South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Children in Care

Annual Report

2017/18

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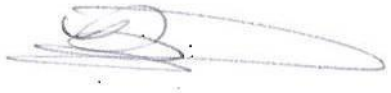
Designated Nurse Children in Care

Foreword by the Chief Nurse

NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group demonstrate a strong commitment to Children in Care within the local communities. There are strong governance and accountability frameworks within the organisations which clearly ensure that Children in Care are core to the business priorities. The commitment to the Children in Care agenda is demonstrated at Executive level and throughout all CCG employees. One of the key focus areas for the CCGs is to actively improve outcomes for children, young people and their families and that this supports and informs decision making with regard to the commissioning and redesign of health services within the Borough.



Debbie Fagan

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1. Executive Summary

1.1 This is the third Annual Report for NHS South Sefton and NHS Southport & Formby CCGs (to be referred thereafter as Sefton CCGs). The report is in relation to Children in Care (CiC) and is authored by the CCG"s Designated Nurse for CiC who commenced in post in May 2018. The role of the Designated Nurse CiC for Children in Care is a strategic role and separate from any clinical responsibilities as detailed in the *Intercollegiate Role Framework for Looked after Children (RCPCH, 2015).*

1.2 In April 2016 Sefton Metropolitan Borough Council (Sefton MBC) was subject to an Ofsted inspection of the services for children in need of help and protection, Looked After Children (LAC) and care leavers; a review of the effectiveness of the Local Safeguarding Children Board ran concurrently. The findings in relation to Looked After Children and care leavers indicated that provision required improvement. Timeliness of Initial and Review Health Assessments was found not to be good enough and delays for some children in receiving Child and Adolescent Mental Health Services (CAMHS) was highlighted.

1.3 In November 2016 Ofsted and the Care Quality Commission (CQC) conducted a joint Special Educational Needs and/or Disabilities (SEND) inspection in Sefton to judge effectiveness in the area of implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. As a result of the findings of this inspection Her Majesty's Chief Inspector (HMCI) determined that a Written Statement of Action was required due to significant areas of weakness in the local area practice. Areas of improvement were identified in relation to LAC with timeliness of Initial Health Assessments (IHA"s). In addition, it was recognised that the alignment of LAC statutory health plans with Education and Health Care Plans (EHCP) was required to appropriately inform the overall care planning process.

1.4 It is the role of Sefton CCGs and commissioned services to address the unmet health needs of LAC by working in collaboration to empower young people and enable them to reach their full potential. Health, in its broadest sense, is the key to allowing children and young people to benefit from life enhancing opportunities. The expected outcome is that all LAC, for whom the Sefton CCGs are responsible, will experience improved health, be motivated and inspired to continue to take responsibility for their own health care.

1.5 This report will provide an overview of population, outline the performance of NHS commissioned services, evidence good practice and key achievements, recognise challenges and identify developments for 2018/19.

1.6 It is produced in line with duties and responsibilities outlined in *Statutory guidance on Promoting the Health of Looked after Children (DfE/DH, 2015)* issued to Local Authorities and NHS Clinical Commissioning Groups under sections 10 and 11 of the Children Act. It is written in the context of a holistic model of health, which ensures the wider determinants of health and well-being are considered. Consideration will be given to the key messages and recommendations of the *CQC report Not Seen, Not Heard (July 2016)* alongside the findings of the *NHS England CCG Benchmarking Exercise*

2016; a piece of work commissioned by NHS England to provide insight into commissioning practice across the North of England in relation to CiC.

2. Introduction

2.1 The purpose of the report is to provide Sefton CCGs and key partners with an overview of the progress and challenges in supporting and improving the health of Sefton LAC and those placed in borough by other Local Authorities. The report has been produced in partnership with NHS commissioned health providers and covers the period from 1st April 2017 to 31st March 2018.

2.2 CiC are often referred to as „Looked After Children". In England and Wales the term „Looked After Children" is defined in law under the Children Act 1989. A child is Looked After by a Local Authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority. LAC fall into four main groups:

- Children who are accommodated under voluntary agreement with their parents
- Children who are the subject of a care order or interim care order
- Children who are the subject of emergency orders for their protection
- 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

2.3 The term „Looked After Children" includes unaccompanied asylum seeking children (UASC), children in friends and family placements, and those children where the agency has authority to place the child for adoption. It does not include those children who have been permanently adopted or who are subject to a special guardianship order.

2.4 CiC find it hard to relate to the term „Looked After" and its abbreviated form of „LAC". Many find it derogatory to be defined in such a way, often sighting that the phrase may be misinterpreted as one that implies they are „lacking" as individuals. Children also highlight that every child should be „looked after" by someone and as such the phrase does not define the uniqueness of their situation when being parented by the State. The remainder of this report will therefore refer to „Children in Care" or „CiC"; the term „Looked After" and „LAC" will only be used in a legislative context.

2.5 CiC share many of the same health risks as their peers, often however, to a greater degree, with many children and young people continuing to experience significant health inequalities. Meeting the health needs of these children and young people requires a clear focus on access to services. This approach can be assisted by commissioning effective services, delivery through provider organisations and ensuring availability of individual practitioners to provide and co-ordinated care.

2.6 Sefton CCGs are able to influence outcomes for CiC acting as a „Corporate Parent". Corporate Parenting is a collective responsibility of the Local Authority (LA), elected members, employees, and partner agencies, to provide the best possible care and safeguarding for the children in care. Every good parent knows that children require a safe and secure environment in which to grow and thrive (Sefton Corporate Parenting

Strategy, March 2017). The Chief Nurse and the Designated Nurse for CiC are partners and active members of the Sefton Corporate Parenting Board.

3. Governance, Accountability and Assurance

3.1 The NHS has a major role in ensuring the timely and effective delivery of health services to CiC and care leavers. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and The NHS Constitution for England (2015) make clear the responsibilities of CCGs and NHS England to this vulnerable group.

3.2 Accountability for Designated Professionals for CiC is set out within the 2015 NHS England Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework. Designated Professionals for Children in Care take a strategic and professional lead across the whole health community providing clinical expertise to Clinical Commissioning Groups and partner agencies on the specific health needs of the cohort.

3.3 The Designated Nurse for CiC has been hosted within the Shared CCGs Safeguarding Service during the majority of 2017-18. However on 1st March 2018 the Sefton CCGs moved from the Shared arrangement to bringing the Designated Nurse CiC post „in house". This has resulted in the existing Designated Nurse CiC, who has been in post since December 2016, covering the post whilst recruitment of a new Designated Nurse CiC was undertaken. Although outside of the reporting period, the new Designated Nurse CiC commenced in post on 21st May 2018.

3.4 Strategic oversight of services is essential to the role to ensure that robust clinical governance of NHS health services for CiC are in place. As a result assurance can be provided to the CCG"s Governing Body"s that clear commissioning arrangements are in situ and that services are fit for purpose.

3.5 Performance of NHS commissioned provider services is determined via analysis of Key Performance Indicators (KPIs) and scrutiny of the adherence to the agreed standards for CiC. The current KPI schedule for providers is monitored quarterly and reported to the CCGs Joint Quality Committee.

4. National Profile of Children in Care

4.1 The demographics for CiC nationally are taken from the Statistical First Release (SFR) England. The full SFR is due to be published for the year ending 31st March 2018 in November 2018. The data below relates to the SFR data published in March 2017.

Key Findings:

- There were 72,670 Children in Care in England as of 31st March 2017; an increase of 3% on 2016 figures and continues the trend of the last nine years
- The number of children entering the care system in 2016-17 has also risen in recent years and has increased by 2% compared with the previous year

- The number of children ceasing to be „looked after" in 2016-17 has fallen by 2% compared with the previous year

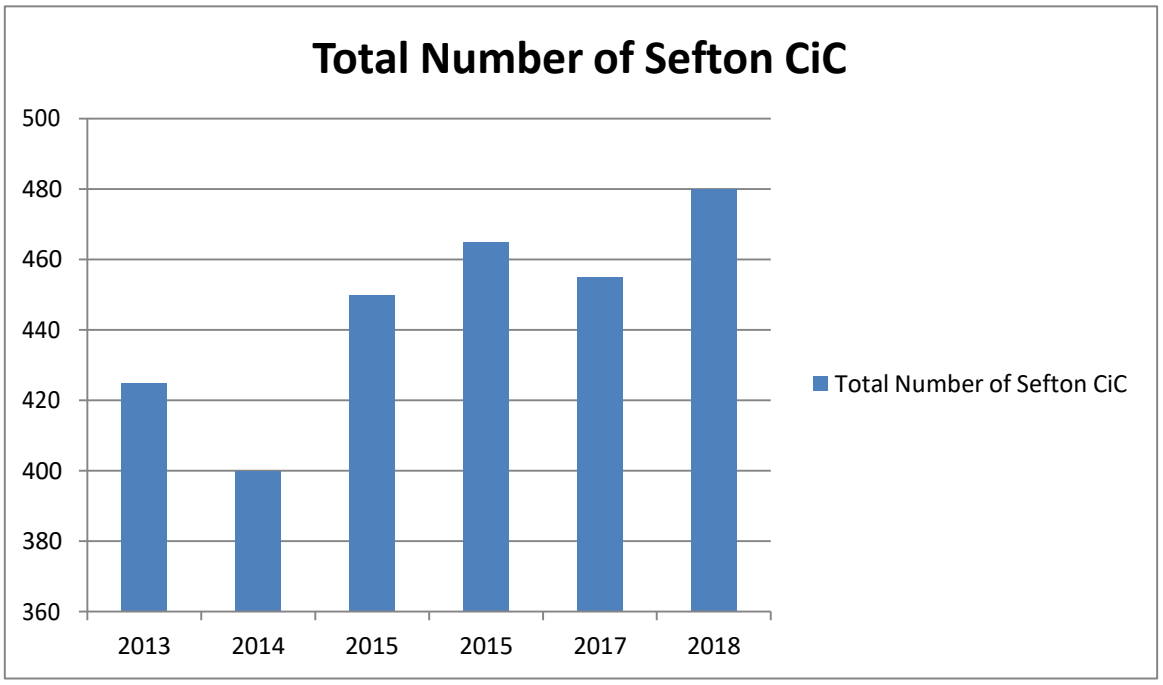
- In 2016 adoptions fell for the first time since 2011 (12%) and in 2017 the number of CiC being adopted has fallen again by 8% to 4,350

5. Overview of Sefton's Children in Care

5.1 The overall number of CiC for Sefton MBC has remained above the national average per 10,000 populations; a consistent finding since 2012. This upward trend mirrors the national picture.

5.2 Graph 1 below, indicates total number of CiC across the borough of Sefton at the end of each financial year. As of 31st March 2018 the total cohort of children in the care of Sefton MBC was **480**. Of these **250** were boys and **230** were girls.

Graph 1 Sefton Children in Care Cohort



5.3 Whilst the end of year figures above provide an overview, consideration must be given to children who may enter and leave the care system throughout the year so the total number of children cared for over the period that this report covers is higher.

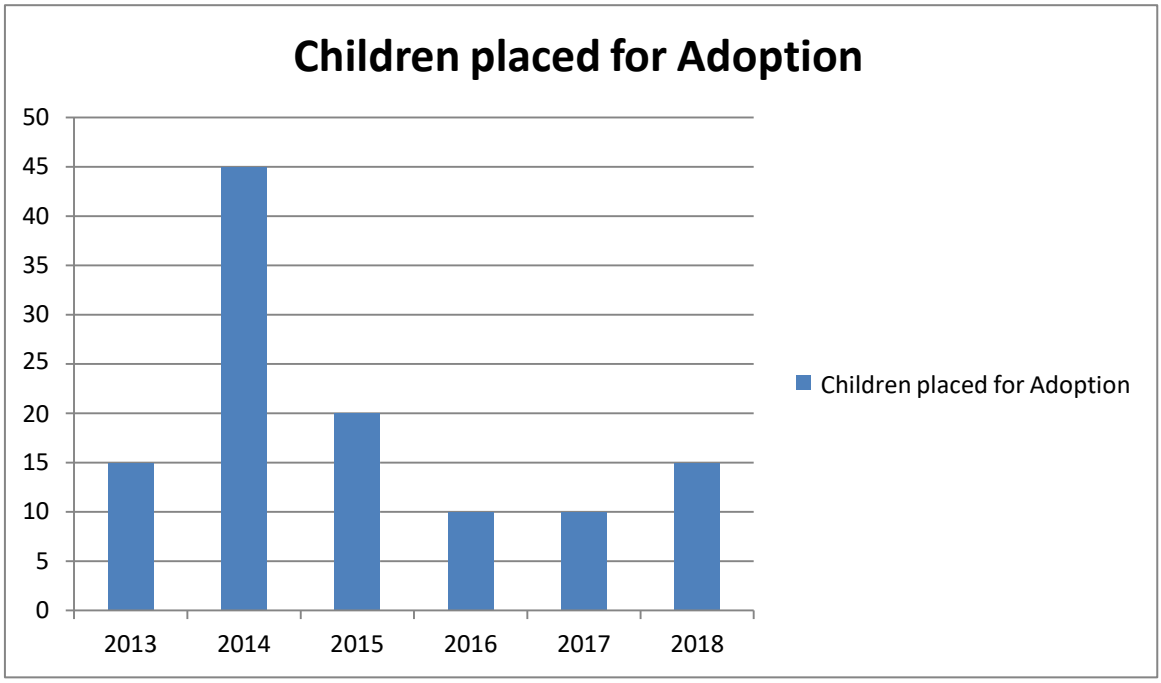
5.4 The cohort of children who have been new into care has been identified as **184**, who have required initiation of a care episode by Sefton MBC.

5.5 The number of children ceasing to be in the care of Sefton MBC by the end of reporting period was **163**; this is a decrease of **17** from the previous year. Children"s care episodes end for a variety of reasons with the majority for Sefton children achieving permanency returning to their family. The Ofsted inspection in 2016 raised concerns regarding the high proportion of CiC in Sefton who are placed at home with parents

(**21%**); as a result, Sefton MBC have focused on this group resulting in 26 children"s „placed with parents" Care Orders being discharged between September 2016 to the end of March 2017. At the end of March 2018 **17%** of CiC are placed with parents.

5.6 Sefton has seen a slight increase in children being placed for adoption during the year, with **9%** of those ceasing to be looked after and achieving permanency via this route.

Graph 2 Sefton children placed for adoption



6. Sefton Children placed out of Borough

6.1 Where a CCG or a Local Authority, or both where they are acting together, arrange accommodation for a CiC in the area of another CCG, the "originating CCG" remains the responsible CCG, and as such retains commissioning responsibilities. Sefton MBC place approximately **150** children (**31%)** out of Borough but for whom Sefton CCGs are the originating CCG. In most cases, placements within a small radius will be sought; Sefton place the majority of these children in the Merseyside area with a high proportion identified as living in the borough of Liverpool.

6.2 Assurance around health needs being addressed for those children and young people is sought via the implementation of a robust quality assurance process, audit and scrutiny. Escalation processes are embedded between commissioned health teams and the Designated Nurse for CiC if difficulties in the completion of health assessments and access to health services are identified.

6.3 During 2017/18 the Designated Nurse CiC was made aware of **14** requests for Initial Health Assessments (IHA"s) and **309** requests for repeat health Assessments (RHA"s) for Sefton children placed out of area. A number of these were duplicate requests for children under 5 years of age. However, it must be recognised that the number of

requests for health assessments over the year does not equate exactly to the number of CiC as the number of CiC over the year changes.

7. Children placed in Sefton from other Authorities

7.1. *Who Pays? Responsible Commissioner Guidance (NHS England, 2013)* states that individual CCGs have a responsibility for children and young people placed in the area whom are receiving a primary care service. However, for CiC, the overall responsibility for co-ordinating the statutory health assessment remains with the originating CCG.

7.2 During 2017/18 the Designated Nurse CiC was made aware of **27** requests for IHA"s for Children in Care Other Local Authorities (CiCOLAs) and **194** requests for RHA"s for CiCOLA"s. A small number of these were duplicate requests for children under 5 years of age. However, on average **120** CiCOLA"s will be the responsibility of Sefton CCGs at any one time. Again, it must be recognised that the number of requests for health assessments over the year does not equate exactly to the number of CiC as the number of CiC over the year changes.

7.3 Decisions to place children outside of the originating Local Authority area often relate to placements with family members or children requiring provision to assist in reducing risks related to Child Exploitation, Missing from Home or offending behaviours. Anecdotal information from provider services indicates that this population generally present with a high level of complex need.

7.4 CiC should never be refused a service, including mental health interventions, on the grounds that their placement is short-term or unplanned. CCGs and NHS England have a duty to cooperate with requests from local authorities to undertake health assessments and help them ensure support and services for CiC are provided without undue delay. Local Authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area.

8. Ethnicity

8.1 CiC are predominantly white according to national statistics; **75%** of children at 31 March 2017 were white, **9%** were of mixed ethnicity, **7%** were black or black British, **5%** were Asian or Asian British and **3%** were other ethnic groups.

8.2 Sefton MBC have not previously submitted data regarding ethnic origin however data for 2017-18 indicates that Sefton"s CiC were **95%** white, **3%** mixed ethnicity, less than **1%** Asian or British Asian and just over **1%** were identified as other ethnic groups.

9. Commissioning arrangements of NHS health provision for Children in Care in Sefton

9.1 Sefton CCGs are responsible for commissioning the dedicated CiC health services in Sefton which include the 16-19"s CiC health team in North West Boroughs Healthcare NHS Foundation Trust (NWBH) (see 9.2). In 2017/18 reporting period statutory IHA provision was commissioned from Alder Hey Children"s NHS Foundation Trust (AHCH) (see 9.3). Child and Adolescent Mental Health Services (CAMHS) (see 12) are also

commissioned from AHCH Trust and Sexual Health services from Southport and Ormskirk Hospital NHS Trust (see 13). It is worthy of note that the majority of statutory Review Health Assessments for CiC are undertaken by the 0-19"s service by NWBH. The 0-19"s service is a Public Health (Local Authority) commissioned rather than a CCG commissioned service. However the CCGs receive and monitor KPI"s that includes the 0-19"s service performance in relation to CiC. This fragmentation of commissioning can lead to some confusion to external agencies about who has overall responsibility for the commissioning of health services to CiC in Sefton.

9.2 Merseycare NHS Foundation Trust / North West Boroughs Healthcare NHS Foundation Trust - Children in Care Health Team

9.2.1 The Children in Care Health team was previously hosted by Liverpool Community Health NHS Trust (LCH) in a co-located service responsible for provision to both Sefton and Liverpool CiC as part of a wider Adult and Children"s Safeguarding offer.

9.2.2 In June 2017 the Children in Care Health team transacted to Merseycare NHS Foundation Trust (Merseycare), with an agreed subcontracted arrangement to NWBH. Sefton CCGs were supportive of this arrangement on the basis that any risk in the system would be reduced. This was following the major shift in local health services as the 0-19s Public Health service commissioned by Sefton MBC had also seen the award of this contract to NWBH.

9.2.3 The transaction of services included the introduction of a Sefton-only facing CiC health team as part of the Safeguarding Children Service which is inclusive of the Sefton Young Offender Health Nurses. The Named Nurse for Safeguarding/CiC for Sefton (1 WTE Band 8a) has management and operational oversight of the delivery of this provision.

9.2.4 The 16-18 year old „care leaver" cohort continue to have access to a dedicated Link Nurse (1 WTE Band 6). Administrative support (1 WTE Band 3) specifically for CiC is in place to manage data flow relating to care status, health assessments and placement changes.

9.2.5 Commissioning arrangements for the team facilitate partnership working with Sefton MBC to ensure health provision to children and young people new into the care is available. Arrangements are in place to maintain service delivery for the existing cohort of CiC in Sefton, inclusive of CiCOLAs and those placed out of area, by ensuring that high quality statutory health assessments are completed in a timely manner.

9.2.6 The team has experienced significant challenges during the reporting period with areas such sickness and capacity impacting on the stability of the service. However, the dissolution of LCH as an organisation, and resultant transaction of all services to alternative health trusts via the NHS Improvement plan, restricted the ability of both provider and Sefton CCGs to make any adjustments to the agreed service specification. During the reporting period Sefton CCGs have not been consistently assured that NWBH have been able to deliver on the commissioned service for CiC and there has been significant CCGs scrutiny and activity by CCGs in relation to preparing to make

changes to service delivery. These changes will occur outside of this reporting period.

9.3 Alder Hey Children's NHS Foundation Trust (AHCH)

9.3.1 Alder Hey Children‟s NHS Foundation Trust delivers the medical services for CiC and those with a plan of adoption. The team consists of a Clinical Lead for CiC, an experienced Paediatric Consultant with expertise in neurodevelopment, and a Specialist Nurse for CiC, in addition to dedicated administrative resource. The team is further supported as a result of organisational arrangements which embed the service within the overall Statutory Safeguarding Children Service at the Rainbow Centre bases in AHCH. Additional resource is available from the Community Paediatric Team and Medical Advisors, who together, complete all IHAs and adoption medicals for children in the Sefton area.

9.3.2 The team work closely with the Designated Nurse CiC in supporting the health agenda for CiC taking an active role at Corporate Parenting events and contributing to both local inspections in year.

9.3.3 The Medical Advisors are involved in all stages of the Adoption Process for children and adults. Medical Advisors also have an obligation to attend permanence panels and are responsible for „Adult Health Clearances‟ for all for foster carer, adoption, Special Guardianship Orders and kinship care applications.

9.3.4 Sefton CCGs have been in negotiation with the Trust to secure the provision of a Designated Doctor for CiC. This post is being undertaken by one of the Senior Paediatric Consultants at AHCH and is jointly commissioned with Liverpool CCG and Knowsley CCG.

10. Statutory Assessments

10.1 **Initial Health Assessments**

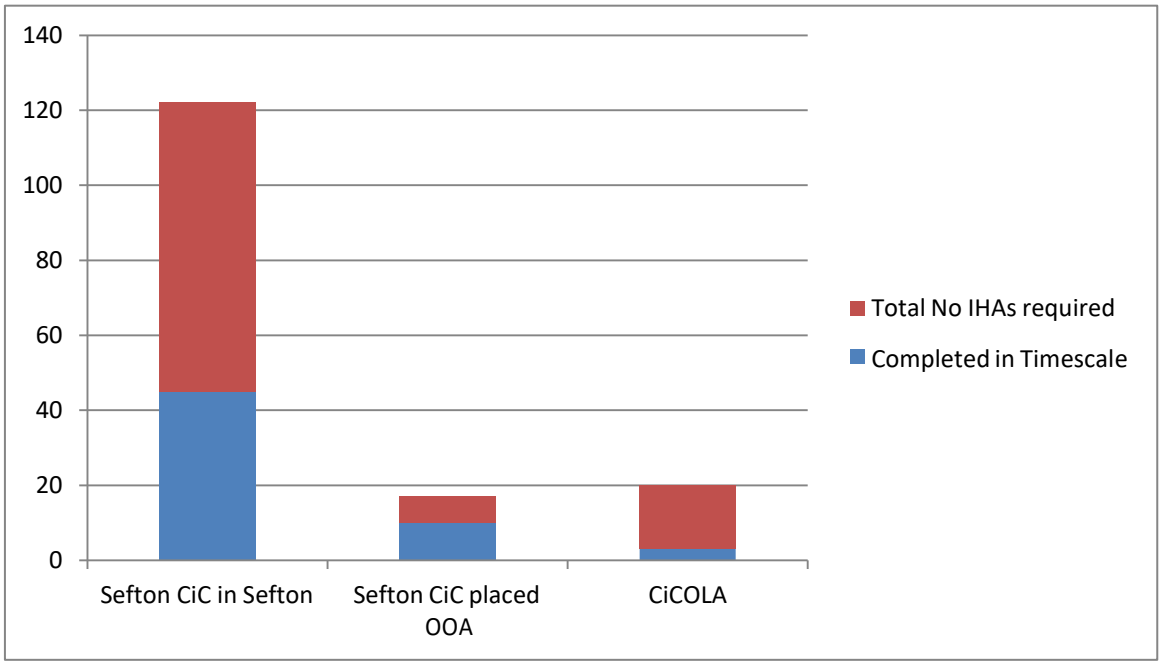
10.1.1 IHA are required to be completed within 20 working days of a child entering care. All IHA‟s are completed by a qualified doctor which is a requirement set out in Statutory Guidance. The IHA should result in a health plan, which is available in time for the first statutory review by the Independent Reviewing Officer (IRO).

10.1.2 To succeed with the 20 working day target, there is a reliance on the establishment of partnership working and excellent communication pathways. Children‟s social care and commissioned health services must work proactively together to facilitate timely assessments. Improvements in notification have resulted from an „Alert‟ system via Liquid Logic, but concerns remain that this process is not being fully utilised contributing to delay in assessment experienced by some children.

10.1.3 Timely notification is just one step within the IHA pathway to be completed if compliance with statutory timescales is to be achieved. Streamlined provision that considers available resource, robust communication and a shared understanding of practitioner/organisational responsibilities is also required.

10.1.4 In the year April 2017 - March 2018, **184** children entered the care of Sefton MBC however only **154** children were reported as requiring an IHA by NWBH Sefton CiC team during the reporting timeframe. This discrepancy may relate to children who entered care briefly and left before the 20 day assessment timeframe alongside those who entered the system late in the reporting period therefore requiring IHA in the following financial year.

Graph 3 Timeliness of Initial Health Assessment



10.1.5 Graph 4 provides overview of performance for both the NWBH Sefton CiC health team and AHCH CiC team in completing IHA"s within timescale. There are many factors at play in achieving 100% compliance with the KPI threshold as set; for Sefton CiC placed out of area there is a reliance on other health teams to facilitate the assessment process. For the CiCOLA cohort it is often the case that significantly delayed notification of new into care status means completion of entire pathway within 20 working days is unachievable from the outset.

10.1.6 From the information available **39%** of Sefton children new into care had their IHAs completed in a timely manner, irrespective of placement area. This is a slight reduction from the **40%** total compliance rate achieved last year and the **51%** achieved the year before but above the current national average of **35%** (NHSE, 2018).

10.1.7 There is a clear requirement for improvement in performance. Joint audit between the CCGs and Sefton LA was completed in 2017/18. This mapped performance across all parts of the IHA pathway against an adapted NHS E IHA exemplar pathway (Appendix 1). Initial findings highlighted process concerns from a community health provider perspective. An action plan to improve performance was agreed and has been monitored by the Designated Nurse for CiC and reported to the Joint Quality Committee.

10.2 eview Health Assessments

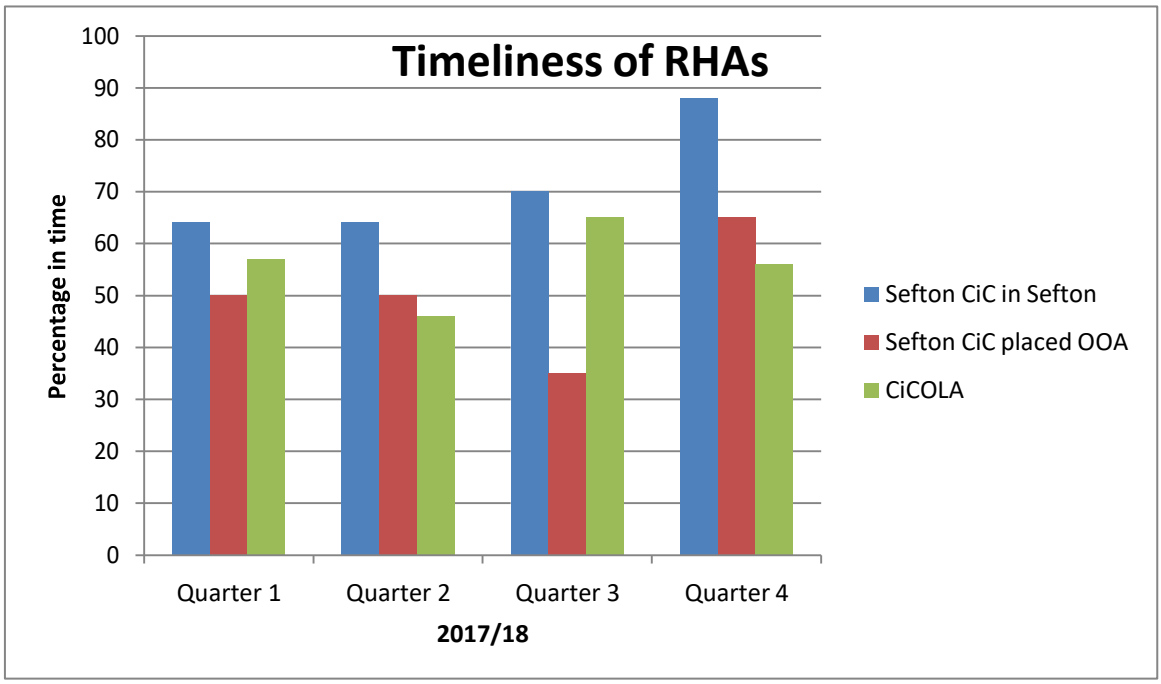
10.2.1 RHAs are a statutory requirement for all CiC, and are required to be completed every six months for children under the age of 5 years and annually for children over this age. The RHA is a holistic assessment including emotional wellbeing and physical health. The recommendations and health plan from all RHAs are shared with the child"s social worker (SW) and IRO.

10.2.2 Health Visitors and School Nurses within the 0-19 service complete the assessments for the majority of the children, whilst the CiC Link Nurse completes assessments for young people aged 16-18 years. The 0-19 service commissioned via Public Health transferred across to NWBH from 1st April 2017. Completion of, or contribution to, RHAs is included the within the contract specification for this service.

10.2.3 In April 2016 the Health Practitioner Checklist/Audit assessment tool was implemented and all RHAs continue to be quality assessed via this tool (Appendix 2). The tool was developed by the previous Designated Nurse for CiC and has been adopted regionally as standard, promoted via NHS E National CiC subgroup as an exemplar tool. RHA"s which do not meet the required standard continue to be returned to the assessing practitioner for amendment. As of 1st April 2017 the Designated Nurse for CiC initiated a process to oversee the quality assurance process from the CCGs perspective for assessments that are completed under the guidance of the Responsible Commissioner (children placed out of area/CiCOLA).

10.2.4 Completion of the RHA"s in a timely manner has been a challenge for NWBH CiC health team; quarterly KPI data identifies performance that is significantly below the 100% compliance threshold, although demonstrates an improving trajectory for Sefton children placed in Sefton (see Graph 5 below). Similarly to IHA, the RHA process is reliant on the performance of external practitioners/services. The service specification is explicit in identifying responsibility for improving performance is with the specialist team with the support of the Designated Nurse for CiC.

Graph 4 Timeliness of Review Health Assessment



10.2.5 The number of children who have been looked after for a period of twelve months or more, who have received their statutory health assessment, is recorded by the Local Authority as part of the SSDA903 return to Central Government.

10.2.6 Performance for 2017/18 showed a decrease in relation to RHA"s from the previous year from **89%** to **88%.** It must be noted however that this performance is related to completion of assessment within year and not timeliness of that assessment.

10.2.7 Whilst the publication of National SSDA903 health data is not available until November 2018, it is possible to provide a projection of the anticipated return using information provided by both NWBH 0-19 service and Sefton MBC.

10.2.8 A cohort of **334** children was identified as being „Looked After" for a period of more than one year and therefore eligible for reporting within the 903 return; **298** children had a RHA undertaken within the reporting period (**88%**), a decrease of **1%** on last year which equates to **2** health assessments**.** The current national average for completion of annual health assessments is **89%**.

11. National Health Indicators – Sefton Children

11.1 Children who have remained in care for a period of more than one year should experience an improved quality of life, not least of all evidencing improvements in holistic health. The SSDA903 return provides crucial data to both the LA and CCGs in understanding the needs of this cohort to enable the commissioning of health services which are able to focus on improving outcomes.

11.2 Dental Health

11.2.1 All CiC are encouraged to register with a local dentist of their choice with advice relating to oral hygiene being provided by health practitioners completing statutory health assessments. Practitioners completing children"s health assessment must record the dental practice and dates of appointments attended. This information assists the Local Authority in confirming compliance with routine dental checks as part of the 903 return.

11.2.2 Unverified figures suggest that **280** children out of **334** were up to date with recommended dental examination (**84%**); this is an **11%** increase on last year and is slightly above the current national average of **83%**.

11.3 Immunisations

11.3.1 Research suggests that CiC often enter the system with incomplete immunisations. It is therefore a priority of the local authority and health care providers to ensure that these children are brought in line with the national immunisation schedule as recommended by the Health Protection Agency (HPA) and Public Health England (PHE).

11.3.2 tal **285** children (**85%**) out of the 903 cohort were identified as being up to date as per current immunisation schedule at the end of March 2018; this is a slight improvement of **1%** on last year and is comparable with the current national average for CiC of **84%.**

11.4 Strengths and Difficulties Questionnaire

11.4.1 CiC are twice as likely to have a diagnosable mental health disorder as their peers. This is in view of their pre and post care experiences which include attachment difficulties, trauma and the effects of abuse on the developing brain. It is therefore important to measure, on a regular basis, the emotional and behavioural difficulties experienced by CiC. Commonly this is achieved via the Strengths and Difficulties Questionnaire (SDQ) which is a clinically accepted brief behavioural screening questionnaire for use with 4-17 year olds. It is internationally validated and simple to implement.

11.4.2 The SDQ provides information to help SWs form a view about the emotional well-being of individual children. It is a requirement of the SSDA903 that local authorities must ensure that the child"s main carer (a foster carer or residential care worker) completes the two-page questionnaire for parents and carers.

11.4.3 In Sefton, the current arrangement for completion of SDQs sits with the Local Authority. Best practice dictates that information in the completed questionnaires is collected by the Local Authority, with the child"s total difficulties score worked out and available to inform the child"s health assessment. It has been highlighted however that there is no formal communication process between social care and health providers in

regard to the SDQ findings for individual children.

11.4.4 During the 2017/18 reporting period the Local Authority reported that **184** (**70%**) children out of eligible cohort had a Carer"s SDQ completed. It is clear from quality assurance of health assessments that the findings of individual SDQs are not effectively shared with health colleagues. This often impacts on the ability to effectively coordinate care in relation to improving emotional health and wellbeing. This has been identified as a priority area for review in 2018/19.

12. Child and Adolescent Mental Health Service (CAMHS)

12.1 The Sefton CAMHS service is delivered by AHCH who provide a range of support to professionals, children, young people and their families, to meet both the mental and emotional needs of those children who live in Sefton.

12.2 CiC present to CAMHS with similar difficulties to the general population, although they frequently have more than one problem and a history of significant adverse early life experiences. Engaging some young people can take time and often alternative approaches are required.

12.3 Children who need an emergency service are assessed the same day at A&E. Average waiting times for CiC who require a „less urgent" assessment was **4.69** weeks in 2017/18. This is an improvement on 2016/17 whereby average waiting times were **5.37** weeks.

12.4 CAMHS received **43** referrals for Sefton CiC in 2017/18 and **76%** of the referrals were accepted and progressed to therapeutic treatment.

12.5 The CiC assessed by CAMHS often presented with multiple difficulties, emotional dysregulation and self-harm. In addition, challenging and aggressive behaviour were common themes noted from referral with a high prevalence of attachment issues, low mood, and anxiety being diagnosed.

13. Sexual Health

13.1 Research illustrates that CiC are three times more likely to become teenage mothers than their peers who have not experienced local authority care (*Coram Report, 2015*). This report also identified that mainstream programmes are not tailored to the specific needs of this group of children. In the main, young people in Sefton access local sexual health services provided by Southport & Ormskirk Hospital NHS Trust. There is no specific service dedicated to CiC.

13.2 The service is confidential and able to offer a choice of walk-in, or appointment clinics with designated „under 25"s only" sessions. Service users can state a preference to be seen by either male or female staff.

13.3 Services provided include issuing of contraception (all methods), sexually transmitted infection testing and treatments including HIV, free condoms and pregnancy tests. In addition, there are referral clinics for psycho-sexual counselling and erectile

dysfunction.

13.4 The clinic service is supported by a clinical outreach service (by referral only) and sexual health promotion team. The availability of an outreach service has proved invaluable for some CiC who have faced challenges in engaging with, and accessing clinical services

13.5 Sexual Health is assessed routinely as part of the annual RHA. This provides a prime opportunity to deliver key public health messages and provide young people information around accessing services and addressing their sexual health needs. Assessing practitioners are additionally guided to discuss healthy relationships, puberty, and to consider risk of Child Sexual Exploitation (CSE).

14. Safeguarding Children in Care

14.1 The *Real Voices* report on CSE (*Coffey, 2014*) stressed that CiC are particularly vulnerable due to their higher levels of emotional health difficulties and special education needs. Additionally, it highlighted the risks to children who go missing from care raising concerns that despite legislation, independent children"s home often fail to notify local authorities when children move in from other areas.

14.2 Children who are considered to be at high risk of being sexually exploited, and those who are considered as currently being sexually exploited, continue to be referred for discussion at the Multi Agency CSE Panel (MACSE). Representatives from agencies working directly with the child are invited to attend to ensure the Multi Agency CSE Plan is appropriate.

14.3 In April 2016 NHS England directed all CCGs and Provider services to identify a nominated lead for CSE. The nominated lead for Sefton CCGs is the Designated Nurse for Safeguarding Children.

14.4 One in five children and young people who go missing from home or care are at risk of serious harm (*Coffey, 2014*). There are major concerns about the links between children running away and the risks CSE. Missing children are also vulnerable to other forms of exploitation, violent crime, gang exploitation, and drug and alcohol misuse.

14.5 Sefton MBC is required to submit data on an annual basis with regard to CiC who are reported as „missing" or „absent/away". A total of **79** CiC were recorded as missing from care in 2017/18; **471** episodes of „missing" were recorded against these children with an average of six incidents per child.

14.6 There were **106** episodes of „absence/away" reported by the Sefton MBC relating to **35** individual children. Children are deemed to be absent if they are away from placement without agreement but professionals are aware of their whereabouts.

15. Care Leavers

15.1 *Promoting the Health of Looked after Children* **(***DfE/DH, 2015***)** states that CCGs have a role in commissioning health provision taking into account the specific requirements for

young people identified as care leavers in the Leaving Care Act (2000). They are required to ensure that plans are in place to enable children leaving care to continue to obtain the healthcare they need and that arrangements are in place to ensure a smooth transition for those moving from child to adult health services.

15.2 There are approximately **131** care leavers aged between 19-21 years within Sefton. National data return requires the Local Authority to report outcomes for this group in relation to education, training and employment. Figures indicate that **32** of these care leavers are recorded as having an illness or disability, and a further **11** are pregnant or parenting which has resulted in them being unable to access employment or education.

15.3 Further review of the current `offer` from commissioned health services is required to ascertain compliance with statutory guidance. On leaving care, young people are provided with a health passport providing details of their medical history and advice on navigating universal health services, with health provision now provided within Primary Care.

15.4 CCGs and Local Authority responsibility for the transition arrangements of young people leaving care to adults services is set out in *Nice Guidance - Transition for YP using health and social care services* and *Statutory Guidance on promoting the health of LAC and Care leavers (DfE/DH, 2015)*. In 2016/17 commissioned health teams were not required to submit performance data in relation to care leavers however in the 2017/18 reporting period a metric was introduced within the KPI schedule in relation to health passports and **21** health passports were issued to Sefton children placed in Sefton by NWBH. This is lower than the number that should have been issued and identified as a priority area for 2018/19.

16. Role of Primary Care

16.1 Primary Care providers have a vital role in the identification of the health care needs of children and young people who are in or leaving care. They often have prior knowledge of the child/young person and have statutory responsibilities to:

- Accept CiC as a registered patient seeking the urgent transfer of the medical records if the child is placed over three months.
- Act as an advocate for the child, contribute and provide summaries of the health history of a child who is in care, including their family history to inform the Statutory Health Assessment process and legal proceedings e.g. Adoption
- Ensure that referrals to specialist services are timely, taking into account the needs and high mobility of children in care
- Ensure the clinical records make the „looked after" status of the child clear, so that particular needs are acknowledged and forwarded for each statutory health review.

16.2 The GP held patient record is a unique health record and is able to integrate all known information about health and events, to provide an overview of health priorities and to review that health care decisions have been planned and implemented.

16.3 Copies of individual health action plans should be provided to GP practices via the Sefton CiC Health Team in NWBH, to ensure that the lead clinical record is updated and health needs followed up within the Primary Care setting. Whilst this is happening in some cases the process has not been fully audited. Review of the robustness of this process is required with provider teams needing to clearly demonstrate that information sharing pathways are effective. Evaluation of sharing of health action plans with GP"s has been identified as a priority for 2018/19.

17. The Responsible Commissioner

17.1 Sefton CCGs are the responsible commissioners of health services for children who are taken into the care of Sefton MBC. When CiC are placed out of area it is the responsibility of Sefton MBC, as lead agency, to advise health as stakeholders, to ensure that children maintain exemplary access to relevant health services. This includes the originating CCG and the receiving CCG where the child or young person has been placed.

17.2 In Sefton, the sharing of information in relation to children placed out of area is coordinated by the Sefton CiC Health Team (NWBH) following notification by the Local Authority.

18. Payment By Results (PBR)

18.1 The Department of Health with NHS England, Monitor, the Royal Colleges and other partners, have developed a mandatory, national currency and tariff for statutory health assessments for CiC placed out of area. In 2016/17, a standard letter was devised informing all CCGs across England that Sefton CCGs would charge for statutory health assessments in line with the national tariff.

18.2 It has been highlighted that the process linked to the Payment By Results (PBR) recharge was not robust, with the framework supporting the implementation of Responsible Commissioner not always clear. A new process which now includes additional scrutiny and oversight by the Designated Nurse for CiC was implemented in May 2017.

18.3 Assurance is obtained that the completed assessment meets required standards by reviewing against the Health Practitioner Checklist/audit assessment tool (appendix 2). The PBR tariff was aimed at improving quality, access to services and providing resources into local areas to meet the demand. However in view of the way CCGs across England have commissioned services in different ways this has caused further delay in accessing services, prior to invoicing arrangements being confirmed. This is currently being reviewed as part of the Regional and National CiC Forums, led by NHS E with clear directive for CCGs being standardised.

19. Conclusion

19.1 Services provided to CiC in Sefton have been under intense scrutiny during 2017/18. Inspection of Local Authority Services in April 2016, closely followed by the Joint SEND Inspection in November 2016 generated a set of „must do" actions to ensure

CiC are safe, healthy and are encouraged to achieve their full potential. The on-going progression of these actions during 2017/18 has not been at the pace desired or required due to a number of complex and complicating factors.

19.2 Sefton CCGs have worked in partnership with the Local Authority and partner agencies to ensure robust arrangements are in place within commissioned services, in line with national guidance and to fulfil the health needs of this group of children. The performance of commissioned services to deliver the statutory standards for CiC has at times, been inconsistent.

19.3 The dissolution of LCH has affected the ability of provider services to maintain a consistent, high standard of service to CiC. The transition of services to new organisations occurred in April 2017 (June 2017 for the Safeguarding and LAC Service) and performance has been monitored throughout 2017/18 with limited, or no significant improvement. This has been high on the agenda for the CCGs with a number of measures undertaken in 2017/18 and planned for 2018/19. The Chief Nurse of the Sefton CCGs has maintained oversight of the situation and reported through to the Joint Quality Committee and Governing Body.

19.4 The role of the Designated Nurse for CiC has now been withdrawn from the CCGs Shared Safeguarding Service and brought „in house" (March 2018). It is anticipated that this new arrangement will provide the opportunity for increased scrutiny of many aspects of health care delivery to this vulnerable group of children during 2018/19 and onwards.

19.5 In depth analysis of KPIs has informed the priorities for the coming year and they are written using recommendations from *Not Seen, Not Heard (CQC, 2016)* to ensure a child-centred approach. The triangulation of this information, in conjunction with a review of the *NHS E CCG Commissioning Compliance Tool for Looked after Children and Care Leaver Health Services 'Right People, Right Place, Right Time, Right Outcomes* has helped to provide a contextual view to assist Sefton CCGs in ensuring effective commissioning to meet the health needs of children in care.

20. Key Priorities for 2018/19

Children & Young People should have a voice
• Consultation with CiC and care leavers to inform services design and delivery and address barriers for young people accessing health services • Alignment of EHCP/CiC Health plans for CiC with SEND supported by the development of robust communication pathway and complimentary training programme for health practitioners
Improving outcomes for children: the 'so what' factor
• Improved performance around national performance indicators – greater compliance by commissioned services around KPIs • Development of a bespoke CiC Nursing Team to sit under CCG commission and focus on improving health outcomes for CiC • Improved quality of CiC health assessments, particularly RHA"s • On-going implementation of Responsible Commissioner and associated quality assurance • Review of current SDQ process to facilitate meaningful contribution to the RHA process
Quality of multi-agency information sharing
• Evaluation of information sharing within Primary Care Services and GP contribution to inform the statutory health assessment process • Review of training for health care staff including Primary Care Practitioners on their roles & responsibilities as corporate parents as commissioners of health services • Implementation of „Care Leaver Code" to identify patients registered with GPs whom are defined as care leavers to enable them provide timely access to services where appropriate
Transition and access
• Review of care leaver *Health Passport* process; utilisation of this to inform transition plan and improve pathways between services • Review of commissioned services in providing extended provision to care leavers and Sefton CiC placed out of area
Leadership
• Review of NHS E Benchmarking Exercise to ensure full compliance with the 33 standards • Contribute to review of Safeguarding/CiC contractual safeguarding standards and KPI"s across the Mersey region • New Designated Nurse CiC to develop an action plan to include the above priorities

"We only get one chance at life…help us make the best of it"

Rebekah, Sefton Care Leaver

21. References

DH/DfE (2015) Promoting the Health and Welfare of Looked After Children https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412486/health_guidance_consultation_response.pdf

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Coram report (2015) Preventing Unplanned Pregnancy and Improving Preparation for Parenthood for Care-Experienced Young People

National Institute for Health and Clinical excellence, (2016) Guidance Transition for YP using health and social care services.

NHS England (2013) Who Pays? Determining responsibility for payments to providers.

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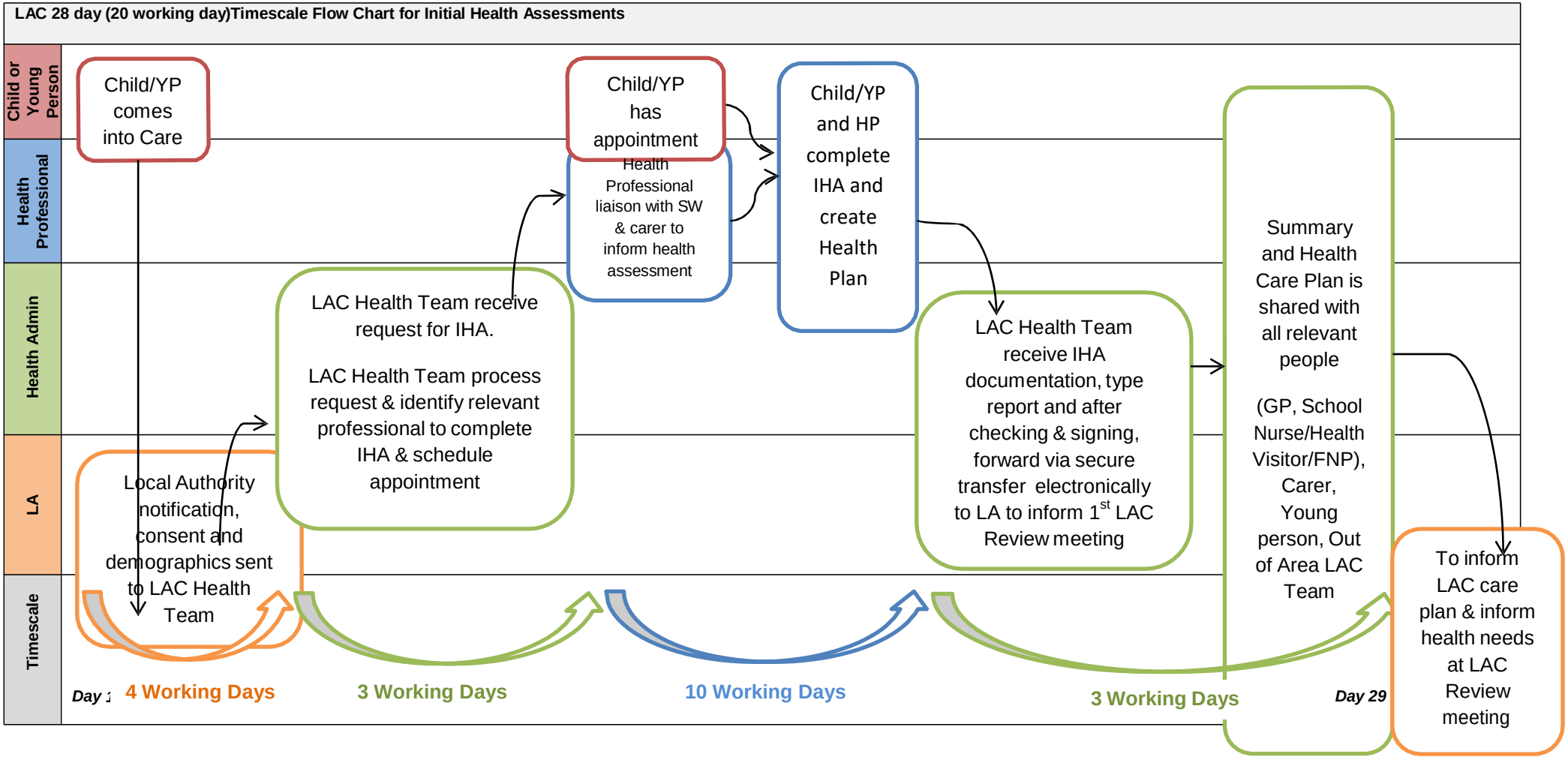
Appendix 1


LAC 28 day (20 working day)Timescale Flow Chart for Initial Health Assessments
Child or Young Person
Health Professional
Health Admin
LA
Timescale
Child/YP comes into Care
Child/YP has appointment
Child/YP and HP complete IHA and create Health Plan
Health Professional liaison with SW & carer to inform health assessment
LAC Health Team receive request for IHA.
LAC Health Team process request & identify relevant professional to complete IHA & schedule appointment
LAC Health Team receive IHA documentation, type report and after checking & signing, forward via secure transfer electronically to LA to inform 1st LAC Review meeting
Summary and Health Care Plan is shared with all relevant people
(GP, School Nurse/Health Visitor/FNP), Carer, Young person, Out of Area LAC Team
To inform LAC care plan & inform health needs at LAC Review meeting
Local Authority notification, consent and demographics sent to LAC Health Team
Day 1
4 Working Days
3 Working Days
10 Working Days
3 Working Days
Day 29

Appendix 2

Looked After Children Health Assessment– Practitioner Checklist

(Based on 2014/15 National Tariff Payment System)

The checklist guides practitioners through the criteria and quality indicators for completion of the assessment. Evidence of quality indicators must be documented within Parts B and Part C of the health assessment. The assessment and checklist will be reviewed by the Provider Children in Care Health Team and/or the Designated Nurse on behalf of Sefton CCGs. It will be used to support payment against the agreed quality framework where applicable

Please complete and return along with full health assessment and additional documents requested

Child's Name:			**Date of Birth:**
			NHS No:
Type of Assessment: INITIAL REVIEW **(Delete as appropriate)**	**Date of Request:**	**Date Assessment Due:**	**Date of Completion of Assessment:**

Part B of BAAF Paperwork	**Yes/ No N/A**	**Comments**
Young person with capacity to consent has signed to say they understand the need for the assessment and have agreed to be seen and to information being shared. Have they been offered a choice of venue and the chance to be seen alone? **If typed please document that verbal consent has been agreed (include date)**		
Evidence that information has been gathered to inform assessment from child"s social worker and other health agencies providing care (e.g. CAMHS, GP, Therapists)		
Evidence of discussion to consider health events since last assessment i.e. A& E attendance, Illness, Immunisations)		
Evidence of assessment (at least 3 indicators for each to be evident) • **Physical Health:** management of medical conditions, Sleep issues, Diet, Illness, Physical activity, Height & Weight (BMI must be calculated), Allergies • **Developmental Health**: Gross & Fine Motor skills, developmental milestones (Ages & Stages), Puberty, educational overview including key transitions in school, independence skills • **Emotional Health / Behavioural:** Attachment, SDQ with score detailed within assessment(if available), anxiety, stress, depression, self-harm, positive mental health, friendships, self-esteem, behaviour		
Dental health -discussion around oral health, sugar intake,		

drinks, diet and tooth brushing needs to be evident		
Vision – date of last vision, use of glasses		
Health professional involvement: details of health agency involvement including last/future appointments		
Immunisation Status: immunised as per schedule, details of recent immunisations and any required in future		
Medication: details of any medication or equipment required		
Keeping safe: Children 0 to 9yrs – safety in the home, appropriate supervision, road safety, exposure to second hand smoke Children 10 to18yrs – consider risk of CSE, missing from care episodes, internet safety, road safety		
Healthy Relationships: including personal checks, puberty & body changes, sexual health and access to services (must be evidence of appropriate discussion for **ALL** children over 10)		
Exposure to substance: Evidence that alcohol / substances have been discussed – „Drugs, Alcohol & Me" screening tool must be completed and referenced within assessment		
Voice of the Child: for younger children evidence this by considering interaction with carer, for older children reflect how they feel about their health		
The social worker does not see Part B of the assessment therefore a comprehensive summary report and a detailed 'SMART' health plan is essential The summary should be the key points from the assessment with a clear analysis of the 'so what does this mean' and 'what impact / difference is this making for the child'		
Part C: Summary Report and Health Plan	**YES/NO N/A**	**Comments**
Overview of health since last assessment: summarise Part B of assessment i.e. A & E attendances, illness or injuries (Section 1)		
Present physical and dental health: Must include date of last dental check, overview of growth (BMI) (Section 4)		
Developmental health/Educational concerns: summarise finding from developmental assessments, comment on current level of functioning, analyse & consider impact (Section 6)		
Emotional Health: overview of emotional & behavioural development, attachment, evidence of analysis		
Lifestyle: overview of keeping safe, risk-taking behaviours, relationships & sexual health		
Health Concerns: Children & Young People"s, Carers" and other professionals" concerns about health are evident and recorded in the summary with action in health plan where appropriate		
Date of Dental Check: Must be recorded (underneath Health Action Plan)		
Immunisations: up to date, detail any outstanding within summary and plan		
Health plan: focused on needs of the young person rather than being task focused **(the word Asthma, Diabetes, Eczema is not sufficient)**		
Timescales and identified responsible person: Recommendations have specific timescales, avoid „ongoing"		

GP and Dental Practice: names of both noted		

The Children in Care Health Team are required to input certain data within Social Care Systems, it imperative that a copy of all requested documentation is returned with original copies remaining within the child's health record		
Return Documents Check	**YES/NO**	**Comments**
Childs name, DOB & NHS Number on every page		
Full Health Assessment with **Summary & Plan** (PartC) being typed		
Immunisation Printout – For children placed in or placed by external trusts (where available)		
SDQ questionnaire Carers Report – 2 page complete document (not score only) for children age 4-16yrs inclusive (If requested – not standard for all assessments)		
Substance Misuse „Drugs, Alcohol & Me" screening tool (Age 10-18yrs inclusive) – Return completed tool		
Universal developmental checks up to date (for children under 5yrs)		

I agree that the completed Initial/Review Health Assessment meets the criteria and quality standards of the practitioner checklist

Competent to Level 3 of the Intercollegiate Competency Framework [1]	**YES/NO**
Name of practitioner completing health assessment:	
Designation:	**Date:**

Internal Quality Assurance		
Assessment meets required standard?	Yes	No
Name:	Designation:	Date:

[1]RCGP, RCN, RCPCH (2015) Looked after children: Knowledge, skills and competences of health care staff: Intercollegiate role framework.
http://www.rcpch.ac.uk/system/files/protected/page/Looked%20After%20Children%202015_0.pdf