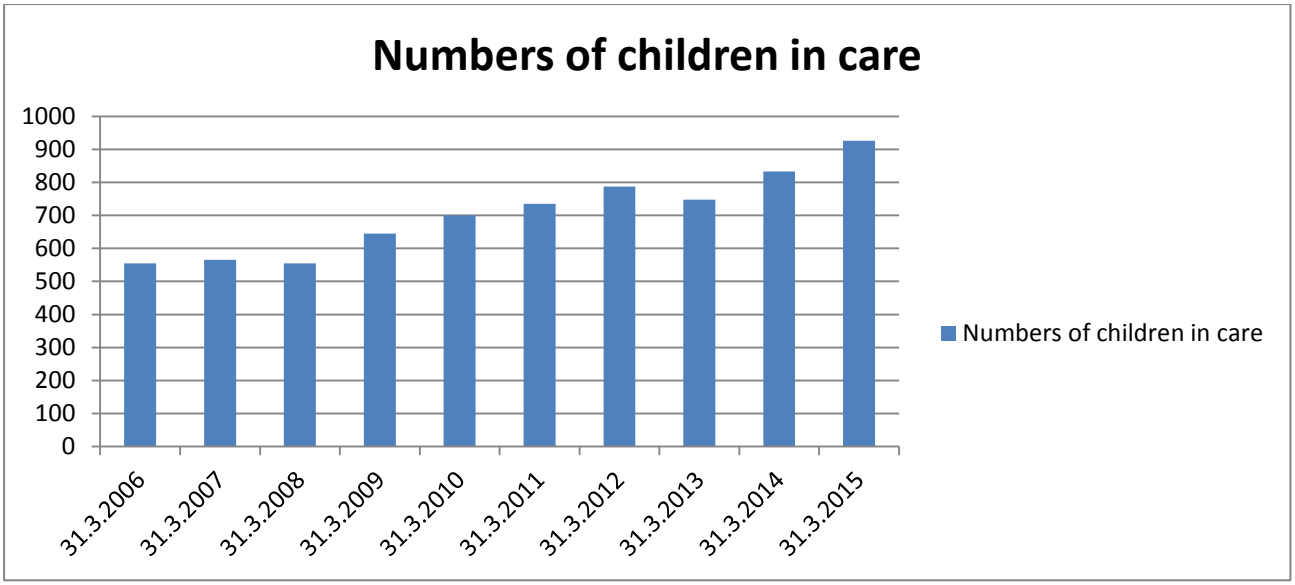
4. Profile of looked after children in Northamptonshire

Nationally there has been a year on year increase in the population of looked after children. Northamptonshire has followed that trend.

By the end of the reporting year, Northamptonshire had a looked after children's population of 926. Of this number within the same reporting period, there are 229 children who are placed out of Northamptonshire County.

The following table illustrates this increasing trend.

As at 31 March	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Number	555	565	555	645	700	735	787	748	833	926



This increase is being monitored by the commissioners and providers through the 'Be Healthy' sub group in order to inform work force planning.

Northamptonshire has a high proportion of unaccompanied asylum seeking children. The total number at the end of the reporting year is 97. (Appendix 1 shows two tables which provides a breakdown of the figure by age and ethnicity).

There are fluctuations in the numbers of children coming into care. In line with the national trend, boys are more likely to become looked after than girls, with 60% of looked after children being male. Nationally, the proportion of looked after children from black and other ethnic minority groups (including mixed backgrounds) is higher than that of the Northamptonshire under 18 population as a whole.

5. Organisation of Health services for Looked after children in Northamptonshire

5.1 Strategic roles

Strategic support and advice is provided by the Designated doctor and nurse for looked after children. The holders of these roles are accountable to the Assistant Director of Safeguarding at the CCG.

The Designated doctor has 2 additional programmed sessions (1 PA=4 hours) per week to deliver the role. Within the job plan of the Designated doctor, there are clinical sessions allocated to undertake an operational aspect of the role and undertake initial health assessments.

The Designated nurse also holds the role of designated nurse for safeguarding. In conjunction with the health providers, both designated professionals participate in the quality assurance of the Initial and review health assessments.

5.2 Integrated LAC health team

In 2012/2013, an integrated health and social care administration team was initiated. Following a period of delay, there is now co-location of Northamptonshire County Council

(NCC) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) administration teams. The purpose of this is to facilitate timely information sharing and requests for initial health assessments when children come into care.

Joint data tracking meetings have continued which is monitored through the 'Be healthy' sub group.

5.3 Work force

Appendix 2 shows the structure of the Integrated LAC team within NHFT.

5.4 Initial and Review health assessments

Children coming into care should receive an Initial Health Assessment within 28 days of becoming Looked After.

Initial Health Assessments (IHA) are carried out by Community Paediatricians from 2 provider organisations (NHFT & Northampton General Hospital NHS Trust (NGH)) and should be completed 25 days from notification by NCC.

The current transformation programme will bring NGH and NHFT into one service with NHFT the Lead Provider which will improve the interface between the 2 services and improve the experience for service users.

There is a connected situation with regard to increased demand for Adoption Medicals (Children and Families Act) which has a direct impact on the context and demand for Initial Health Assessments as children are 'twin' and 'triple' tracked to prepare for every possible outcome for permanence.

We are currently amalgamating the administrative processes for all Health Assessments by co-locating the administrative teams from NHFT and NCC.

The local CCG performance target for completion of Independent Health Assessments (IHAs) within 25 days is set as 85%.

Review Health Assessments (RHA) take place annually or bi-annually for under 5's. Health Visitors complete the bi-annual assessments for the under 5's and Specialist Health Assessors, over 5's.

The local CCG performance target for completion of Review Health Assessments (RHAs) due based on the Care Start Date is 85%.

We have made good and steady progress with RHAs although there have been a number of months when the 85% target has not been reached. We continue to develop our services to ensure we are offering a range of appointments and have recently introduced clinic appointments. Future plans include better use of IT (eg Skype) and the introduction of Saturday and evening clinic appointments.

5.5 Children leaving care

Care leavers are offered health reviews by the LAC assessors with a copy of the health summary, which includes key information such as immunisation details. This was a key

requirement of the 2011 joint inspection and the 2013 Ofsted inspection, which has now being achieved.

It has been recognised both nationally and locally that the information gathered from a final review health assessment is critically important in the transition of health care needs for young people leaving care. The higher prevalence (NICE – 60% of Looked After Children will have emotional well-being and mental health needs) of both physical and mental health needs are indicative for a more positive transition into adult health services. Final review health assessments are completed within the 17th year of a young person in care. The local authority leads on facilitating pathway planning meetings, all health information should be embedded in a report following this meeting.

A project undertaken by the team to evaluate and audit the current systems in place for children leaving care in regard to the quality and timing of the information shared between children's health and the local authority is reported in Appendix 3.

The recommendations made contribute to the performance and quality priorities across the partnership.

The review and improvements to the offer to our care leavers is a key aspect of the action plan of the 'Be healthy' sub group which is reviewed against objectives on a regular basis.

5.6 CAMHS Provision for Looked After Children

The CAMHS element of the Integrated Health Team for Looked After Children has the responsibility for assessing and planning interventions with the children, young people, carers and families of Looked After and Adopted Children in Northamptonshire with regard to emotional well-being and mental health difficulties.

A team of 4 clinicians cover the large geographical area of Northamptonshire and an increasing population of looked after children in a wider social context of increasing referrals to CAMHS services.

Working with Looked After Children differs from other CAMHS work in that the social and attachment context is important to understand. In addition to this there is a requirement to understand the statutory process and multi-agency working necessary to achieve successful outcomes for this client group.

The emotional wellbeing and mental health of Looked After Children is of paramount importance as Looked After Children experience the same difficulties but with much higher frequency as the general population. The emotional wellbeing and mental health needs of Looked After Children are well documented in NICE Guidelines 2010.

The NHFT CAMHS-LAC team works with Looked after Children, Adopted children and children in connected persons placements.

There were 224 referrals into the CAMHS LAC service from Jan – Dec 2014 and an additional 53 referrals for children from Other Local Authorities (OLA's).]

The CAMHS LAC team is able to offer psychology, social work and specialist CAMHS nursing services (2 Social Work posts are vacant and we are working with NCC to get these posts filled).

Referrals to the CAMHS-LAC team are processed at the ATLAS multi-agency meeting. (The ATLAS name was chosen in consultation with young people and is not an acronym). In these meeting representatives from Health, Education and Social Services make joint decisions on the appropriate actions to take following a referral.

The possible outcomes are:

- Social Work consultation, where, the child's social worker and carers are invited to meet with a team member to discuss a child's needs. The information gathered at this meeting is presented back to the ATLAS panel to plan further actions.
- Initial Assessment, where, the child is seen to assess their mental health needs.
- Consultation with the Specialist Educational Psychologist.
- Feedback to the social worker via the social work management structure.
- Signposting to an appropriate service i.e. Service 6/Serenity for post- abuse work.

In addition to consultation and initial assessment the CAMHS-LAC team provide where appropriate:

- Short term pieces of individual work focussing on specific mental health difficulties Family based attachment interventions i.e. Theraplay or Dan Hughes Dyadic Developmental Psychotherapy (DDP).
- Individual work with carers or adopted parents.
- Group work for carers.
- Work closely with NCC residential care homes and private providers who accommodate Northamptonshire children.

The full time clinicians in our team carry a caseload of between 20-30 children, young people or families at any one time.

In 2014 NHFT delivered our key training programme for foster carers and adopters, Managing Behaviour with Attachment in Mind (MBAM). This training was facilitated 9 times and we had 107 attendees and we have been approached by neighbouring counties and an independent fostering agency to offer this training. Courses are commonly attended by two adults per child and are run over 6 weeks, two hours per week. The aim of the course is to increase knowledge of attachment disorder, make people more aware of the types of difficulty commonly associated with attachment disorder and to introduce the DDP model of interaction known as PACE. The feedback we receive from this group programme is very positive and we receive referrals from social workers specifically requesting that carers attend MBAM.

In addition, NHFT co-facilitated, with Kate Cairns Associates, 'Five to Thrive' training for foster carers which focused on repairing early attachment and secondary trauma. We are currently developing a 'Five to Thrive Toolkit' for foster carers which will support carers to improve attachment behaviours by including attachment promoting behaviours as part of their day-to-day care. In 2015 we have increased the frequency of groups across Northamptonshire and will be offering evening groups to ensure accessibility.

6. Priorities which were set in the preceding reporting year's annual report

As the performance and activity data in further sections will show, there has been significant improvement with ongoing work in these priorities. Some have been partially achieved and scoping work has been undertaken to understand the challenges presented by those that have not been achieved. Business case has been submitted to the CCG in relation to the issue of the lead health professional role:

- A continued drive to improve the timeliness of Initial health assessments, with a focus on partnership working arrangements to ensure that accurate and timely information sharing on children coming into care to support improvement in the numbers of children for whom assessments can be completed within the statutory timescale.

- Maintain and further improve the percentage of review health assessments completed within statutory timescales

- Ensure that by the end of 2014/15, all children and young people who are looked after have an identified lead health professional

- Develop a robust quality assurance process which makes use of the data recorded in the summary questionnaire and through this demonstrate over 2014/15 clear and effective health plans to respond to issues such as substance misuse and improvement in key indices such as the number of children accessing dental reviews.

6.1 Performance

The local CCG performance target for completion of IHAs within 25 days is set as 85%. An average completion rate for IHAs per month has increased from 72% in 2013/14 to 82.08% in 2014/15.

The local CCG performance target for completion of RHA due based on the Care Start Date is 85%. An average completion rate for RHAs per month has increased from 64.8% in 2013/14 to 84.43% in 2014/15.

	Number of Initial Health Assessments due to be recorded as completed within 25 days from notfication	% of Initial Health Assessments sent to IRO within 25 days of receipt of notification each month (All Ages)	Number of Review Health Assessments that were due to be recorded as completed in month	% of Review Health Assessments due to be recorded as completed on care first and uploaded onto alchemy in month that were completed within timescale
Apr-13	3	66%	35	33%
May-13	5	89%	37	30%
Jun-13	12	41%	92	26%
Jul-13	18	16%	45	53%
Aug-13	25	68%	45	57%
Sep-13	11	100%	47	85%
Oct-13	27	92%	49	88%
Nov-13	29	86%	57	81%
Dec-13	31	64%	51	84%
Jan-14	20	85%	56	85%
Feb-14	37	61%	58	88%
Mar-14	36	76%	57	86%

	Number of Initial Health Assessments due to be recorded as completed within 25 days from notfication	% of Initial Health Assessments sent to IRO within 25 days of receipt of notification each month (All Ages)	Number of Review Health Assessments that were due to be recorded as completed in month	% of Review Health Assessments due to be recorded as completed on care first and uploaded onto alchemy in month that were completed within timescale
Apr-14	30	68%	124	43%
May-14	57	79%	72	71%
Jun-14	31	68%	50	84%
Jul-14	41	86%	55	82%
Aug-14	28	73%	44	75%
Sep-14	22	76%	66	82%
Oct-14	36	91%	86	83%
Nov-14	33	84%	68	83%
Dec-14	56	60%	53	87%
Jan-15	33	76%	71	85%
Feb-15	42	81%	73	87%
Mar-15	37	89%	80	84%

6.2 Reasons for target breaches include:

- Young people refusing IHA.
- DNA's resulting in lateness of report.
- Referrals discharged form care prior to the assessment.
- IHAs not completed or completed late for children placed out of county.
- Recording inaccuracies / completed and distributed outside timescales.
- IHAs completed on time but written reports sent late to the IRO.
- IHAs not completed.

Actions taken to avoid breaches include:

- Monitoring of clinic capacity to ensure most efficient use of appointments.
- Providing additional Community Paediatric appointments.
- Text/phone reminders for Foster Carers prior to the appointments.
- Weekly reports from NCC with detailed information of children coming into / leaving care / care moves.
- Meetings between NHFT/NCC to track the process.

6.3 Review Health Assessments

Review Health Assessments take place annually or bi-annually for under 5's. Health Visitors complete the bi-annual assessments for the under 5's and Specialist Health Assessors, over 5's.

The local CCG performance target for completion of RHA due based on the Care Start Date is 85%.

We have made good and steady progress with RHAs although there have been a number of months when the 85% target has not been reached. We continue to develop our services to ensure we are offering a range of appointments and have recently introduced clinic

appointments. Future plans include better use of IT (eg Skype) and the introduction of Saturday and evening clinic appointments.

Reasons for breaches include:

- Young people refusing RHA.
- DNA's resulting in lateness of report.
- Number RHAs were late and were not completed for children placed out of county. We have asked other local authorities to conduct these on our behalf but have limited control over timescale resulting in lateness.
- RHAs had recording inaccuracies or completed outside timescales.
- RHAs were not completed as young people have reached upper age limit before the RHA due date.

Actions taken to avoid breaches include:

- Both NCC and NHFT developed an accurate system of submitting and recording RHA referrals.
- There is very good forward / appointment planning.
- To mitigate DNA's and refusals carer's are reminded of appointments by phone or text.
- Appointments are agreed with carer and young person to fit in with their activities as far as is possible.
- Majority of Northamptonshire children in out of county placements are seen by the LAC Health Assessors although this is not possible in some cases due to the geographic location eg Scotland, although we do travel as far away as Wales.

7. Quality Assurance, Services and Outcomes for Looked After Children and governance arrangements

In Northamptonshire, health and local authority partners have outlined key areas of outcomes. These are:

- Key performance indicators such as the timeliness of the initial health assessment,
- the standards to which these assessments are undertaken,
- the 'SMART'ness of the action plans and
- the extent to which the assessments tells the child's story
- the relevance and continuity of all the assessments within the Looked After process are areas that the partnership are working on.

Other health outcomes which are monitored includes uptake of immunisations, dental care provision, identification of areas of unmet medical needs, monitoring of health issues for our children placed out of county amongst others.

The 'Be Healthy' subgroup of the Corporate Parenting Board is the vehicle through which these improvements are driven. There are monthly meetings with representation from across the health economy and from the local authority to drive the action plans. These plans are continually updated as priorities are achieved. The Corporate Parenting Board has governance oversight to the activities of the sub group.

Nationally, there has been a steady rise in the number of children coming into care and this is well reflected within Northamptonshire, where numbers have doubled over the past 2/3 years from 450 to over 900. This has resulted in a significant increase in the number of requests for both Initial and Review Health Assessments. We have put in additional resource to deal with the increase in Initial Health Assessments and Adoption Assessments, and are planning to increase resource to address the rise in the numbers of Review Health Assessments and the implementation of the Lead Health Professional Role for Looked after Children. Recurrent funding for this increase in resource has been identified within the 2015/16 CCG contract settlement and will be allocated following final contract sign-off**.**

Looked after Children and Safeguarding services were reviewed by CQC in March 2015 as part of a 2 year programme and we are awaiting the final written report is awaited. The feedback was generally positive with some areas of learning, for example, the audit process of the clinical content of Initial and Review Health Assessments, which is now in place and described later in this report. We received very good feedback on the quality of referrals made to the MASH and a number of these redacted samples were taken away to be used as exemplars.

In NHFT we have made good progress within LAC services and have amalgamated the previously 2 discrete elements of physical health and mental health, to make up an Integrated LAC Team.

Within Northamptonshire, a required part of the health assessment process is the completion of a summary questionnaire which is directly recorded into the Child health system. It is also part of what has been put in place to hear the voice of the child. It was implemented during 2013/14 and is now established in its use across within health. It is titled ‘I want great care’

8. Voice of the Child

One way of promoting and respecting the rights of children is to ensure that they are listened to and their views responded to. It is important therefore that as far as possible, the child's voice should be heard as directly as possible and care should be taken to ensure assumptions are not made about their ability to communicate.

Where possible, children's views should be expressed in their own words and/or communicated in the way which is most comfortable for them and recorded using their own words. Where it is not possible because the child is not able to verbalise, the practitioner should use the mentalisation approach and record in their own words, and not speak for the child in the first person.

The Voice of the Child is a specific element of each mental and physical health assessment and is explicitly recorded at each interface.

‘I Want Great Care’ is an additional method of capturing the Voice of the Child and we ask that children and young people complete a short questionnaire after each appointment.

Examples of these questions include:

- What did you think about your care?
- Were the people looking after you kind?
- Did people help you understand what was going to happen?
- Did people listen to you?
- Did you feel safe?

Additional questions are asked of Carers at each appointment which include:

- Were you and your child treated with dignity and respect?
- Did you feel involved in decisions made about your child's care and treatment?

We are exploring the development of a 'LAC@nhs.net' email address which will allow children and young people to email to share any concerns they may have had during their appointment but did not feel able or comfortable share.

We are in the process of making a video clip for our website which explains and demonstrates what Children, Young People and Carers can expect when attending a health assessment. Service user input will be included in the making of this video.

9. Quality Assurance for Health Assessments

A quality standards audit tool has been developed to audit Review Health Assessments based on the following Quality Standards:

1. The assessment "tells the story" of the child clearly and comprehensively
2. The assessment reflects the voice of the child
3. The assessment effectively identifies any health needs
4. There is a linked health plan which effectively addresses identified needs.

Grading is linked to the Ofsted Judgements – Outstanding, good, requires improvement or inadequate for each of the standards.

There is now an expectation all health plans will effectively address the identified needs with a responsible person for the action identified with SMART outcomes over an expected timescale for completion and to include the named responsible Lead Health Professional.

Through the activities of the 'Be Healthy' subgroup, a process mapping meeting has been scheduled for June 2015. Clinicians mangers and key administrators who work to deliver health assessments and adoption permanence medicals will come together to consider how the child's health story can be told and actions delivered seamlessly across the various processes.

A peer review meeting which will drive the quality agenda of the group including the audit of medical assessments is also been arranged. Work on a quality framework has taken place and is presented at Appendix 4.

10. Training

There is an active training programme in Northamptonshire which professionals involved in delivering care to looked after children access.

There have been learning events from serious case reviews, multi-agency case audits, emotional health and wellbeing events on self-harm and Child sexual exploitation.

A key priority within the 'Be Healthy' action plan is training. In this reporting year 2015/2016, a programme of training has been put in place for social workers to further inform the importance of the health care assessments and the completion of health plans for children, regardless of their placements.

This will be rolled out to health visitors and lead health professionals once that has been fully established.

11. Challenges encountered and priorities for the coming year

The planned co location of NCC and the Integrated LAC team took longer to implement than planned. This has now occurred. A regular tracking of progress being made on the key performance indicators is reported to the 'Be Healthy' group. The reports so far have been encouraging and will need to be sustained.

The issue of receiving filled SDQs (Strengths and weaknesses questionnaire) has also been challenging. Progress is now been made and it remains a key priority.

The priorities for the coming year are as stated in the 'Be Healthy' action plan. A copy of the most recent version is attached at Appendix 5.

12. Conclusion

A significant degree of concerted work to drive the improvements reported in this report. The progress in achieving timeliness of assessment has been sustained from the previous reporting year. The continued focus on partnership working should be able to sustain improvements and allow progress to me made in the quality improvement, training and peer review work which is scheduled for the next reporting year.

Appendix 1

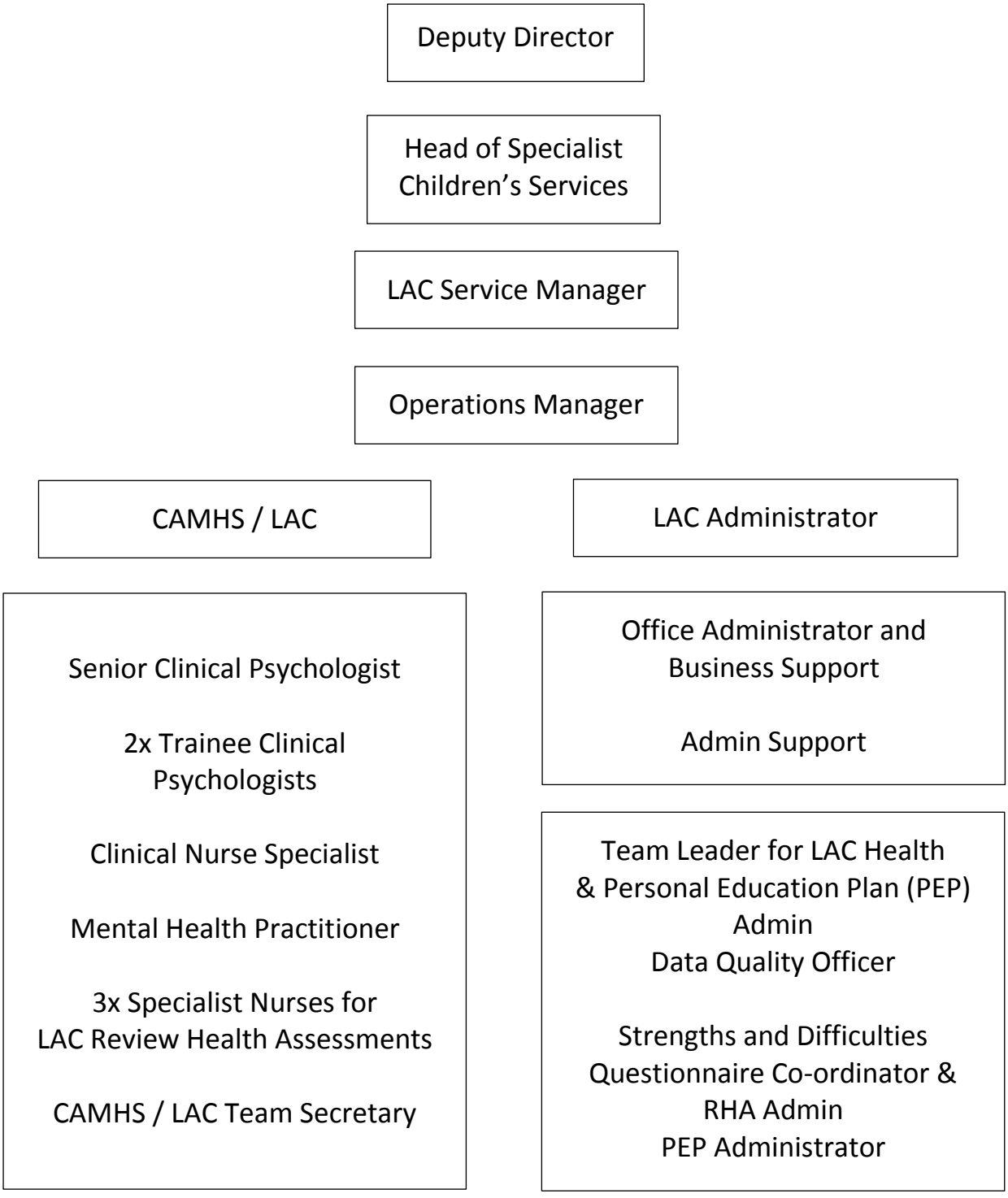
Total Unaccompanied Asylum Seekers by age and ethnicity 2014/15

Age in years	Total number
12	2
13	3
14	6
15	20
16	31
17	35

Ethnicity	Number	% of cohort
Any other Asian background	49	49.48
African	17	17.52
Any other Black background	3	3.09
Any other ethnic group	7	7.21
Arab	5	5.15
Any other White Background	16	16.49

Appendix 2

Looked After Children Integrated Team



Appendix 3

LAC Leaving Care Transitions Project

Project: To evaluate and audit the current systems in place for children leaving care in regard to the quality and timing of information shared between children's health and the local authority.

Rationale: It has been recognised both nationally and locally that the information gathered from a final review health assessment is critically important in the transition of health care needs for young people leaving care. The higher prevalence (NICE – 60% of Looked After Children will have emotional well-being and mental health needs) of both physical and mental health needs are indicative for a more positive transition into adult health services. Final review health assessments are completed within the 17th year of a young person in care. The local authority leads on facilitating pathway planning meetings, all health information should be embedded in a report following this meeting.

Introduction:

This project identified the need to scope young people leaving care (LAC) aged 17 years to 17 ½ years between the months of January 2015 and the end of June 2015. These were identified through SystemOne where 70 young people's health records are registered. These 70 young people were then cross referenced on Care First (NCC database) and further detail was extracted from this information.

Method:

Information was audited by both myself and an NCC colleague. The information was gathered by administrators.

Findings:

- 64 of these young people were known to both the Northamptonshire local authority (NCC) and NHFT – children's services. All these young people had a pathway plan in place and either a completed final review health assessment or a date in which to complete the final health review assessment. Dependent on the date at which a pathway planning meeting was held reflected as to how current the health needs reported were.

Objective	So far	Ongoing action
To scope young people who are aged 17 to 17.5 years between January and July 2015 that are known on systemone as looked after children.	70 young people identified. • 10 of these known to CAMHS. • All had an up to date Final RHA or a date identified.	
To cross reference young people through care first and identify service input – NCC transitions team/Leaving care team.	Cross reference with both teams and findings: • 16 young people not known or closed to NCC LAC. • 0 are not known to the NCC transitions team. • 2 were re assessed by immigration and age changed.	
To identify which young people have transition plans and look at content – health input.	All young people from this cohort have pathway plans in place.	
To identify 20% of young people from this group that have Final RHA and identify if this information is reflected in a pathway plan.	65% of the health information in a pathway plan was reflective of final review health assessment.	Report findings to relevant services.
To identify mental health input and transition planning.	Very few young people have current mental health input.	To further investigate and share findings.
To review processes and protocols in place for CAN to input into pathway plans.	Meetings held with CAN team, recognised obstacles in inputting into pathway plans. Primarily confidentiality. CAN to discuss project with clients and gather consent for info to be shared.	A number of CAN clients have agreed to share info and also meet with myself to discuss/reflect on their involvement in pathway planning.

Recommendations:

Both health and local authority have processes in place (health – Final review health assessments) and NCC pathway planning meetings. Due to limited collaborative processes in place, health reporting can often take place a few months prior to, or after a pathway planning meeting. Though a lot of information maybe static (immunisations/diagnosis/health conditions), current care plans need to be embedded in an accurate and timely way.

One suggestion is that final review health assessments take place on the day of a pathway planning meeting as there is often increased commitment to attend these meeting by the young person.

Vic Evans

Transitions Co-ordinator in Health

Appendix 4

Looked After Children Qualitative Audit 2014

LAC initial and review health assessments – Audit Process and Quality Standards

Audit process: All permanent clinicians regularly undertaking health assessments i.e. LAC health assessors and paediatricians providing LAC clinics, are part of the core audit team. Paediatricians in training and Health visitors are encouraged to participate. Other interested clinicians may participate in audit meetings by invitation.

Monthly audit meetings will have typically 4-6 participants. All core members of the team should participate at least three times per year. Each participant will review an initial or review assessment against the quality standards and give a grade for each standard. This should take around 10 minutes. There will then be time for discussion to check judgements eg to recognise any particularly good practice and to establish a consensus consensus for any assessments which do not clearly meet the standard for "good". Any poor practice (i.e. an inadequate grading)and in particular evidence of unmet needs or other risk will need discussion to agree remedial actions, including arrangements for practitioner feedback and any actions to be assured of the health of the child or young person. In a one hour meeting this process can be repeated, so typically around 10 assessments can be reviewed in each meeting, and 100+ per year assuming monthly meetings.

A coordinator within the LAC health assessor team will be responsible for printing off cases for audit. Cases will be selected randomly from IHAs and RHAs completed in the previous month but the coordinator will ensure that at least 5 assessments per year are audited for each member of the core audit team.

The quality standards are as follows:

1. The assessment "tells the story" of the child clearly and comprehensively
2. The assessment reflects the voice of the child
3. The assessment effectively identifies any health needs
4. There is a linked health plan which effectively addresses identified needs.

Grading will be linked to Ofsted Judgements – Outstanding, good, requires improvement or inadequate for each of the standards.

Descriptors of a good standard of assessment are given below. Assessments not fully meeting good standards will be graded as "requires improvement". Assessments should be graded inadequate where there is no information about the child's health history, no evidence of engagement with or

consideration of the voice of the child, where the auditor considers that significant health needs have not been recognised or addressed. An outstanding assessment will meet the criteria and in addition show some or all of the following: high levels of flexibility and commitment to engagement with a young person; innovative approaches to addressing unmet health needs; specific actions by the assessor with a focus on addressing a specific health need and improving the health of the child.

A good assessment:
The health summary report provides a comprehensive narrative of the child's health and developmental history in a way that will be informative to the social worker, foster carer and older child or young person.

It should be comprehensive and should include place of birth, gestation, birth weight, any antenatal or postnatal concerns and any treatment required around the time of birth. This will not need to be repeated on every occasion but the assessor should then comment that a comprehensive birth history is available. Where there are information gaps, the assessor should note these and there should be an action in the plan to address these.

Family history should include any known physical, developmental or mental health issues for parents and siblings, including drug and alcohol problems. Where this information is not known, this should be noted and actions developed in the plan to obtain this information if possible. Once a comprehensive family history is available this can then just be noted in the summary, unless there are family health issues which may have on-going implications for the child in which case this should be recognised within the child's health needs and plan.

The summary should provide a concise but comprehensive picture of the child's current physical, emotional and developmental status.

The summary should also cover immunisations, dental and eye checks. Lifestyle issues and health promotion should have been covered comprehensively in the assessment – if there are no needs at all, an appropriate statement could be "(CHILD) has a healthy weight, no lifestyle issues have been identified and both he and his carer know how to access a range of health promotion information resources".

The assessment and health summary reflects the voice and experiences of the child
The assessment should show that the child's own views on their physical and emotional health were sought, that they had opportunities to discuss any worries or concerns about their health, and opportunities to discuss a range of health promotion and lifestyle issues more generally.

Where the assessor considers that the child or young person is not able to engage fully in a health discussion, alternative and preferred sources of advice and information should be explored. Appropriate follow up actions should be developed in the plan to develop assurance that the young person can discuss and get advice on health issues from trusted and reliable sources.

Age appropriate views on health and wellbeing can be sought form all but the youngest children eg what they like to eat, favourite activities, who to talk to if they are sad, do they like going to see the doctor or nurse.

For pre-verbal children the voice of the child should be reflected from direct observations of the child's emotional state and interactions, supplemented by reports of observations from carers and social workers on issues such as separation and night settling, presentation at and after contact, any anxieties or fears in other situations, seeking comfort or reassurance, to allow an overall view of the health and in particular emotional wellbeing of the child.

For children with developmental communication difficulties it will be particularly important to explore how the child communicates likes, dislikes, fears, enjoyment, interest and so on.

The assessment effectively identifies any health needs

Where there has been a comprehensive assessment the identification of needs should follow in a straightforward way. There should be identified needs in all cases because -

- In all cases children will need to access routine preventive health care including eye and dental checks
- In all cases, children should be able to access health promotion information from trusted and reliable sources
- Any level of developmental or emotional concern (or risk eg based on significant adverse experiences, for children coming in to care) should be recognised as a need, although the action required may simply be monitoring by the carer with advice on contacts and service for further concerns

There is a linked health plan which effectively addresses identified needs

Needs, as outlined above, should be identified in the health plan. For each identified needs there should be one or more specific actions, with the responsible person for the action identified and an expected timescale.

Appendix 5

Be Healthy Sub-Group Action Plan

Objectives from the Corporate Parenting Strategy

Looked after children can access the same universal, targeted and specialist health services and receive the same quality of services as do children living with their parents. Where they have specific needs or have difficulty accessing mainstream services, looked after children receive specialist and/or dedicated services to meet these needs. Differences in health outcomes are reduced with the aim that looked after children can be as physically and mentally healthy as any other children in Northamptonshire**.**

Membership

Chair: Michelle Dominic, Designated Doctor for Looked After Children
Councillor: Wendy Brackenbury
Members: Jackie Adams – IRO, Julie Ashby-Ellis – Designated Nurse LAC, Aruna Bhala – Paediatrician, NGH, Matthew Estill – Specialist Senior Educational Psychologist, Jane Hadley – Service Manager Safeguarding, Sian Heale – Commissioning Manager (Children and Young People with Complex Needs and Continuing Care), Mikesh Kotak – Service Manager LAC North team., Sharon Robson – Head of Specialist Children's Services, Abi Gibbs Fostering Service

1	**Looked after children to have timely and high quality assessments and services by appropriately qualified staff who have easy access to knowledge held by social care colleagues.** (Key areas for development from the Corporate Parenting Strategy– 1, 2, 3 & 6).					
	Action	**By When**	**Delivery Lead**	**Target & Measure**	**Links to other plans**	**RAG**
1.1	Looked after children receive initial and review health assessments within timescales. Agreed reporting mechanisms to be established with exception reporting to allow the Be Healthy subgroup to identify further actions to address any systematic barriers to achieving targets.	IHA / RHA in timescale is ongoing. Joint mechanism by end Mar 15	Charlotte Bucknell, Sian Heale, Sharon Robson	Joint reporting mechanism and issues escalation process in place. Performance Tracking. 85% for IHAs and RHAs. Joint process has been agreed and is in place. Format for breach reports and issues escalation process agreed.  IHA process flowchart.doc	Improvement Plan 3.3.3	G
1.1a	Breach reports from health and NCC to be presented to the sub-group.	From May 2015 and every month thereafter	Sharon Robson, Charlotte Bucknell	Target: NCC 28 days from entering care – 75% NHFT: 25 days from referral – 85%.		A

1.2	Ensure that social workers engage with the health assessments process for children on their caseloads. Social workers to provide thorough, timely reports to health professionals and to attend health assessments where appropriate. • Communication from senior management to all children's social work teams regarding this standard. . • Establish recording arrangements and obtain baseline and reporting to sub-group	End May 15 End May 15	Mikesh Kotak Sharon Robson / Mikesh Kotak	Audit of feedback from paediatricians confirms adequate information / appropriate social worker attendance (or availability) to allow high quality assessments to be done.	Action 1.6 (health training for social work staff)	R
1.3	Agree process and standards to provide health summaries and plans for children with disabilities / complex medical needs, reducing the need to attend a separate appointment. Update Jan 15 – draft guidance circulated	End June 15	Michelle Dominic	Audit evidence – high quality health summaries and plans. Reduction in number of children attending multiple appointments.		A

1.4	A model for provision of the lead health professional role and an implementation plan to be agreed between health commissioners and NHFT.	Model and implementation plan agreed by end Feb ’15.	Sharon Robson / Sian Heale	Model and implementation plan to be written. Numbers / percentage of LAC with named lead health professional. *This has been scoped and a business case for additional resource put to the CCG. Within resource we have introduced the Lead Health Professional Role within Health Visiting, Special Schools and for LAC placed out of county.* *We will increase this function if / when funding is increased.*		A
1.5	CPD programme to meet intercollegiate competency framework requirements for health professionals to be developed and implemented.	Audit by May 15 Ongoing development programme.	Sharon Robson	CPD strategy agreed. % of staff meeting training standards. *Audit undertaken to identify training needs. Meeting booked to develop action plan.*		A

1.6	Develop and implement a training strategy for LAC workforce across health and social care, to ensure that all staff and carers understand the health needs of looked after children, local health service arrangements to meet these.	Training strategy agreed by end May 15 Training to commence from June 15 Completion end 2015	Julie Ashby-Ellis (health) Mikesh Kotak (social care)	Training programme in place. Audit evidence of improved social work engagement.		A
1.7	Emotional health and wellbeing pathway to be updated and re-launched – to provide clear guidance on support offer and referral routes at all levels of need.	End March 15	David Loyd-Hearn (with Mikesh Kotak, Matthew Estill) Sharon Robson)	Outcome evidence to be developed. *Pathway documents in place (draft) pending adoption by the Healthy Young Minds Sub-group when they will be finalised and circulated.*	Improvement Plan 1.4.6	G
1.7a	Further document to be written and circulated setting out the health offer for those with emotional health and well-being issues as per the threshold document at 1.7.	End May 15	Sharon Robson	Health offer document written and circulated.		R

1.8	Develop an implementation plan for "five to thrive" interventions for looked after children.	By end Dec 14	Anwen Pugh	Plan written. Implementation starts. *An annual report is being produced by the Steering Group on the activity of Five to Thrive over the past year.* *It will include action plans from each of the organisations on how they will take the methodology forward. The two main areas of focus from NHFT are within Health Visiting and* LAC.  Five to Thrive Implementation...  FTT LAC Factsheet.docx		A
1.9	Develop effective processes to allow carers and children to complete SDQ's and use these to inform assessment and planning at health and LAC reviews.	Re-launch by end March 15 Training by end May 15 Completion end June 15	Mikesh Kotak, Matthew Estill, Richard Lindsley	Process re-launched. Training delivered. Increased return of and use of SDQ. Monitoring via 13 week plan.	Improvement Plan 3.3.3	A
2	**LAC to be provided with information about their health and the full range of services available.** (Key area for development from the Corporate Parenting Strategy – 5).					

2.1	Service information leaflets to be developed to inform and prepare children and young people for health assessments.	By End June 15	Sharon Robson	Health assessment leaflet produced. *I have engaged NHFT comms team to assist with this. Am hoping to involve young person in video describing their experience. Have contacted Hospital and Outreach.*		R
2.2	Information resource list to be developed and maintained, to include service information leaflets re sexual health, drug and alcohol service, mental health resources eg Ask Normen, general health advice resources for young people.	By End May 15	NHFT Health Assessors	Recommended resource list drawn up and made accessible to all health staff working with LAC, social workers and foster carers, link on relevant websites etc. *This action may be covered by the links on Ask Normen. Evidence requested for May meeting to show whether this site includes the information needed and that the relevant parties are aware of the site.*		R

3	**LAC to be given the opportunity to provide feedback about their experience of health provision.** (Key area for development from the Corporate Parenting Strategy - 4).					
3.1	Feedback from questionnaire to be incorporated into regular reporting arrangements.	Interim Report Jan 15 Annual report May 15	Sharon Robson	Service user feedback to be included in annual report, interim report to Be Healthy sub-group. Be Healthy Interim Report Action LAC 3. *I Want Great Care is embedded which provides regular feedback which is used to inform service improvements.*	Improvement Plan 2.1.7 / 3.1.7	G
3.2	Ensure the views of disabled children are sought on health assessments and services.	By End April 15	Questions / areas of concern to be provided by Helen Adams	*I Want Great Care is embedded in respite care providing feedback to inform improvements.* Short Breaks March 2015.docx Audit of voice of the child for LAC with disabilities to be undertaken.	Improvement Plan 2.1.7 / 3.1.7 Positive Contribution 1.2	A

3.3	Review / incorporate health questions in viewpoint.	By End March 15	Jane Napier to review questions / suggest changes	Viewpoint health questions reviewed and changes implemented. Review of Viewpoint questions.doc *Paper written and submitted to the group but not reviewed due to lack of time.*	Improvement Plan 2.1.7	R
4	**Meeting the health needs of target groups.** (Key areas for development from Corporate Parenting Plan – 7, 8 & 9 – 7 with **Economic Wellbeing** and 9 with **Stay Safe**).					
4.1	Ensure that health transition planning, is integrated into the pathway planning process from age 15. Including provision of a 'health passport'.	By End June 15	Sharon Robson / Vic Evans / Janet Simon	Updated Pathway Plan document created and in use with comprehensive health plan incorporated into it.	Economic Well-being 5.3 / 4.3 Improvement Plan 3.3.4 & 3.4.16	A
4.2	Care leaver health "offer" to be developed.	By End June 15	Sharon Robson	Clear offer of range of accessible services to meet the needs of care leavers is accessible to LAC and carers.	Economic Well-being 4.3 / 5.3 Improvement Plan 3.3.3 & 3.3.4	A

4.3	Ensure that health needs of UASC are being met effectively: Ensure that face to face interpreters are used at health assessments. Thematic analysis of unmet health needs of UASC to be completed, to identify any further actions required	By June 2015	Julie Ashby-Ellis, Janet Simon, Rob Turner	Where interpreter is required, Face to face interpreters available at 90% of assessments. Thematic analysis presented to CPB		A
4.4	Develop a clear offer of support to young women who become pregnant, expectant dads, and young parents. This should include FNP, alternative if FNP is not available, HV offer, other programmes, support and interventions.	By June 2015	Helen Willis, Richard Bailey and social care rep tbc	Clear offer and referral mechanism in place.	Improvement Plan 1.3.6 1.4.3 & 1.4.7	R

RED STATUS	Actions underway but no significant change in target and performance measure.
AMBER STATUS	Actions underway with evidence of significant shift and direction of travel in target and performance indicator.
GREEN STATUS	Targets and Measures met.

Glossary

IHA	:	Initial health assessments
RHA	:	Review health assessments
BAAF	:	British Association of Adoption and Fostering
LAC	:	Looked after children
UASC	:	Unaccompanied asylum seeking children
IRO	:	Independent Reviewing Officer
CQC	:	Care Quality Commission
NSCB	:	Northampton Safeguarding Children's Board
CAMHS	:	Children and Adolescent Mental Health Services
Ofsted	:	The Office for Standards in Education, Children's Services and Skills
AIB	:	Adoption Improvement Board
NIB	:	Northamptonshire Improvement Board
SMART	:	Specific, measurable, achievable, realistic and time limited
CCGs	:	Clinical Commissioning Groups
NCC	:	Northamptonshire County Council
NHFT	:	Northamptonshire Healthcare NHS Foundation Trust
NGH	:	Northamptonshire General Hospital NHS Trust
NICE	:	National Institute for Health and Care Excellence
DDP	:	Dyadic Developmental Psychotherapy
MBAM	:	Managing behaviour with attachment in mind
DNA	:	Did not attend
PEP	:	Personal Education Plan