CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
22 FEBRUARY 2016

ITEM NO. .....

HEALTH ASSESSMENTS FOR CHILDREN LOOKED AFTER

SUMMARY REPORT

Purpose of the Report

1. To update members on Health Assessments for Children Looked After

Summary

2. This report outlines the importance of undertaking Health Assessments for Children Looked After and sets out the key performance measures and plans to improve performance.

Recommendation

3. It is recommended that Members note the action being taken to address a dip in performance in 2015/16.

Susanne Joyner
Director of Children & Adult Services

Background Papers

(a) Children Act 1989
(b) The Care Planning, Placement and Case Review (England) Regulations 2010
(c) SCIE/NICE recommendations on looked after children: Promoting the quality of life of looked-after children and young people Published: October 2010 Review date: October 2013
(d) Ten questions to ask if you're scrutinising services for Looked After Children (LGA, NCB, CfPS, 2012)
(e) Promoting the health and wellbeing of looked-after children (DfE, 2015)
(f) Inspection of services for children in need of help and protection, children looked after and care leavers, (OFSTED, 2015)

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	Supporting Looked After Children to maintain their health and well-being.
Carbon Impact	There are no implications arising from this report.
Diversity	Ensuring all children and young person's health needs are addressed.
Wards Affected	All wards are affected.
Groups Affected	Looked After Children.
Budget and Policy Framework	This decision does not represent a change to the budget and policy framework.
Key Decision	No.
Urgent Decision	No.
One Darlington: Perfectly Placed	Support for Looked After Children contributes to the One Darlington priority and to provide children with the best start in life.
Efficiency	Streamlined practice and improved outcomes.

MAIN REPORT

Legislative Context

4. The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after. 'Promoting the health and well-being of looked-after children' (2015) is statutory guidance for local authorities, clinical commissioning groups and NHS England.

5. The corporate parenting responsibilities are relevant regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

   (a) The local authority that looks after the child must arrange for them to have a health assessment as required by *The Care Planning, Placement and Case Review (England) Regulations 2010*.
   (b) The initial health assessment must be done by a registered medical practitioner. Review health assessments may be carried out by a registered nurse or registered midwife.
   (c) The local authority that looks after the child must ensure that every child it looks after has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment. The health plan forms part of the child's overall care plan.

6. The local authority that looks after the child must arrange for them to have a health assessment as required by *The Care Planning, Placement and Case Review (England) Regulations 2010*.

7. The initial health assessment must be done by a registered medical practitioner. Review health assessments may be carried out by a registered nurse or registered midwife.

Health Assessments and Plans

8. Local authorities are responsible for making sure a health assessment of physical, emotional and mental health needs is carried out for every child they look after, regardless of where that child lives. Regulation 7 of the *Care Planning, Placement and Case Review (England) Regulations, 2010* requires the local authority that looks after them to arrange for a registered medical practitioner to carry out an initial assessment of the child's state of health and provide a written report of the assessment.

9. The initial health assessment should result in a health plan, which is available in time for the first statutory review by the Independent Reviewing Officer (IRO) of the child's care plan. That case review must happen within 20 working days from when the child started to be looked after.

10. The statutory health assessment should address the areas specified in section 1 of Schedule 1 of the care planning regulations. These areas are:

    (a) the child's state of health, including physical, emotional and mental health
    (b) the child's health history including, as far as practicable, his or her family's health history
    (c) the effect of the child's health history on his or her development
    (d) existing arrangements for the child's health and dental care appropriate to their needs, which must include:
        i. routine checks of the child's general state of health, including dental health
        ii. treatment and monitoring for identified health (including physical, emotional and mental health) or dental care needs
        iii. preventive measures such as vaccination and immunisations
        iv. screening for defects of vision or hearing
        v. advice and guidance on promoting health and effective personal care any planned changes to the arrangements
        vi. the role of the appropriate person, such as a foster carer, residential social worker, school nurse or teacher, and of any other person who cares for the child in promoting his or her health.

Impact of undertaking Health Assessments for Children Looked After: Research

Health assessments, records and information

11. Evidence indicates that accurate and up-to-date personal health information has significant implications for the immediate and future wellbeing of children and young people during their time in care and afterwards. Understanding their own 'health history' is an essential part of growing up securely. Inconsistent record keeping can lead to wrong decisions by professionals and adversely affect the child or young person. SCIE/NICE (2013).

12. Looked After Children and young people share many of the same health risks and problems as their peers, but they frequently enter care with a worse level of health due to the impact of poverty, abuse and neglect. Evidence suggests that looked-after children are nearly five times more likely to have a mental health disorder than all children. As with educational attainment, there is statutory guidance on promoting the health and wellbeing of Looked After Children (DfE, 2015). This applies to local authorities, CCGs and NHS England. The health needs of each Looked After Child must be assessed within four weeks of a child becoming looked after and should form the basis of their health plan. As with the Personal Education Plan (PEP), this feeds in to the child's care plan. Local authorities are also required to make sure that a 'strengths and difficulties' questionnaire is completed to assess for emotional and behavioural difficulties.

13. The publication 'Ten questions to ask if you're scrutinising services for Looked After Children' produced for elected members and others working in children's services suggests the following questions should be asked:

    (a) What proportion of children's health assessments and dental checks are carried out on time?
    (b) Is there a designated doctor and nurse for looked-after children?
    (c) Are looked-after children a priority group for getting access to child and adolescent mental health services (CAMHS) and how long are waiting times for referrals?
    (d) As an at-risk group, what access do looked-after children and young people get to services to help with substance misuse, sexual health and teenage pregnancy?
    (e) What support is given to foster carers and young people themselves about promoting healthy lifestyles?
    (f) Do you receive regular reports on the health needs and outcomes of looked-after children?
    (g) What do looked-after children and young people themselves say about their health needs and priorities and how well they are met?
    (h) Is this evidence about outcomes and experiences used to inform the commissioning of services?
    (i) (LGA, NCB, CfPS, 2012)

14. The Corporate Parenting Panel monitor our performance in the provision of high quality care to children looked after, including monitoring their health and wellbeing.

OFSTED report (2015)

15. In September 2015 OFSTED published a report following an inspection of services for children in need of help and protection, children looked after and care leavers.

16. The report highlighted some improvement in performance regarding the completion of initial health assessments within timescales, but performance was still deemed to not yet be good enough. Performance regarding review health assessments, dental checks and immunisations was deemed good and all are above the England average. Up-to-date immunisations were, at 94%, an improvement on 2013–14 when they were at 85% and the England average was 87%. Dental checks stood at 93%, the same as 2013–14 when the England average was also 93%. Completed annual health assessments were at 94%, an

improvement on 2013–14 when it was 93% and the English average was 88%.

17. OFSTED also stated that strengths and difficulties questionnaires (SDQs) did not systematically inform health assessments but recognised that the Family Intervention Team (FIT) had recently reviewed the emotional health needs of all school age children looked after using SDQs. Where concerns were identified, the FIT therapy service consulted with the child's social worker about the need for therapy. OFSTED found there was good access to therapeutic services located in FIT and in child and adolescent mental health services.

Improvement Plan

18. Following the OFSTED report an improvement plan was developed which addresses issues regarding health raised within the report.

19. Recommendation 15 of the improvement plan was to ensure that all children looked after have timely initial health assessments. The improvement outcomes being that Looked After Children have regular health checks and enjoy good health outcomes and all health needs are dealt with at the earliest point.

20. Actions:

    (a) Multi-agency review of consent form to improve process.
    (b) Social Workers and LAC Nurse to work closely to ensure timely health assessments when children become looked after and annual reviews.

21. The measures of improvement are an increased percentage of initial health assessments being completed within timescales, the percentage of Looked After Children with a completed annual health assessment and the percentage of paperwork sent to CDDFT within seven days. Additionally, the percentage of Looked After Children (1 year +) that have up to date dental checks. The targets and current performance are as follows:

Key Performance Indicators	Target	Current Performance / Progress
% paperwork sent to CDDFT within 7 days	75% March 2016	@ 30-09-15 was 50%
% of new children looked after where initial health assessment has been completed within 20 working days.	95% March 2016	@ 30-09-15 was 85%
% of CLA with up to date Health Checks (CLA 1 yr +)	90% June 2016	61.60% @ 22-01-16
% of CLA with up to date Dental Checks (CLA 1 yr +)	90% June 2016	69.78% @ 31-01-16

22. In order to make improvements and meet the targets action has been taken to improve practice and processes. A new process has been agreed operationally that commences on the 15th February 2016 to ensure paperwork is sent to CDDFT in line with the 7 day requirement alongside ensuring the 20 day IHA deadlines are met. There is also a process in place to ensure the completion of medical consent forms within the 7 day timescale. Team managers and practitioners are looking into every case where dental checks are required for Looked After Children to ensure they are booked and subsequently attend the appointment.

23. The introduction of a new case management system in Children's Social Care will provide an even more streamlined process for practitioners to assist in the timely assessment of both health and dental checks.

Current numbers of Looked After Children

24. The number of Looked After Children @ 25 January 2016 is 191.

25. This number is broken down as follows:

    (a) Male: 106
    (b) Female: 85

26. Age breakdown:

    (a) 0-4 50
    (b) 5-9 39
    (c) 10-15 65
    (d) 16+ 37

27. The Looked After Children Health Nurse undertakes regular audits of the timeliness of Initial Health Assessments (IHA). The following data is taken from these audits. Full audit report for data, process and actions – see **Appendix 1.**

    Audit outcomes:

    01.07.15 – 30.09.15 (3 month period) – 85% IHA completed within 20 working days

    01.04.15 – 30.06.15 (3 month period) – 77.7% IHA completed within 20 working days

    01.01.15 – 31.03.15 (3 month period) – 46.1% IHA completed within 20 working days

    01.10.14 – 31.12.14 (3 month period) – 11.1% IHA completed within 20 working days

    01/12/13 – 30/05/14 (6 month period) - 55.2% IHA were completed within 20 working days

    01/06/13 – 30/11/13 (6 month period) - 58.6% IHA were completed within 20 working days

28. Where there have been dips in performance as noted above actions have been taken to address the issues such as outlined above regarding changes to processes and using escalation where appropriate (see appendix 2)

The Looked After Children Health Nurse also reports on the following:

LAC health outcomes 2014-2015 (Children looked after continuously for 12 months)

29. The census statistics for April 2014 to the end of March 2015 are as follows:

    (a) Immunisations 91.04% (up from 85% last year) – Above 87.1% England LA outcomes at 31.03.14 & 88% at 31.03.15

    (b) Teeth check 93.28% (up from 93% last year) – Above 84.4% England LA outcomes at 31.03.14 & 86% at 31.03.15

    (c) Annual health assessments 94.78% (up from 93% last year) – Above 88.4% England LA outcomes at 31.03.14 & 90% at 31.03.15

Data

Dental

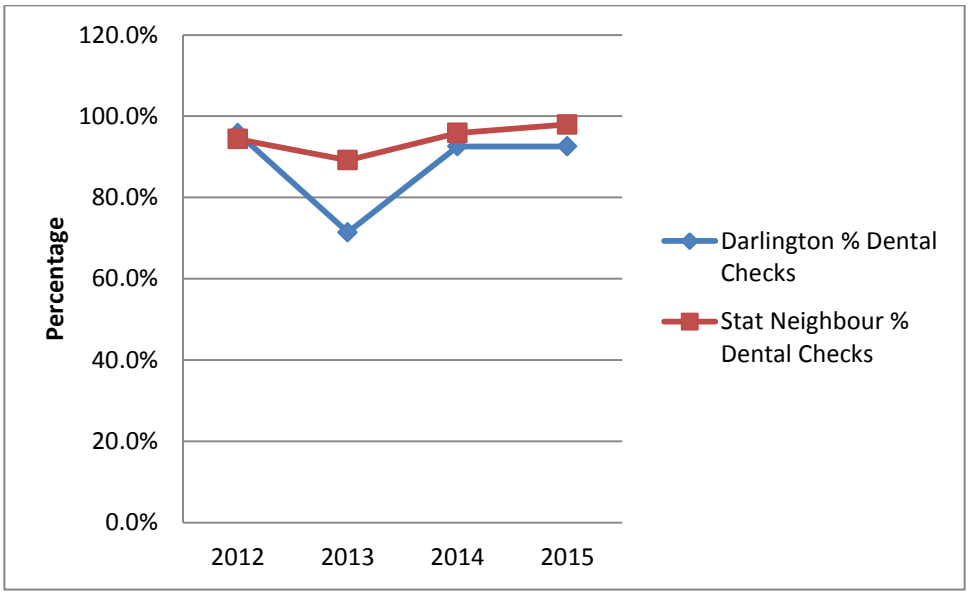
30. The population of children looked after for longer than 12 months in Darlington has been consistently lower than that of statistical neighbours, and therefore the cohort requiring annual dental checks is lower.

	Darlington LAC > 12 months	Darlington Dental Checks
2012	120	115
2013	140	100
2014	135	125
2015	135	125

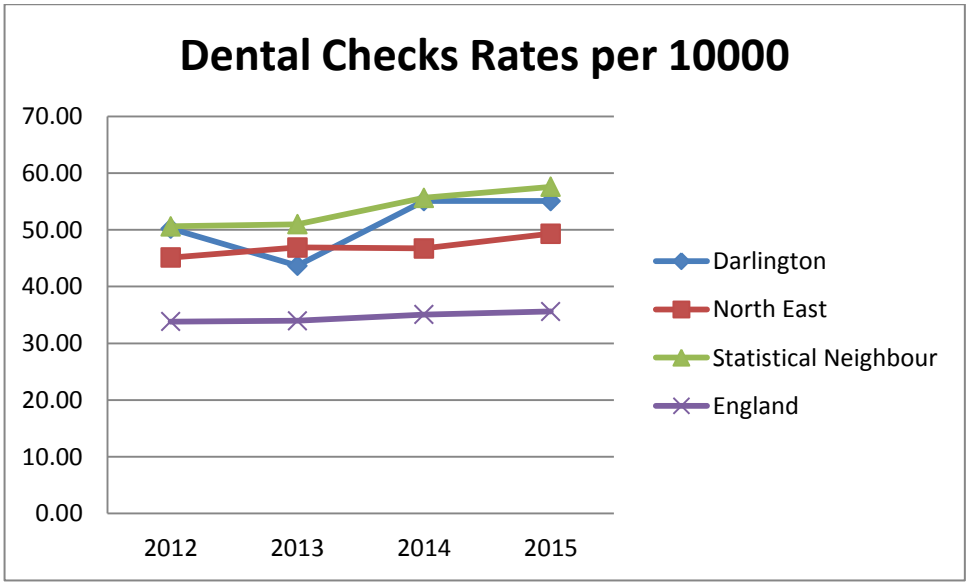
	Stat Neighbour LAC > 12 months	Stat Neighbour Dental Checks
2012	266	251
2013	284	253
2014	287	276
2015	291	286

31. When comparing percentages of dental checks completed since 2012, we can see that both Darlington and statistical neighbours achieved a high rate of compliance (95.8% and 94.4% respectively). Levels of performance dipped in 2013 both locally and for statistical neighbours, with Darlington dropping to 71.4 % dental checks completed against a larger cohort than the previous year.

32. Performance improved in 2014 back up to 92.6% (95.9% for statistical neighbours) and has been maintained against the same size cohort for 2015. Statistical neighbours have improved slightly.



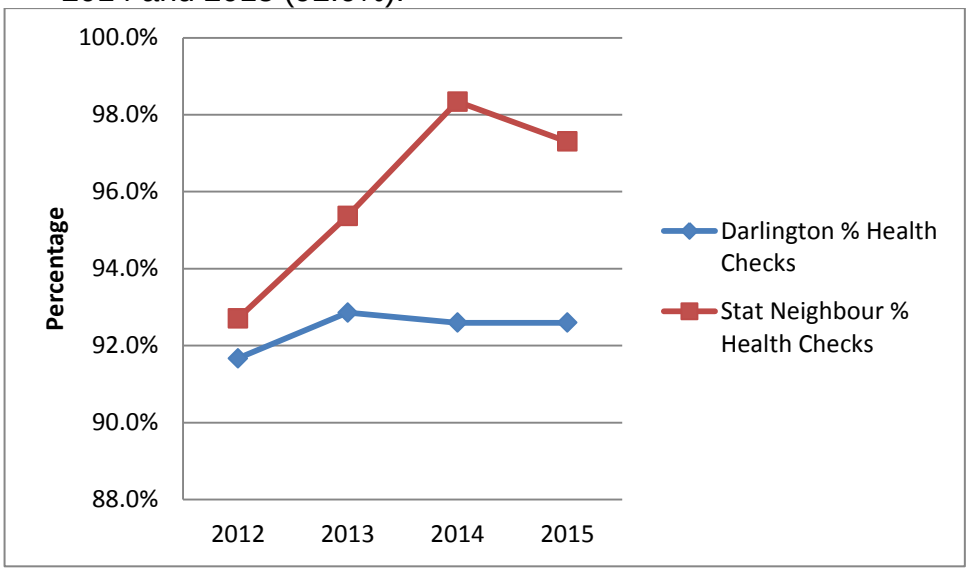
33. The figures taken from published data have been extrapolated up over into rates per 10000 to enable comparison with the North East and national outturn. In this respect the data shows that Darlington has performed consistently above the national level and in 2012 was performing better than the North East outturn, as were statistical neighbours.



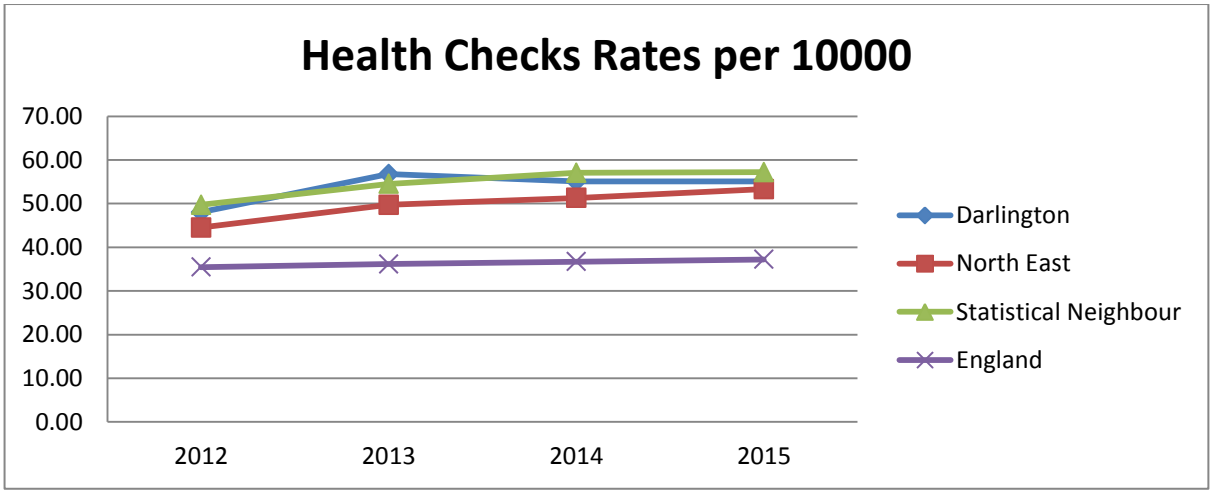
34. In 2013 rates dipped below that of the North East, but rose significantly in 2014 to closer to that of statistical neighbours. This level of performance was maintained in 2015.

Health

35. Performance on annual health checks for both Darlington and statistical neighbours has been over 90%. Performance in Darlington peaked in 2013 (92.9%) and dipped slightly for 2014 and 2015 (92.6%).



36. Similarly the data has been converted into rates per 10000 to enable comparison with the North East and national outturn. In this respect Darlington compares consistently higher than both the North East and national rates for annual health checks. Rates per 10000 were also higher in 2013 than statistical neighbours, but have dipped slightly below this across 2014 and 2015 (although still above the North East rate).



Issues to overcome to improve performance

37. The key issue with achieving improvements in the timeliness of IHAs is ensuring the forms are completed in a timely manner at the point a child is taken into care. The actions within the improvement plan will address this issue in terms of form review and improved process. The introduction of an improved social care case management system called Liquid Logic

during 2016 will provide more streamlined processes.

38. Where problems remain a robust escalation policy is in place (see Appendix 2). All communication (telephone/emails) with social workers, practice supervisors and team managers is recorded in each child's individual record. This is not currently collated into a report. See **Appendix 2** for escalation policy.

Developments

Health Passports

39. 'Health Passports' are designed to accompany children through their time in care. They can be used to keep together important medical and historical information which the child or young person can take with them and pass on to their carer. The passport moves around with the child or young person providing essential information for the child's future carer.

40. The 'Health Passport has now been developed and a pilot across County Durham and Darlington is running. Five care leavers have been identified from Darlington. The LAC nurse will be arranging to see the identified young people in February to complete the 'passports' and will also ask them to complete an evaluation sheet. A further meeting will then be held to evaluate the pilot and establish what changes are required.

Escalation Policy

41. Improved data collation has been discussed with the LAC nurse who is to raise this with her line manager.

Health Data Collection

42. County Durham and Darlington NHS foundation trust have developed newstandard operating procedures that include an updated review health assessment template which gathers more data from GPs and other health sources that will enable more meaningful data that will better inform individual health plans and service improvements.

Further Developments to Improve Performance Including Related Health Issues

43. The health and wellbeing of Looked After Children is influenced by nearly all aspects of their lives and the care they receive. As Looked After Children they are more likely to have experienced deprivation and poverty and as a result are more likely to experience poorer health outcomes than their peers much of which is preventable or modifiable. Recent guidance highlights the importance of adopting approaches which facilitate early identification and prevention of health problems (DfE, DoH 2015).

44. The assessment process is but one part of ensuring the holistic health needs of Looked After Children are met. Good quality interventions and cooperation between partner agencies is essential to make the improvements required and enable Corporate Parents to be reassured the questions to be asked when scrutinising services are adequately

addressed. As part of making these improvements the following developments will be taken forward.

(a) Robust management oversight of the performance data to ensure we are on target regarding health and dental checks via monthly performance clinics, team meetings and individual supervision sessions with practitioners
(b) Weekly discussions with the senior nurse for Looked After Children at the Darlington Access to Resources Panel to check on performance and take remedial action where required
(c) Use the escalation policy where required
(d) Ensure the processes regarding the collection of data from the SDQ scores (Strengths and Difficulties Questionnaire) are complied with and the services put in place where there is an identified need
(e) Development of pathways for 0-19 and sexual health services to ensure Looked After Children have the same level of access as their peers – a task and finish group to be convened to include LAC nurse, RESH Coordinator, Public Health Lead and a representative from 0-19 service and links to the Darlo Care Crew.
(f) Liaise with the Darlo Care Crew to gain views on how will current actions meet the health needs of children looked after and to discuss improvements eg health passports

Department for Education & department of Health (2015). *Promoting the health & well-being of looked after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England.*

Appendix 1

DARLINGTON Initial Health Assessment TIMESCALE Audit
July - September 2015
(1st October 2014 – 30th September 2015)

Jayne Ralphs
Senior Nurse Looked After Children

DARLINGTON Initial Health Assessment TIMESCALE audit
1st October 2014 – 30th September 2015

Purpose of the audit

All young people who become Looked After (LAC) by the Local Authority are required to have an Initial Health Assessment (IHA) by a medical adviser within 20 working days of them becoming LAC. The purpose of this audit is to monitor the number of IHA being completed within the 20 working days timescale, the aim of which is 100%.

There are different stages to achieving these timescales which are being actively promoted and monitored by the escalation SOP. The process is influenced by:

1. The Local Authority (obtaining and sending completed IHA paperwork)
2. The LAC team (requesting a paediatric appointment)
3. The Paediatric Team (arranging appointments and completing the health assessments)

1. Data collection

1.1 Total number of young people becoming looked after.

1.2 Total number of LAC IHA paperwork received by CDDFT LAC Team this quarter.

1.3 IHAs paperwork received from LA within 20 working days of coming into care.

1.4 IHAs paperwork received from LA within 0-7 working days of coming into care.

1.5 IHAs paperwork received from LA within 8-20 working days of coming into care.

1.6 IHA paperwork received from LA after 20 working days of coming into care.

1.7 Number of IHA requests processed by LAC admin within 2 working days of the paper work being received.

1.8 Number of children seen by a paediatrician within 20 working days of coming into care.

1.9 Number of children seen by a paediatrician within 20 working days of receiving IHA paperwork from LAC Health Team.

1.10 Number IHAs outstanding after this quarter.

1.11 Total number IHAs outstanding including previous quarters.

Table Data collection

		Q3 :01/10/14–31/12/14	Q4:01/01/15–31/03/15	Q1:01.04.15-30.06.15	Q2: 01.07.15-30.09.15	
1.1	Total number of young people becoming looked after	**27**	**13**	**18**	**20**	
1.2	Total number of LAC IHA paperwork received by CDDFT	**19 (70.3%)**	**12 (92.3%)**	**18 (100%)**	**20 (100%)**	
1.3	IHAs paperwork received from LA within 20 working days	**11 (40.7%)**	**10 (76.9%)**	**18 (100%)**	**19 (95%)**	
1.4	IHAs paperwork received from LA within 0-7 working days	**1 (3.7%)**	**5 (38.4%)**	**11 (61.1%)**	**10 (50%)**	
1.5	IHAs paperwork received from LA within 8-20 working days	**10 (37%)**	**5 (38.4%)**	**7 (38.8%)**	**9 (45%)**	
1.6	IHA paperwork received from LA after 20 working days	**8 (29.6%)**	**3 (23%)**	**0 (0%)**	**1 (5%)**	
1.7	Number of IHA requests processed by LAC admin within 2 working days of the paperwork being received.	**17 (89.4%)**	**12 (100%)**	**17 (94.4%)**	**20 (100%)**	
1.8	Number of children seen by paediatrician within 20 working days of coming into care.	**3 (11.1%)**	**6 (46.1%)**	**14 (77.7%)**	**17 (85%)(plus X1 cancelled, X1 DNA, X1 not informed LAC until 24.09.15)**	
1.9	Number of children seen by a paediatrician within 20 working days of receiving IHA paperwork.	**14 (73.6%)**	**12 (100%)**	**15 (88.2%)**	**17 (85%) (plus X1 cancelled twice & X1 DNA & then cancelled, carer unable to attend in timescale)**	
1.10	Number IHAs outstanding after 20 working days.	**9 (33.3%)**	**1 (7.6%)**	**1 (5.5%)**	**1 (not informed**	

					LAC until 24.09.15)	
1.11.	Total number IHAs outstanding including previous quarters.	**9**	**10**	**3**	**3 (X1 unable to process-YOI, X1 LAC since 27.02.15-not informed until 20.10.15, X1 LAC since 31.07.15-not informed until 24.09.15)**	

Analysis of the results:

The overall aim of this audit is to monitor the number of IHA's being completed within the statutory 20 working day timescale, the aim of which is 100%.

From the results, it can be seen that in quarter 3 (Oct-Dec 2014), 11.1% of children were seen by a paediatrician within 20 working days of coming into care. In the current reporting period (quarter 2 Jul-Sep 2015) this has increased to 85%, which is an increase of 73.9% during this timeframe.

Further analysis of the results can be broken down into the 3 stages that influence this process. These 3 stages are now actively promoted by the escalation SOP, which was formulated and implemented in response to poor compliance with the above target.

The 3 stages:

1. **The Local Authority (obtaining and sending completed IHA paperwork).**

From quarter 3 (Oct-Dec 2014), to quarter 1 (Apr-Jun 2015), there was a significant increase of IHA paperwork received from the LA within 20 working days from 40.7% to 100% (Table 1.3). In the current quarter 2 (Jul-Sep 2015), this figure has dropped however to 95% demonstrating the need to improve.

Receiving the IHA paperwork in 0-7 days (Table 1.4) is crucial to allow the paediatric team to provide an appointment and complete an IHA in 20 working days of a child coming into care. From the results, it can be seen that in quarter 3 (Oct-Dec 2014), 3.7% of paperwork was received in these timescales and this figure increased to 61.1% in quarter 1 (Apr-Jun 2015). However, in the current reporting period quarter 2 (Jul-Sep 2015), this figure has decreased to 50% showing fluctuations in improvement and the need to significantly improve this part of the process.

It is therefore important that the above areas are closely monitored by the Escalation Policy to ensure that this part of the process is embedded into practice.

There has been an increase from 37% in quarter 3 (Oct-Dec 2014) to 45% in the current quarter 2 (Jul-Sep 2015) of IHA paperwork being received after this timescale (within 8-20 working days), which as previously highlighted, leaves little or no time for the paediatric team to arrange the IHA.
It is also important to note that in the current quarter 2 (Jul-Sep 2015) there was still a small percentage of paperwork (1%) received after the 20 working day deadline resulting in this IHA being completed outside of timescales.

Action required:

1. Meeting with the Local Authority 11.11.15:
   - Local Authority to consider area team admin personnel to be allocated secure email accounts and chase up IHA consent forms
   - Local Authority has distributed LAC process to social work teams including process for IHA consent
   - Local Authority will consider letters of manager's advice for Social Workers who fail to follow management instruction.
2. Continued implementation of escalation policy.
3. Checkpoints are as follows where Social Workers are informed to gain consent and forward paperwork within 0-7 days:
   - Placement Resource Panel for planned placements
   - By Local Authority if emergency placement
   - When referral made for placement
   - Fostering Service when placement arranged
   - LAC Health Admin – 2 working days of becoming LAC – email to:
     Social Worker
     Local Authority Practice Supervisor

- LAC Health Admin – 5 working days of becoming LAC – email to:
  Social Worker
  Local Authority Practice Supervisor
  Local Authority Service Manager
  Senior Nurse LAC

- Senior Nurse LAC – 7 working days of becoming LAC - telephone call:
  Local Authority Service Manager
  Local Authority Strategic Manager/Head of Service

- A weekly list of any outstanding paperwork exceeding 20 working days is sent to:
  Local Authority Service Managers
  Local Authority Strategic Manager/Head of Service
  Health LAC Manager and Designated Nurse

4. The Senior Nurse LAC has, and continues to raise awareness of the consent process for the timely completion of IHA's by visiting the social work teams, providing a bite-sized training session and continuing to raise awareness of the timely completion of IHA's at the Darlington Access to Resource Panel (DARP) and at various key meetings.

2. The LAC Team (requesting a paediatric appointment)

The percentage of IHA requests processed within 2 working days (Table 1.7) in the current quarter 2 (Jul-Sep 2015) has now returned to 100%, having fluctuated slightly over the last 4 quarters. The lowest figure was 89.4% in quarter 3 (Oct-Dec 2014).
Action required:
LAC admin to prioritise IHA paperwork to ensure 100% is processed within 2 working days.

3. The Paediatric Team (arranging appointments and completing the health assessments)

There has been a significant increase of children coming into care being seen by a paediatrician within the statutory 20 working day timescales between quarter 3 (Oct-Dec 2014) 11.1% to quarter 2 (Jul-Sep 2015) 85% (Table 1.8). The latter figure would have been 95%; however there was one cancellation by carers and one DNA. In respect of the remaining child, the LAC health team were not informed that this child had become looked after until after the 20 working day deadline.

In the last report, there had been a slight decrease in the percentage of children being seen by a paediatrician within 20 working days of the paediatric team receiving the IHA paperwork; 100% in quarter 4 (Jan-Mar 2015) to 88.2% in quarter 1 (Apr-Jun 2015)). Figures for this quarter 2 (Jul-Sep 2015) have decreased slightly to 85% (Table 1.9):

- Two children were offered *two* appointments each within 20 working days of the paediatric department receiving paperwork. Had both children attended either of these appointments the figure would have been 95%.
- One child has been offered an IHA appointment outside of the targeted timescale in line with carers wishes.

Action required:

1. Paediatric Team from beginning November 2015 are monitoring DNAs, cancellations and paediatric system problems. This will be reflected in subsequent quarterly reports.
2. Senior Nurse LAC has met the Local Authority 11.11.15 and highlighted the importance of Looked After Children/Young People attending for IHAs.
3. Leaflet re importance of IHAs being developed in partnership with Designated Doctor for LAC and Senior Nurse LAC for foster carers, residential homes, birth parents and Social Workers.
4. Social Workers need to be reminded that they can give consent if a child has an Interim Care Order.

Conclusion of the audit:

It can be seen from the analysis that the number of IHA's being completed within the statutory 20 working day timescale, has increased from 11.1% in quarter 3 (Oct-Dec 2014) to 85% in quarter 2 (Jul-Sep 2015). The implementations of the escalation procedures and a number of other strategies discussed earlier have enabled this improvement. It is important not to become complacent however, as the fluctuating percentages in the various stages evidences the process is not robust. The targets for IHAs being completed by the paediatrician within 20 working days of the child coming into care and for IHA paperwork being received within 0-7 working days of the child coming into care are both 100%. The exception to this would only be that the person with PR is refusing to give consent.

Recommendations

i. The LA to ensure the timely completion of IHA's is a priority.
ii. The LA to ensure policies and procedures are in place so that all children coming into care have an IHA completed within the statutory timescale of 20 working days.
iii. The LA should send all IHA paperwork to the LAC admin within the first 0-7 working days (optimum standard) of a child coming into care.
iv. The LAC Health Team to ensure that 100% of all requests are processed within 2 working days.

v. The LAC Health Team to continue to implement the Escalation SOP.
vi. The Designated Doctor for LAC to ensure completion of IHA's within statutory timescales is a priority for the paediatric team.
vii. The Designated Doctor for LAC to ensure the paediatric team maintains and makes further improvements of processes to facilitate the timely arrangement and completion of IHA's.
viii. IHA audit to continue on a 3 monthly basis.

CHILD IS PLACED IN LOCAL AUTHORITY CARE

It remains the responsibility of the Local Authority Social Worker to ensure that timescales are met

Appendix 2

IMMEDIATELY
or next working day

SOCIAL WORKER

A **signed** Consent to Share form and Initial Health Assessment form are completed by the Social Worker and sent via secure email to the LAC Health Administrator

1. BAAF Initial Assessment form
2. BAAF Consent to share information form

Both forms should be on your desk top

The Social Worker will inform the LAC health administrator that a child has been placed in LA care

Durham cdda-tr.LACTeam@nhs.net

Darlington cdda-tr.DarlingtonLAC@nhs.net

IMMEDIATELY
on receipt of consent

LAC HEALTH ADMINISTRATOR

On receipt of the BAAF forms a request is made for Paediatric Initial Health Assessment

IMMEDIATELY
or next working day

LAC HEALTH ADMINISTRATOR

If no BAAF forms are received by the LAC Health Administrator an email request will be sent to the Social Worker for the BAAF forms

Within 2 WORKING DAYS of becoming LAC

LAC HEALTH ADMINISTRATOR

If no BAAF forms are received in 2 working days the LAC Health Administrator will email the

- Social Worker
- LA Team Manager/Practice Supervisor

Within 5 WORKING DAYS of becoming LAC

LAC HEALTH ADMINISTRATOR

If no BAAF forms are received in 5 working days the LAC Health Administrator will email the

- **Social Worker**
- **LA Team Manager/Practice Supervisor**
- **LA Service/Operations Manager**
- **LAC Nurse**

Within 7 WORKING DAYS of becoming LAC

LAC NURSE

If no BAAF forms are received in 7 working days the LAC Nurse will telephone

- **LA Service/Operations Manager**
- **LA Strategic Manager/Head of Service**

Timescales exceeded 20 WORKING DAYS

LAC HEALTH ADMINISTRATOR

If no BAAF forms are received in 20 working days the LAC Health Administrator will on a weekly basis send a list of those consents which are outstanding and exceeding 20 working days to

- **LA Service/Operations Manager**
- **LA Strategic Manager/Head of Service**
- **Health LAC Manager and Designated Nurse**

A 3 monthly report will be presented to the LSCB Performance Sub-group

Case review must happen within 20 working days from when the child started to be looked after Regulation 33(1) of the Care Planning, Placement and Case Review (England) Regulations 2010