Derbyshire Healthcare
NHS Foundation Trust

ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year: 2018/19

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)
Dr A Marudkar (Medical Advisor for Children in Care – DHcFT)
Dr V Kapoor (Medical Advisor for Children in Care – DHcFT)
Maria Moore (Specialist Nurse for Children in Care – DHcFT)
Satvieer Dutton (Specialist Nurse for Children in Care – DHcFT)
Emma Fennell (Specialist Nurse for Children in Care – DHcFT)
Jane Mason (Administrator Coordinator – DHcFT)

Section 1: Introduction and context

Introduction

1.1 The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see appendix 1 for explanation of the differing cohorts).

1.2 The report will outline how Commissioners, Designated Professionals, Local Authority and health providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2019/20) for looked after children in Derby City.

1.3 This report has been compiled in partnership with the Named Nurse for children in care; Designated Nurse & Designated Doctor for looked after children and the Medical Advisors and Specialist Children in Care Nurses supporting children in care.

1.4 The report contains and analyses the compliance to the statutory framework in respect of timeliness and quality of health assessments and is obtained by the use of snapshot audits.

1.5 Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care.

Context

1.6 Definition of a looked after child/ child in care

A child that is being looked after by the Local Authority, they might be living with:

- foster parents
- at home with their parents under the supervision of Children's Social Care
- in residential children's homes
- other residential settings like schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.7 It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.8 The Royal College of Paediatrics and Child Health (2015) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 **Children Act (1989)**

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 Adoption and Children Act (2002)

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 Children and Young People's Act (2008)

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs.

2.4 Children and Families Act (2014)

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 Promoting the health and wellbeing of looked after children (March 2015)

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

2.6 Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015)

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 The Children and Social Work Act (2017)

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 75,420 looked after children on 31 March 2018, an increase of 4%, compared to 31 March 2017. The most up to date national figures for 2018/19 are not yet available from the Department for Education (Stats: Looked after Children, Department for Education, 2018), the usual publication date being December 2019.

3.2 Number of children looked after in England at 31 March 2013 to 2018

2013	**68,080**
2014	**68,800**
2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**

Ref: Data made available from Derby City Local Authority Informatics Department

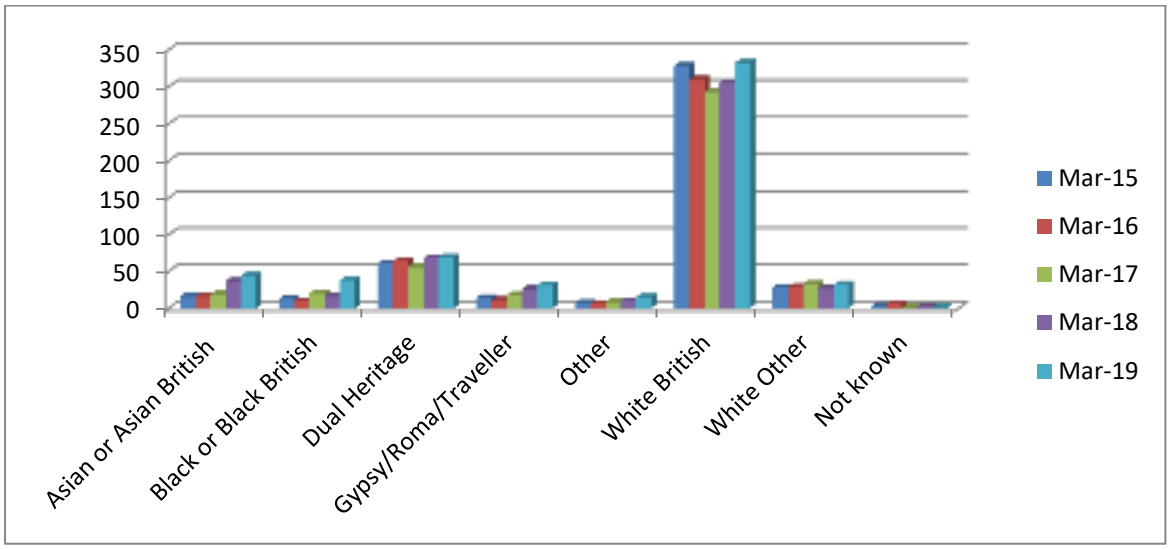
3.3 Number of children looked after in Derby at 31 March 2013 to 31 March 2019

2013	**465**	
2014	445	4% decrease from 2013
2015	470	5% increase from 2014
2016	452	4% decrease from 2015
2017	448	0.8% decrease from 2016
2018	491	8% increase from 2017
2019	562	12% increase from 2018

Ref: Data made available from Derby City Local Authority Informatics Department

Profile of looked after children in Derby City

3.4 Ethnicity comparisons over the last five years:



Ref: Data made available from Derby City Local Authority Informatics Department

On analysing the data, it is clear that there is an increase of looked after children from the Gypsy/Roma/Traveller, Asian/Asian British, Black/Black British and Dual Heritage ethnic group; this reflects the Derby City picture of the diverse demographics within Derby City and the new emerging communities. There have been significant cultural differences found in the new emerging communities, in relation to childcare, parenting, discipline and safety aspects. This has resulted in an increase of cases being referred to Children's Social Care and involvement at all levels of intervention; in some cases children/young people taken into care. The number of White British children coming into care has increased again within this financial year, after a fall over previous years; this may be reflection of the overall increased population changes within Derby City.

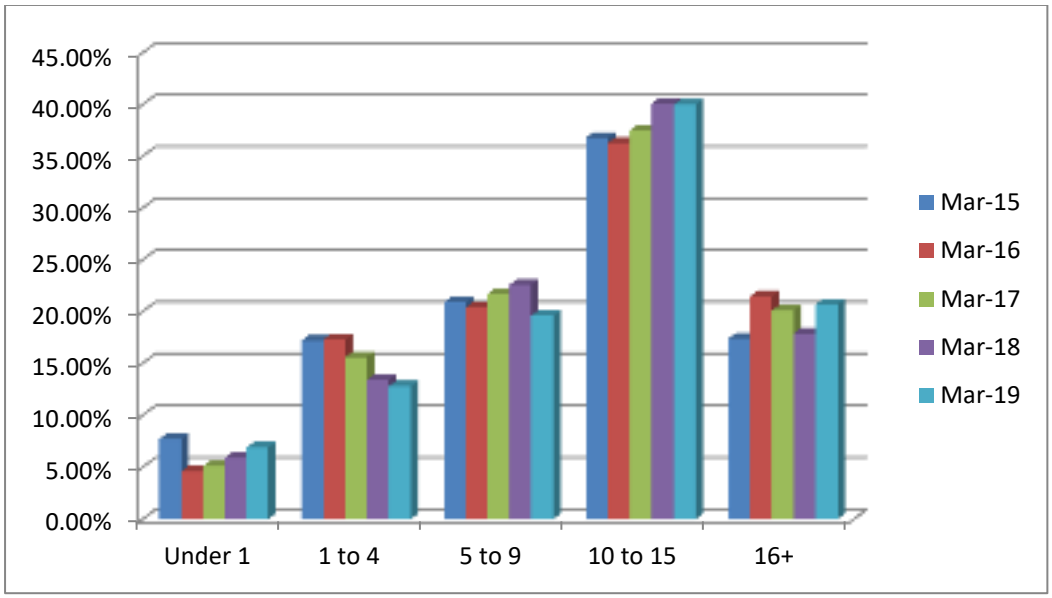
3.5 Gender of looked after children in March 2019

Gender	
Male	57.3%
Female	42.7%

Ref: Data made available from Derby City Local Authority Informatics Department

This data indicates that there is a static gender split between males and females (which mirrors previous years) and the national picture.

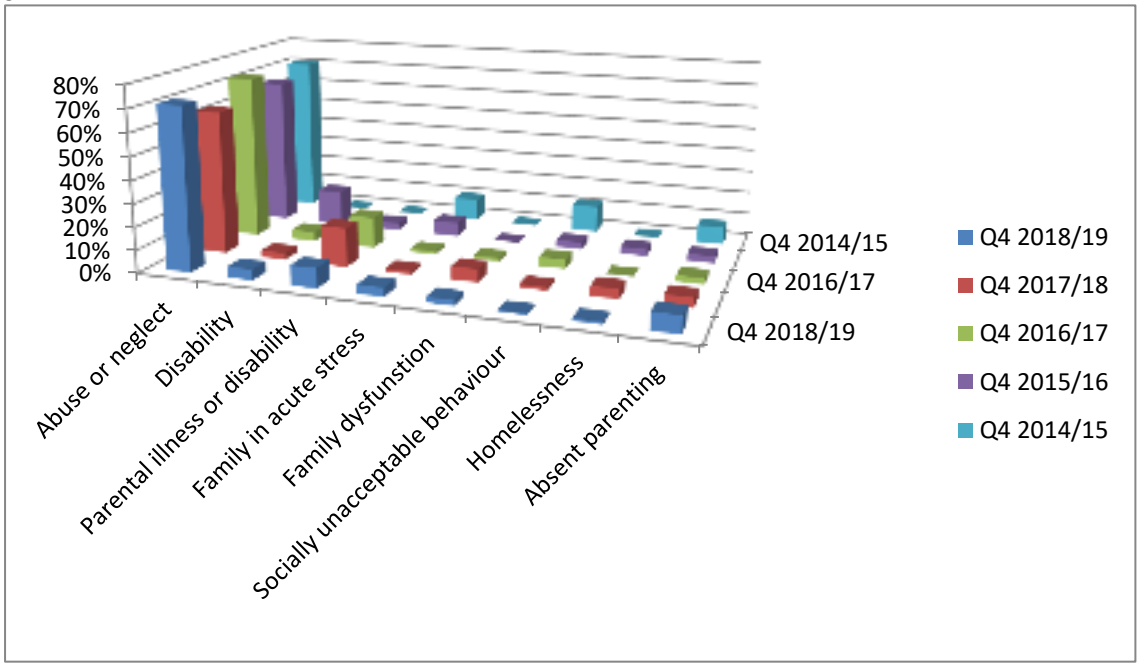
3.6 Age comparisons over the last five years:



Ref: Data made available from Derby City Local Authority Informatics Department

In comparing the data for the past four years, the 10 to 15 year old age group consistently remain the highest number of children/young people coming into care. It is difficult to determine the definitive reasons for this but it may be linked to the increase in socially unacceptable behaviour, abuse/neglect, acute stress within the family home vocalised by children/young people and family dysfunction identified as a reason for coming into care. There is an increase in the 16 years + cohort, this may be as a result of the increased Unaccompanied Asylum seeking Children coming into care (as a direct result of the local dispersal centre that opened in 2018), who have all been aged 16 years or above.

3.7 Reasons for children coming into care – comparison in quarter 4 data over last five years



Ref: Data made available from Derby City Local Authority Informatics Department

Abuse or neglect remains the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable in reason categories reflected in the above data. When making comparisons of a quarter by quarter basis over the past four years, there is a change in the overall trend with more children being taken into care due to homelessness (Local Authority category - low income), disability and family in acute stress. This may in some circumstances be associated to the financial climate within England, changes in benefit systems which is then reflected in family pressures; this is difficult to confirm. The cohort with the most significant increase is those children coming into care as a result of 'absent parenting' and predominantly Unaccompanied Asylum Seeking Children.

3.8 Distribution of Looked after Children placed In and Out of Derby City

	March 2019	March 2018	March 2017	March 2016	March 2015
Within Derby City	39.7%	36.3%	38.6%	42%	46.2%
Outside of Derby City	60.3%	63.7%	61.4%	58%	53.8%

Ref: Data made available from Derby City Local Authority Informatics Department

3.9 The Local Authority has acknowledged that the shift of Looked after Children placed out of Derby City has been increasing over recent years; this is not always in the best interests of the child. Children placed out of Derby City can potentially not receive a timely service or have access to timely specialist services this is due to the child having to be referred to services in the area they are residing in; this clearly needs addressing and resolving as all looked after children should wherever they reside receive services they need in order to meet their individual identified needs. Derby City Local Authority continues to work in partnership with Derby City Foster Carers and Independent Fostering Agencies, in order to increase the level of Foster Carers /placements within the City or placements close to Derby City, which has had a positive impact on the availability of suitable placements within the local area.

3.10 The Local Authority also continues to make progress in placements within a 20/40 mile radius of Derby City and indeed has approximately 78% of Derby City Looked after Children placed within that parameter. The continuation of the Children in Care health team undertaking health assessments at a 20 mile radius of Derby City; has had a positive impact on improved quality and timely health assessments for those living within an approximate 30 mile radius.

Section 4: Summary of achievements in year 2018/19

4.1 During the period of 2018/19 the Children in Care health team have continued to experience significant change and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration Team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

4.2 The role of the newly appointed Administrative Coordinator for Children in Care and Adoption commenced during the start of quarter 2. During quarter 2 the Administrative Coordinator and Named Nurse have worked internally with the provider to develop a new Initial Health Assessment Pathway. These changes have resulted in more efficient working, improved compliance with initial health assessment statutory timescales and improved service delivery across administration and clinical areas.

4.3 The provider has used a flexible approach in the use of resources by increasing the number of clinic slots to reach the demands of the increase in children entering care and to improve compliance for statutory initial health assessments. The CiC Specialist Nurses have adapted their way of working with Review Health Assessments by looking at what is required to engage young people to attend their Review Health Assessments working in partnership with the Local Authority to improve overall health compliance.

4.4 Completion of the CCG 'Markers of Good Practice' assurance framework and the implementation of an improvement plan in collaboration with Designated Professionals (detailed in section 10, pages 18-19).

4.5 Review of the service specification took place and agreed between provider and commissioners.

4.6 The Named Nurse for Children in Care and the Designated Nurse for Looked after Children redeveloped the training programme for Foster Carers and Residential Care Workers and this commenced in March 2018 and continued throughout the year 2018/19 (detailed in section 6.14, page 15).

4.7 Action learning sets facilitated by the Designated and Named Nurse have continued within the service. Sessions have focussed on a variety of relevant topics, for example: Serious Case and Learning Reviews in preparation for the Joint Target Area Inspection, smoking cessation and social media and SEND. This also acts as an assurance that the Children in Care health team undertake required specialist training and maintain their skills and knowledge.

4.8 Designated Nurse, Designated Doctor, Named Nurse and the Administrator Coordinator have continued to strengthen existing relationships and networks with key professional, local partners and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area).

4.9 Health access to Liquid Logic Child Social Care system has been established, which has been proven to improve information sharing between agencies (in the best interest of looked after children) and had a positive impact on the accuracy and validity of health data reportable to Department for Education.

4.10 Health history booklet and process has been improved in partnership with the Provider, Local Authority, leaving care teams (recommended in Ofsted inspection). The Designated Nurse for Looked after Children has secured funding to purchase Health History folders which will follow the child/young person through their time whilst in care.

4.11 Reporting and assurance into the SDCCG (now DDCCG) Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the Children in Care service. This has allowed the Named Nurse for Children in Care the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

4.12 Health performance although provisional until submitted in July is the highest it has been in many years. The completion rates for both annual assessments (over 5's) and development assessments (under 5's) are really high and this is very positive.

4.13 The CiCA administration team have worked exceptionally hard over the past 6 months to ensure all the out of area requests for children placed outside of a 20 mile radius are sent out in a timely manner (by 8 weeks of the due date) and this has seen a marked improvement in the amount of review health assessments being sent back within the statutory timescale.

Section 5: Provider and Partnership Working

Below are examples of partnership working within the Children in Care team:

5.1 The Children in Care Team have a champion for Child Sexual Exploitation and Child Criminal Exploitation. Part of the role involves attending Missing Children's Forum, where possible, which take place monthly. This is a multi-professional meeting involving multiple agencies from Health, Education, Police and Local Authority. Intelligence is gathered and shared regarding children who have a pattern of missing episodes; identifying risks, any associates involved and discussions around how any risks can be reduced. Information sharing is pivotal to ensure the safety of all children and young people in care. If the child is at risk of going missing an alert can be placed on a central database which is a Police based system as well as alerts going out for Health.

5.2 Once a child has been seen by a Social Worker (which is statutory) following a missing episode it is good practice for the worker to complete a Child Sexual Exploitation (CSE) matrix risk assessment form, this consists of a set of indicators and is used to score how high the risk a child or young person is of child exploitation. Any child which is deemed as a high risk, triggers local safeguarding protocols to be followed such as completion of an Operational Liberty Form, Strategy Meetings and an Initial Child Sexual Exploitation Strategy Meeting.

5.3 Part of the role is identifying the various types of exploitation models used, such as, party mode; peer on peer and boyfriend model. In addition to this, it is about using the professional language to identify the abuse and name it for what it is, this is to move away from incorrect terminology which may place the blame or imply the young person is consenting to the exploitation.

5.4 Part of the Specialist Children in Care Nursing role is to raise the profile of exploitation as a public health concern. This can involve working with the young person on recognising healthy/unhealthy relationships and working on the young person's resilience. Direct work involves raising awareness around signs of exploitation and risks to empower the young person to actively report concerns.

5.5 In a July 2016 policy document, Keep on caring, the Department for Education (DfE) concluded that outcomes for care leavers were much worse than their counterparts in the general population. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. Almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs, Promoting the health and wellbeing of looked after children (March 2015).

5.6 The care leaver cohort is also changing, as more children enter care at age 16 and over, and with more unaccompanied asylum seeking children (UASC) entering the care system. These changes could present new challenges for service providers and requires strong collaboration with partner agencies to ensure their needs are fully met.

5.7 It was stipulated within the Children and Social Work Act 2017 mandated Derby and other local authorities to publish a 'Local Offer to Care Leavers. The act also states that a young person who has experienced care can ask for support from the Leaving Care services up to the age of 25, whether you are in education or training.

5.8 In the children in care team there is a champion for care leavers who works closely with the Leaving Care Team.

The benefits of having a champion are:

- Development of stronger links between the children in care nurses and the leaving care team offering support and advice
- Ensure all young people who leave care have a health passport completed, which is accessible to the leaving care team.
- Working more collaboratively with service providers such as ANEW housing, sexual health services and the YMCA offering health advice and support for the young people they work with.
- Improved liaison with care leaving services to support the young person to access their last review health assessment, including different ways of working that is convenient to the young person, such as joint visits with their care worker, home visits or visiting at times that suit the young person due to education or employment.

5.9 The Children in Care team facilitate pre-registration students as a 'spoke' placement and student public health nurses with increasing frequency. We have also supported a number of students completing further professional development visits, providing an opportunity for them to shadow the work completed by the Children in Care Department. The students will learn about the Statutory Service the Children in Care Team provide giving them the opportunity to oversee Initial Health Assessments, Review Health Assessments and visits to the Residential Children's Homes. There is also an opportunity to spend time with the Designated Nurse for Looked after Children to provide an understanding of Commissioning and the importance of quality and audits. This will increase their knowledge and understanding about the service provided to all Children in Care. As a team we have been able to show all students how important the work completed by the Children in Care team is to such a vulnerable population group, and also educate students on how integrated and multi-disciplinary team work is of benefit to all services in meeting health needs.

Section 6: DHcFT service provision for Looked after Children

6.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2015). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

6.2 The team have improved their offer for Looked after Children by including; the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child sexual exploitation (including boys/young men) and provision for children who have special needs and/or disability (revised service specification during 2018/19).

6.3 The staffing levels for the health team at the end of the financial year (March 2019) were as follows:

Designation	Hours	WTE
Designated Doctor	4 hours (1 session)	
Designated Nurse (SDCCG)	37.5 hours	1 (From May 2017)
Named Nurse	30 hours	0.8
Specialist Nurse	14 hours	0.37
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	32 hours	0.85

Specialist Nurse	26 hours	0.7

6.4

Placement	**Number of LAC**	
Living in Derby and close to Derby City (within 30 mile radius)	350 (approx.)	Total number of children likely to be under direct care of Derby City LAC health team = 350-390
Living close to Derby (between 30-40 miles)	40 (approx.)	
Living at a distance	170 (approx.)	RHA's are completed by an out of area provider under national tariff agreement

On reflection of the distribution of looked after children the Health Provider is deemed to almost have staff in post at a level advised within the Intercollegiate Document (March 2015), being only short of between 0.18-0.58 WTE. It is worth noting that the Health Provider also utilises regular bank Specialist Nurse when required to support busier periods.

However, it has to be acknowledged this document is deemed to be 'gold standard' and one for services to aspire and fulfil as much as possible; to ensure that looked after children receive the healthcare services they require by skilled competent staff and in a timely manner.

6.5 In 2018/19 the service specification for the Children in Care health team was revised, agreed and continues to be implemented to reflect current statutory requirements and completion of health assessments within a 20 mile radius. The Children Commissioners, Designated Nurse and the Provider have and continue to work collaboratively to monitor performance, in line with statutory guidance.

6.6 Over 2018/19 additional nursing hours have been utilised to capture the requests for review health assessments for the 'Born-out-lives in' (BOLI) children and young people. There have been 36 completed review health assessments for the BOLI cohort during 2018/19 and the Provider has received funds at the National Tariff payment rates.

6.7 Over the past year there have been many changes within the Children in Care and Adoption Administration Team. For the first half of the year the team had a vacant post for the Administrator Coordinator therefore the existing administrative team were offered additional hours and an agency administrator was temporarily employed to support the Children in Care Team to cover the required work during this period.

6.8 A successful candidate was appointed as the Administrator Coordinator and started in post in July 2019. Following on from this, the Administrator Coordinator and the Named Nurse for Children in Care worked closely together to ensure improvements were made to improve statutory timescales for Initial and Review Health Assessments.

6.9 A new flowchart for Initial Health Assessments was developed; this is a more structured and robust process which allows the Administrative Coordinator and Administrative Team to be more proactive thus enabling the Administrator Coordinator the ability to professionally challenge the Local Authority enabling the Children in Care Team to increase their compliance and meet their statutory duty.

6.10 The Administrator Coordinator and Children in Care Named Nurse are currently in the process of producing a new Blood Born Virus Test flowchart, thus offering a clearer more robust service to Children/Foster Carers/Social Workers.

6.11 The Administrator Coordinator and Children in Care Named Nurse worked collaboratively with the reporting team to design and produce a reporting process to capture Initial Health Assessment compliance separate to the existing compliance report.

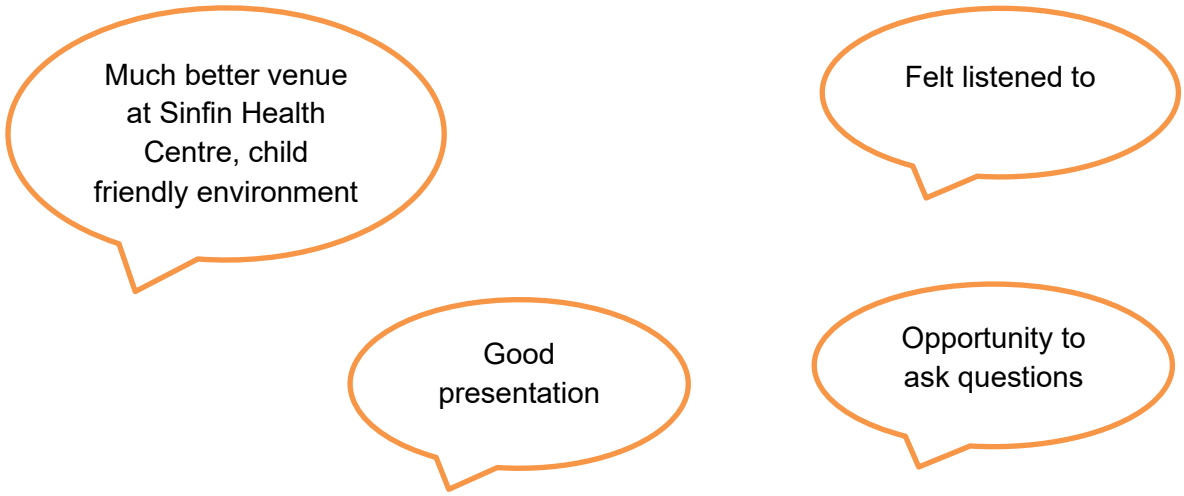
6.12 The Administrator Coordinator and the Designated Nurse worked with the Local Authority to agree on one consent form which incorporated all the previous five consent forms and this has resulted in gaining consent in a more timely fashion, decreasing delay for the child.

6.13 The Administrator Coordinator and Children in Care Named Nurse now organise all Review Health Assessments for children born in Derby City living within 20 miles, these are distributed to Children in Care Nurses for them to manage, book accordingly and increasing the ability to flex to the needs of the child and foster carer. As a result of this the Review Health Assessments for Children who are born in Derby but live out of the area are now organised by an Administrator which has enabled us to reach our compliance.

6.14 The Named Nurse Children in Care and the Designated Nurse for Looked after Children have been commissioned to deliver training to Local Authority foster carers and residential workers twice a year, however the attendance to a planned training day at the beginning of the year had a low attendance and the feedback received from the attendees was that they would prefer regular shorter sessions which covered a particular health theme in the future. Since receiving this feedback, the Named Nurse for Children in Care and Designated Nurse for Looked after Children have been delivering themed sessions to foster carers. The themes covered over the last year were weaning, infant feeding and immunisations. Additional feedback received resulted in a change of venue to a health centre setting due to the previous venue not being a child friendly environment.

6.15 Both the Named Nurse for Children in care and the Designated Nurse for Looked after Children have delivered training to Barnardo's foster carers on request. This was a full day session on various topics covering all age ranges. On reflection and following their feedback from the session the plan for next year is to deliver certain topics chosen by the foster carers.

6.16 Below are some of the comments from the foster carers following on from our training sessions:



Section 7: Strength and Difficulties Questionnaire (SDQ)

7.1 The Local Authority, Designated Nurse and Named Nurse worked together to redevelop the Strengths and Difficulties Questionnaire (SDQ) pathway (see appendix 2), in order to ensure a more robust process and increase the completion rate of the questionnaire. This process ensures that the SDQ score provided by the Local Authority was in line with the Review Health Assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required). The SDQs are being completed in good time to enable this information to feed into other work, such as the health assessment. An audit was completed by the Named Nurse see appendix 3.

7.2 All data shown below for 2018/19 is provisional until submitted to Department for Education in July;

Year	SDQ received	Percentage of completion rate	Average score (higher the score = higher need)
2016-2017	189	79%	16.3
2017-2018	236	93.6%	16.2
2018-2019	275	92.6%	14.7

7.3 Throughout 2018/19 296 Children in Care required the Strengths and Difficulties Questionnaire completing. From the table above the overall completion rate was 92.9%; this is slightly lower than last year, however much higher than previous national and comparator figures. The average score for 2018-19 was 14.7 which is a significant drop from 15.9. This is our lowest average score ever! This potentially indicates improved emotional health and wellbeing of children and young people in care.

Section 8: Analysis of Adoption and Medical Adviser Activity

This section compiled by Derby City medical advisers Dr A. Marudkar and Dr V. Kapoor, CICA-Derby City

8.1 This section of the report has been prepared based upon the information available from DHCFT data and data provided by the Local Authority regarding adoption related work

Adoption activity:

8.2 There are two medical advisers (Dr Marudkar and Dr. Kapoor) contributing to the Adoption work for Derby city. This includes attending the Adoption panels and preparing the reports for the children coming for adoption panel. The Adult health reports are prepared separately by GP specialist Dr Maclachlan.

8.3 From 1st April 2019, The Adoption services have become regionalised and are now part of Adoption East Midlands.

One adoption panel per month is attended by either of medical adviser in role of panel member, on alternate month basis.

8.4 From 1st April 2018 to 31st March 2019, as per data provided by Derby City social care,

- Number of children matched with adopters - 21.
- Number of children adopted - 30
- Number of separate ADM reports between 1st April 2018 to 31st March 2019 - 7
- Number of Adult medical reports completed by Dr McLachlan - 110
- Number of approved adopters at panel 17
- Number of prospective adopter consultations 20

8.5 The two medical advisers also provide regular training sessions for prospective adopters, foster carers and social workers 3 times a year regarding common clinical issues in adoption scenario, i.e. Impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood borne infection screening in vulnerable and high risk children.

8.6 Dr Kapoor (Medical Advisor) and Named Nurse for Children in Care also deliver a training lecture on Children in Care as apart of GP vocational training course in Derby.

Section 9: Health Data and Performance for Year 2018/19

9.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last three years:

*please note all health data for 2018/19 is provisional until submitted to the Department for Education in July 2019

Health Data Indicator	Year 2016/17	Year 2017/18	Year 2018/19
Annual health assessments	91.2%	92.7%	96.1%
Dental checks	84.1%	87.6%	91.4%
Immunisations up to date	97.7%	93.9%	92.8%
Development checks (two RHAs in the 12 months for under 5 years old)	81.6%	87.5%	91.9%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

9.2 Overall performance of the Health Provider's provision continues to improve with the support of both the clinical and administration team and has been acknowledged within the Clinical Commissioning Group, DHcFT and Local Authority.

9.3 The immunisation uptake rate data is noted to have declined over the last three years, however it has been acknowledged that the data in 2015/16 and 2016/17 is likely to be inaccurate. The Local Authority informatics system had undergone a significant change just before 2015 and this may have had an impact on accuracy of the immunisation data. Since the Children in Care team have access and mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The completion rate of immunisations has decreased slightly during 2018/19 from 2017/18, however even after a slight decrease the performance remains higher than the comparator (90.2%) and national averages (85.3%).

Section 10: Markers of Good Practice (MOGP)

10.1 In November 2018 the Children in Care team submitted the Markers of Good Practice – self assessment tool for Children in Care within Derby City. The Markers of Practice tool, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.

10.2 With the submission of evidence and 'RAG' rating, the tool supports the Children in Care team highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

10.3 Following the MOGP submission, representatives from the Clinical Commissioning Group and Designated Professionals completed a site visit to the Provider in January 2019. A discussion was held between key representatives from DHcFT and the commissioners from both SDCCG and NDCCG (now DDCCG). Each standard was discussed and it was confirmed whether or not the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

10.4 During the MOGP site visit the following was identified by the provider:

- The Trust found the MOGP self-assessment tool easy to understand and were clear around provision of relevant evidence to provide CCG assurance. As the assessment tool was pre-dominantly the same as year 2017/18, allowed benchmarking and opportunity for a stronger and more in depth evidence to be submitted
- The Trust felt that the tool aided them to be 'inspection ready' with regard to CQC
- The Trust found the MOGP process to be an opportunity to reflect, evaluate progress and plan for future improvements
- The Trust found the process to be fair, open, honest and a true reflection of the service
- Discussion took place regarding how to monitor progress year on year and agreements made to utilise the previous year RAG rating within the self-assessment tool and include previous action plans.

10.5 Strengths and challenges were identified, agreed by both parties and an action plan developed for the provider to work through within the year to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice Tool and action plan has been fed back to the Safeguarding Children's Committee by the Head of Safeguarding Children's Service and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

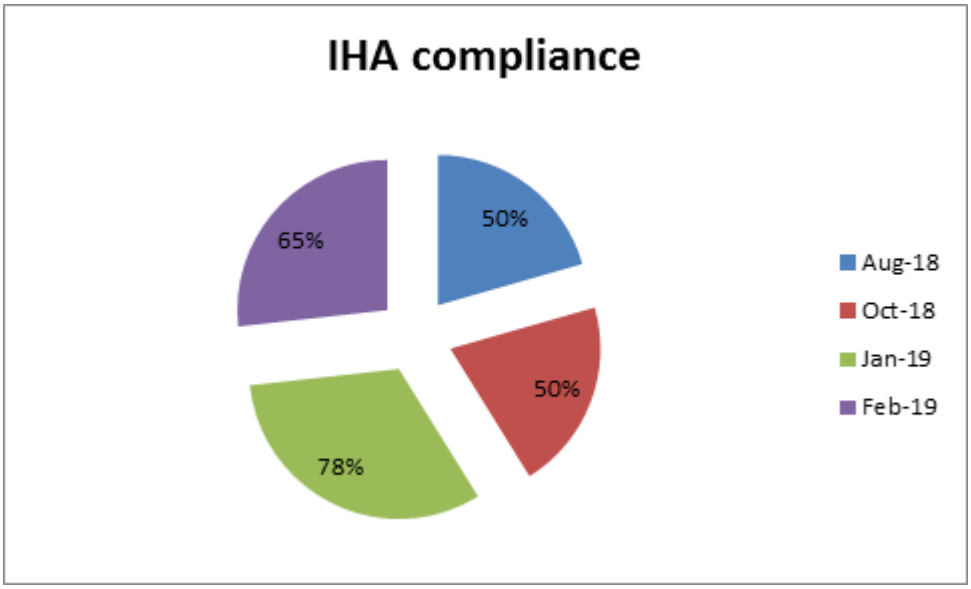
10.6 The Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the Health provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

Section 11: Quality Assurance Processes

11.1 From September 2018 the service provision for Initial Health Assessments developed by increasing the number of Initial Health Assessment clinic slots being offered. Prior to this from July to September temporary provision was put in place to carry out a 'mop up' of outstanding Initial Health Assessments.. This resulted in an increase in compliance, during the last 7 months of 2018/19, with the statutory requirement of all children and young people having an Initial Health Assessment and all relevant completed paperwork being sent back to the local authority within 20 working days.

11.2 The Children in Care Administration team worked together with our reporting team to include a reason for delay on the referral to enable the Provider to understand the narrative behind the non-compliance.

11.3 The Designated Nurse for Looked after Children completes a monthly audit on compliance of Initial Health Assessments; this was set up from August 2018. A snapshot of the results is shown below:



11.4 The Children in Care team complete peer record audits on a quarterly basis using a template which captures if health information is included within the review health assessments. The purpose of these audits is to identify best practice and improvements. The results of these are discussed as a team to share learning. The Designated Nurse for Looked after Children also completes a snapshot of quality audits on the review health assessments completed by the children in care team and completes quality audits on all review health assessments completed by out of area provision. A sample of the results taken from 10 review health assessment quality audits completed by the Designated Nurse for Looked after Children are shown below:

Month of audit	Quality level	Timeliness
November 2018	10 - outstanding	70%

There was a narrative for the 20% (2) that were delayed due to 'was not brought' with 10% (1) having no identifiable reason within the health record of the lateness.

Section 12: Voice of the child

12.1 The voice of the child/young person is embedded in all aspects of the Children in Care service development and delivery. It is essential that children and young people are listened to and their views responded to in order to promote and respect the rights of children.

12.2 The voice of the child is obtained through a variety of mechanisms (dependent on their age, capacity, levels of understanding, analysis of non-verbal cues and body language):

- The child/young person is offered the opportunity where age appropriate to be seen alone

- At each appointment confidentiality is explained to the child or young person
- Identification in collaboration with the child/young person of their own strengths, wishes, feelings and their needs
- Use of the evaluation form after health assessments or any individual contact with a child or young person
- Clear documentation of the child's voice by using direct speech quotes or agreed summary of conversations

12.3 Designated Nurse for Looked after Children and the Named Nurse for Children in Care spent a day with the Local Authority Participation Officer and some young people from the Children in Care Council looking at how to develop the Children in Care website and to gather feedback around the proposed new health passport folders. This was a really productive day with lots of ideas from the young people on how to improve the design of the children in care website and the proposed health passport.

Section 13: Special Educational Needs / Disability

13.1 All children in care who have a Special Educational Need or Disability (SEND) have a flag on their electronic records. All children in care who have an Educational, Health and Care Plan (EHCP) have a patient status alert on their electronic records.

13.2 Universal services also have the patient status alert for Education, Health Care Plan (EHCP) and the flag for Special Educational Needs / Disability (SEND). For all children with an EHCP, the Trust has been informed via internal systems (in collaboration with Local Authority) and received a copy of the plan on the child's electronic records. Early identification of any learning concerns can be captured pre-school during Review Health Assessments for example; developmental delay, behavioural issues and school readiness. The graduated response is delivered where low level intervention can be put in place with support before deciding to refer onto specialist services. The graduated response helps providers, specialist and mainstream provision to work together on achieving the best outcomes for children and young people. If the pre-school child does have a confirmed diagnosis we have a team of specialist health visitors who will support the child and their family as appropriate.

13.3 If a child or young person is born in Derby City and placed in Derby City or is born out of Derby City and placed in Derby City the responsibility of the EHCP lies with Derby City Local Authority. For children and young people who are born in Derby City and placed outside of Derby City the responsibility of the EHCP lies with the Local Authority where the child or young person is placed (see extract from the Code of practice below).

13.4 'A significant proportion of looked after children live with foster carers or in a children's home and attend schools in a different local authority area to the local authority that looks after them. Local Authorities who place looked after children in another authority need to be aware of that authority's Local Offer if the children have SEN. Where an assessment for an EHC plan has been triggered, the authority that carries out the assessment is determined by Section 24 of the Children and Families Act 2014. This means that the assessment must be carried out by the authority where the child lives (i.e. is ordinarily resident), which may not be the same as the authority that looks after the child. If a disagreement arises, the authority

that looks after the child, will act as the 'corporate parent' in any disagreement resolution.' (Special educational needs and disability code of practice: 0 to 25 years (2015).

13.5 The Designated Nurse for Looked after Children has worked closely with Derby City Local Authority and other Local Authorities to get a copy of all final Education, Health and Care Plans to be attached to the electronic records of all children in care. This has improved over the past year so that the children in care team have a copy of the final EHCP attached to the electronic records.

13.6 The Children in Care Nurses complete Review Health Assessments (RHA) on all children and young people who are placed in care (by the health team depending on where the child is living). The Review Health Assessment follows on from the Initial Health Assessment for all children under 5yrs they have a RHA every 6 months and for those over 5yrs every year. The nurse carries out a holistic assessment recognising any health needs, a health care plan is developed and referrals on to appropriate specialist services. The plan is to get appropriate services involved early, supporting the child or young person to prevent the issue moving up to EHCP. This is known as the graduated response. The graduated response is monitored whilst the child or young person is in care through the Children in Care review meetings. This is a child focused meeting where the following topics are discussed;

- Care Plan
- Contact
- Placement
- Health
- Education

This is a multi-agency meeting where services in place are identified and achieved outcomes are discussed.

13.7 All nurses in the children in care team have attended a multi-agency SEND training days on writing outcomes for EHCP and the local Graduated Response. The DHCFT SEND coordinator for the Children's Services has also been out to visit the team to discuss the SEND process and the Local Offer.

13.8 The Children in Care team use a service feedback form which has been adapted to meet the needs of children and young people with special educational needs or disabilities. The Named Nurse for Children in Care and the Designated Nurse for Looked after Children visited one of the Local Authority Children's Homes specifically for children and young people with special educational needs and disabilities to obtain their feedback on the form before implementing this into practice. The form received positive feedback and is now used to gather the views of the children and young people following their Review Health Assessments.

Section 14: Priorities for Year 2018/19

14.1 **DHcFT Provider key priorities for 2019/20:**

- To roll out and implement the use of the new health passports
- To finalise the staff bio's ensuring they are available to all Children in Care, to be enclosed with each appointment letter
- To develop a dashboard and report activity both internally and externally to the Clinical Commissioning Group on a quarterly basis
- To continue to be part of the CONCORDAT operational meetings to ensure this is adhered to for Children in Care
- To deliver themed health sessions to foster carers bi-monthly
- To pilot new Review Health Assessment forms in conjunction with Derbyshire Children in Care Team with a potential improvement in obtaining the voice of the child
- To continue to deliver quarterly action learning sets for all Children in Care Nurses in collaboration with the Designated Nurse for Looked after Children
- To continue to contribute towards the Children in care website
- To focus on quality of Initial Health assessments and Review Health Assessments

14.2 These key priorities are an overview of some of the on-going work and strong commitment to improving the health and welfare of children in care. The vision continues to be that we ensure all children in care reach their natural potential through the interventions of competent, skilled, compassionate professionals and their drive to make a difference to this vulnerable group of children and young people.

Section 15: References

Keep on Caring: Supporting Young People from Care to Independence, June 2016, Department for Education

Promoting the health and well-being of looked-after children, March 2015, Department of Health and Department of Education

Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

Stats: looked after children, Department for Education, 2017
https://www.gov.uk/government/collections/statistics-looked-after-children

APPENDICES

Appendix 1 – Looked after Children cohorts explanation

BORN IN, LIVES IN – Looked after Children born in Derby City and reside within the City.

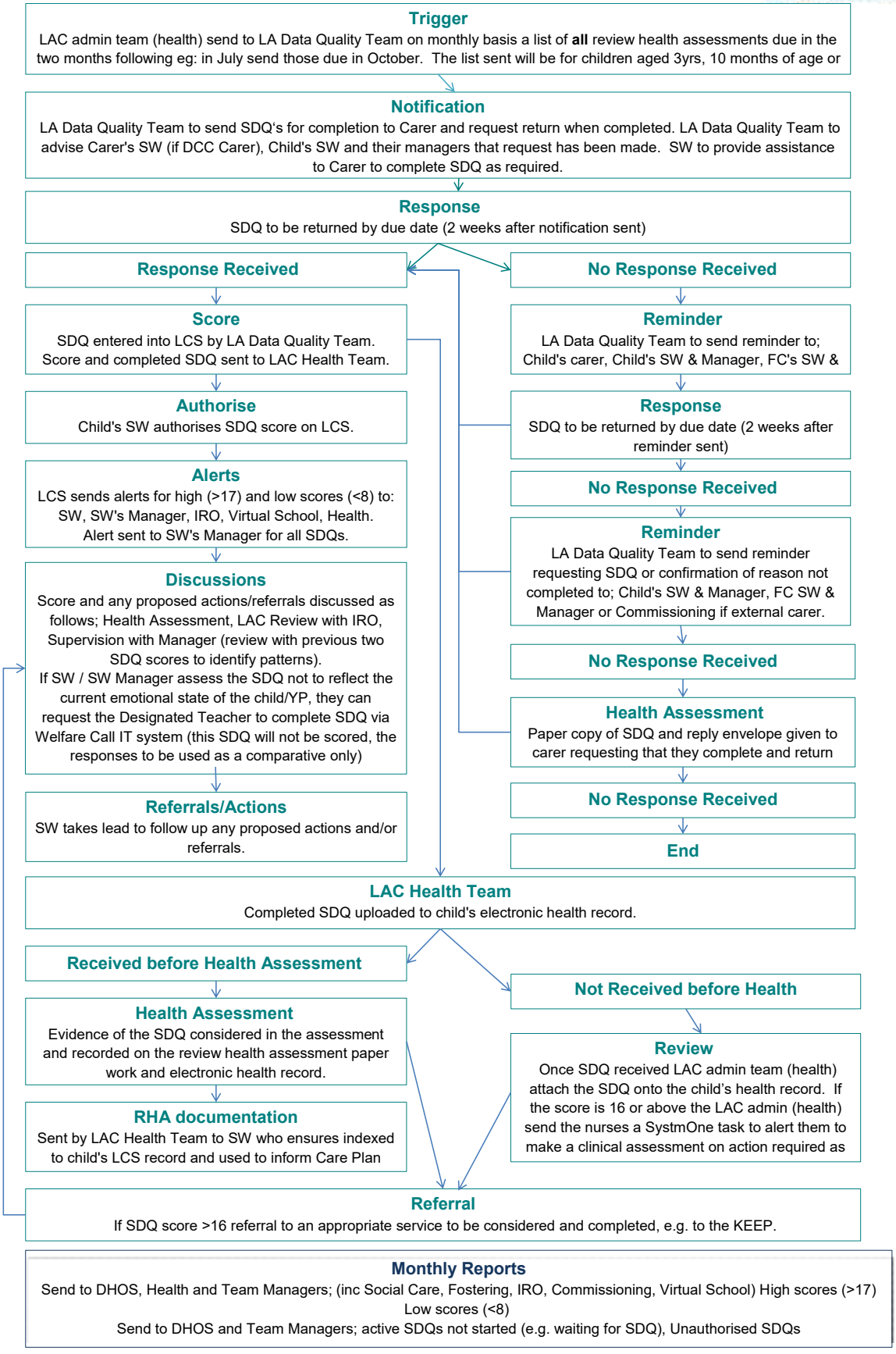
BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City but reside in Derby City.

Appendix 2

See page 25 for the reviewed and implemented Strengths and Difficulties pathway developed by the Local Authority, Designated Nurse for Looked after Children and Named Nurse for Children in Care.


Trigger
LAC admin team (health) send to LA Data Quality Team on monthly basis a list of **all** review health assessments due in the two months following eg: in July send those due in October. The list sent will be for children aged 3yrs, 10 months of age or
Notification
LA Data Quality Team to send SDQ's for completion to Carer and request return when completed. LA Data Quality Team to advise Carer's SW (if DCC Carer), Child's SW and their managers that request has been made. SW to provide assistance to Carer to complete SDQ as required.
Response
SDQ to be returned by due date (2 weeks after notification sent)
Response Received
No Response Received
Score
SDQ entered into LCS by LA Data Quality Team. Score and completed SDQ sent to LAC Health Team.
Authorise
Child's SW authorises SDQ score on LCS.
Alerts
LCS sends alerts for high (>17) and low scores (<8) to: SW, SW's Manager, IRO, Virtual School, Health. Alert sent to SW's Manager for all SDQs.
Discussions
Score and any proposed actions/referrals discussed as follows; Health Assessment, LAC Review with IRO, Supervision with Manager (review with previous two SDQ scores to identify patterns).
If SW / SW Manager assess the SDQ not to reflect the current emotional state of the child/YP, they can request the Designated Teacher to complete SDQ via Welfare Call IT system (this SDQ will not be scored, the responses to be used as a comparative only)
Referrals/Actions
SW takes lead to follow up any proposed actions and/or referrals.
Reminder
LA Data Quality Team to send reminder to; Child's carer, Child's SW & Manager, FC's SW &
Response
SDQ to be returned by due date (2 weeks after reminder sent)
No Response Received
Reminder
LA Data Quality Team to send reminder requesting SDQ or confirmation of reason not completed to; Child's SW & Manager, FC SW & Manager or Commissioning if external carer.
No Response Received
Health Assessment
Paper copy of SDQ and reply envelope given to carer requesting that they complete and return
No Response Received
End
LAC Health Team
Completed SDQ uploaded to child's electronic health record.
Received before Health Assessment
Not Received before Health
Health Assessment
Evidence of the SDQ considered in the assessment and recorded on the review health assessment paper work and electronic health record.
RHA documentation
Sent by LAC Health Team to SW who ensures indexed to child's LCS record and used to inform Care Plan
Review
Once SDQ received LAC admin team (health) attach the SDQ onto the child's health record. If the score is 16 or above the LAC admin (health) send the nurses a SystmOne task to alert them to make a clinical assessment on action required as
Referral
If SDQ score >16 referral to an appropriate service to be considered and completed, e.g. to the KEEP.
Monthly Reports
Send to DHOS, Health and Team Managers; (inc Social Care, Fostering, IRO, Commissioning, Virtual School) High scores (>17) Low scores (<8)
Send to DHOS and Team Managers; active SDQs not started (e.g. waiting for SDQ), Unauthorised SDQs

Appendix 3

Strengths and Difficulties Audit – completed October 2018

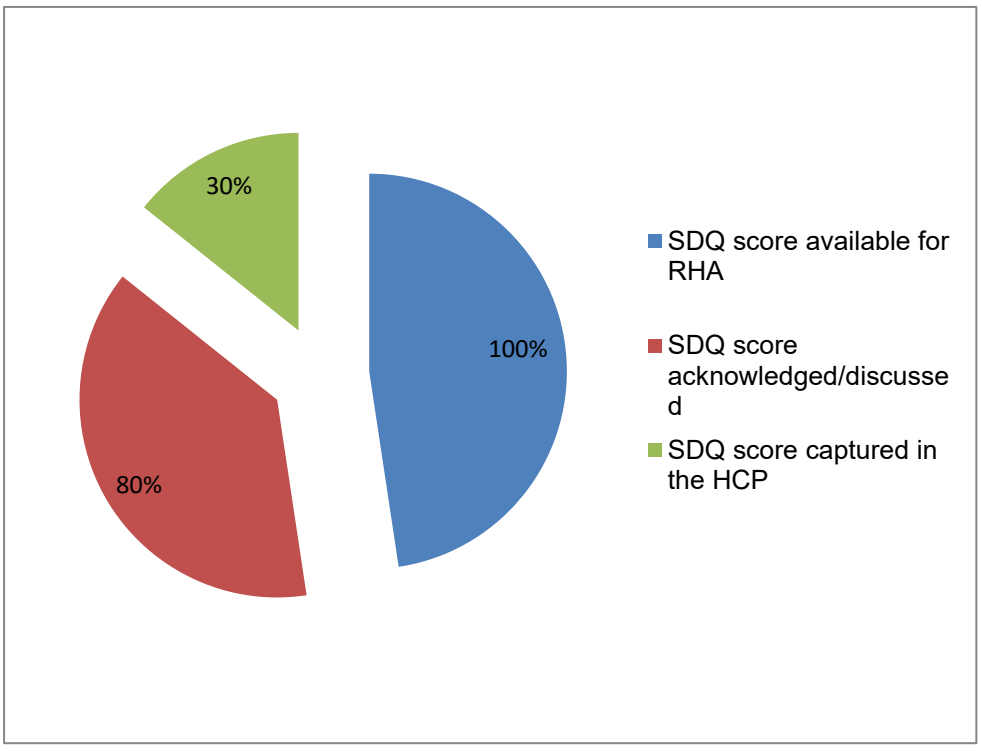
Over the past year DHcFT, SDCCG and the Local Authority have been having regular meetings around the Strengths and Difficulty Questionnaires to develop a process in order to increase the completion rate of the questionnaire. This process ensures that the SDQ score provided by the Local Authority is in line with the review health assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required).

The completion rate of SDQs is significantly higher within year 2017/18 than previous years and this is a direct result of the newly implemented process and joint efforts from the Children in Care team and Local Authority Business Support Services. Further work is being undertaken in order to ascertain progress and to further develop the meaning/impact of the SDQ score for the child/young person.

I randomly selected 10 children and young people's electronic records to identify whether the process was successful. The three areas I focused on were;

- Was the SDQ score available prior to the RHA appointment
- Was the SDQ score acknowledged and discussed with the child/young person or carer by the nurse
- Was the SDQ score captured in the child or young person's health care plan

Please see below for the results following the audit;



From all the records involved in the audit the SDQ score was available prior to the review health assessment being completed by the Children in Care nurse. If the score is not available at the time of the review health assessment the Specialist Nurse ensures the carer receives a blank copy of the SDQ form, provided by the Local Authority and requests it's submission via a stamped addressed envelope. Once the SDQ score is received by the Children in Care Health team, post review health assessment, the administration team follow a defined process, alerting the Specialist Nurses to high score SDQs. This allows the Children in Care Nurse to make a decision as to whether a referral on to another service is required or any other action is needed.