CORPORATE PARENTING PANEL

FRIDAY, 30 OCTOBER 2020

10.00 AM, CC1, COUNTY HALL, LEWES

++Please note that this meeting will be taking place remotely++

MEMBERSHIP - Councillors Charles Clark, Chris Dowling, Kathryn Field, Jim Sheppard, Colin Swansborough, Sylvia Tidy (Chair) and Francis Whetstone

A G E N D A

1 Minutes of the meeting held on 24 July 2020 *(Pages 3 - 8)*

2 Apologies for absence

3 Disclosure of Interests

Disclosure by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4 Urgent items

Notification of items which the Chair considers to be urgent and proposes to take at the end of the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgently.

5 Exclusion of Press and Public

To consider excluding the public and press from the meeting for the next two agenda items on the grounds that if the public and press were present there would be disclosure to them of exempt information as specified in Category 1 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended), namely information relating to any individual.

6 Children's Home Regulations 2015, Regulation 44: Inspection reports for July 2020 - September 2020

6a Acorns at Dorset Road *(Pages 9 - 76)*

6b Brodrick House *(Pages 77 - 190)*

6c Hazel Lodge *(Pages 191 - 286)*

6d Homefield Cottage *(Pages 287 - 370)*

6e Lansdowne Secure Unit *(Pages 371 - 470)*

6f The Bungalow, Sorrel Drive *(Pages 471 - 568)*

7 Any other exempt items considered urgent by the Chair.

8 Annual Report of Services for Looked After Children 2019-20 *(Pages 569 - 602)*

9 Independent Reviewing Service Annual Report *(Pages 603 - 628)*

10 Virtual School Annual Report - 1 April 2019 - 31 March 2020 *(Pages 629 - 638)*

11 Looked After Children Health Report *(Pages 639 - 712)*

12 Looked After Children (LAC) Statistics *(Pages 713 - 716)*
Report by Director of Children's Services.

13 Any other non-exempt items considered urgent by the Chair.

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
LEWES BN7 1UE

22 October 2020

Contact
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NOTE: *As part of the County Council's drive to increase accessibility to its public meetings, this meeting will be broadcast live on its website. The live broadcast is accessible at: www.eastsussex.gov.uk/yourcouncil/webcasts/default.htm*

CORPORATE PARENTING PANEL

MINUTES of a meeting of the Corporate Parenting Panel held remotely on 24 July 2020.

PRESENT	Councillors Chris Dowling, Kathryn Field, Jim Sheppard, Colin Swansborough, Sylvia Tidy and Francis Whetstone
ALSO PRESENT	Liz Rugg – Assistant Director, Early Help and Social Care
	Sally Carnie – Head of LAC Services
	Beverly Moores – Strategic Lead – Children's Disability Social Care ISEND
	Sally Williams - Operations Manager, ISEND Children's Disability Social Care
	Adrian Sewell – Operations Manager, Fostering Team
	Carole Sykes – Operations Manager, Adoption and Permanence
	Helen Simmons – Registered Manager, Lansdowne Secure Children's Home
	Heather Lomas - Assistant Head of and Designated Nurse, LAC
	Aaron Sams – Democratic Services Officer

39 MINUTES OF THE MEETING HELD ON 24TH JANUARY, 2020

39.1 RESOLVED: to agree as a correct record the minutes of the meeting held on 24 January 2020.

40 APOLOGIES FOR ABSENCE

40.1 Apologies were received from Councillor Charles Clark.

41 DISCLOSURE OF INTERESTS

40.1 There were none.

42 URGENT ITEMS

42.1 There were none.

43 THE LAUNCH OF ADOPTION SOUTH EAST, THE REGIONAL ADOPTION AGENCY

43.1 The Panel considered a report by the Director of Children's Services which provided an update on the launch of Adoption South East, the Regional Adoption Agency (RAA).

43.2 The Panel were informed about four main areas of work which have been taken forward since the launch of the RAA on 1 April 2020. These included:

- **Recruitment and Assessment of adopters:** The Panel were informed that initial data indicates that since the formation of the RAA there has been a significant increase in adoption enquires and an increase in the rate of these enquires leading to initial interviews. There have been 305 enquires, 11 Information sessions and 55 Registrations since the launch of the RAA.

- **Family finding and matching:** The linking and matching of children for adoption has been the responsibility of the RAA since April 2020. The current activity in this area includes 59 children with a plan for adoption, 38 Placement Orders in place and 50 approved adopters.

- **Adoption Panels:** The Panel were informed that in response to the Covid-19 national emergency, Adoption Panel meetings were conducted remotely via video conferencing technology. Members were also informed that both Panels and service users had provided positive feedback about the effectiveness of the technology and the benefits of having remote meetings.

- **Adoption Support:** Adoption Support services are a key part of the long-term development plan for the RAA and the Panel were informed that since going live during the Covid-19 national emergency, a key priority has been to ensure continuity of adoption support provisions. Another priority has been to ensure compliance on the part of all providers with the requirements of their accrediting bodies for the safe provision of virtual therapies. The Panel also heard that £350k of additional funding for Covid-19 specific support was secured for adopters and special guardians following a successful joint application from the RAA and the four local authority Special Guardianship Services.

43.3 The Panel sought clarification about the role of Medical Advisors within the new RAA structure. In particular, Members asked if the Medical Advisors for East Sussex would be required to work for other authorities within the Agency. In response, the Department informed the Panel that the Medical Advisors for East Sussex County Council would continue to work within the county. However, if there was an absence on a Panel in another authority within the RAA, a Medical Advisor from East Sussex could potentially be asked to assist if required and the reverse would also be true. The Panel were satisfied that this was a reasonable arrangement and welcomed the increased freedom and resilience this would bring to the service.

43.4 The Panel welcomed the positive developments within the RAA.

43.5 RESOLVED: to note the report.

44 ANNUAL PROGRESS REPORT OF EAST SUSSEX ADOPTION SERVICE 1 APRIL 2019 - 31 MARCH 2020

44.1 The Panel considered a report by the Director of Children's Services which outlined the performance and progress of the East Sussex Adoption Service for the period 1 April 2019 – 31 March 2020. Carole Sykes (Operations Manager – Adoption and Permanence Service), introduced the report and highlighted various activities such as: work on recruiting adopters, family finding and linking, adoption support, and the work of the Adoption Panels.

44.2 The Panel were informed that nationally there is a challenge with regard to ensuring sufficient numbers of adopters and that this was also the case in East Sussex. The total number of adopters approved in 2019/20 was 22 compared to 33 in the previous year. The decrease is representative of the national picture and is reflective of a rise in more complex applications which inevitably take longer to process.

44.3 The Panel asked whether future Annual Adoption reports for East Sussex would continue, given that the East Sussex Adoption Service has now been incorporated into Adoption South East, the Regional Adoption Agency. In response, the Department informed the Panel that future reports would provide an annual update on the work of the Regional Adoption Agency and these reports would continue to include information regarding services in East Sussex.

44.4 RESOLVED: to note the report.

45 ANNUAL PROGRESS REPORT OF EAST SUSSEX FOSTERING SERVICE - 1 APRIL 2019 - 31 MARCH 2020

45.1 The Panel considered a report by the Director of Children's Services which outlined the performance and progress of the East Sussex Fostering Service for the period 1 April 2019 to 31 March 2020. Adrian Sewell (Operations Manager – Fostering Service) provided further detail regarding some of the key activities undertaken by the service, including: recruitment & retention work, fostering panels, foster carer training, the Children in Care Council, and ongoing publicity campaigns to promote fostering in East Sussex.

45.2 The Panel were informed that 381 in-house fostering placements were made during 2019/20 and matching referrals to place children have risen from 532 in 2018/19 to 553 in 2019/20.

45.3 The Panel discussed the impact of Covid-19 on the Fostering Service. Members were informed that the preceding months had been a challenging time for the service. However, during the national lockdown period between 21 March to 17 June, there were 122 Matching referrals completed and 68 new in-house placements identified. The Panel thanked the service for its professionalism and resilience in response to the challenges it faced during the national emergency.

45.4 Members also discussed the challenges of securing supported lodgings. In response members were informed that, for example, the use of the Department's 'recruitment van' was continuing and that this offers the service another way to engage with local communities throughout the county, including in rural areas. It was confirmed though that the provision of supported lodgings for the more densely populated coastal strip of the county remains a priority for the Department.

45.5 RESOLVED: to note the report.

46 LOOKED AFTER CHILDREN (LAC) STATISTICS

46.1 The Panel considered a report by the Director of Children's Services which provided an update on Looked After Children (LAC) statistics.

46.2 The Panel were informed that in comparison to other local authorities the numbers of LAC in East Sussex have remained relatively stable during the Covid-19 pandemic. However, there is pressure on the Fostering Duty system due to children moving between placements. The national emergency has also placed additional demands on many households and this in turn has caused a decrease in the number of internal placement options available, with external placement options also becoming more limited and more expensive during this period.

46.3 RESOLVED: to note the report.

47 ANY OTHER NON-EXEMPT ITEMS CONSIDERED URGENT BY THE CHAIR.

47.1 There were none.

48 EXCLUSION OF PRESS AND PUBLIC

48.1 The Panel agreed to exclude the press and public for the next two agenda items on the basis that if they were present there would be disclosure to them of information considered exempt by virtue of Category 1 of Part 1 of Schedule 12 A of the Local Government Act 1972 (as amended), namely information relating to an individual.

49 THE IMPACT OF COVID- 19 ON CORPORATE PARENTING SERVICES

49.1 The Panel considered a report by the Director of Children's Services regarding the impact of the Covid-19 pandemic on Corporate Parenting services in East Sussex.

49.2 The Panel were assured that the Department have monitored a range of indicators to assess the impact of Covid-19. These include:

- **Front Door contacts:** There was an initial reduction in the activity of the front door teams, but referral rates have been steadily rising since mid-May. The Panel were informed that during May 80% of mandated health visiting contacts took place and 82% of children open to a Locality social work team have had contact with their social worker.

- **Child Protection Plans:** The Panel heard that in part due to Child Protection Plans not ceasing due to safety issues, the number of children on Child Protection Plans has increased from 542 in the week commencing 9 March, to 574 by 26 June, and that during the pandemic more than 90% of children subject to a plan have had contact with their social worker.

- **LAC (Looked After Children):** The numbers of LAC have remained stable during the Covid-19 pandemic. The Panel also noted a major improvement which has occurred during the pandemic with regards to Initial Health Assessments of LAC, with 89% of assessments being completed within 20 days and 100% being completed within 25 days during April.

- **Unaccompanied Asylum-Seeking Children (UASC):** The has been international concern regarding Covid-19 cases in the migrant camps in France and nationally there has been a significant increase in migrants making their way to the United Kingdom. This has been particularly impactful in Kent, but East Sussex has also seen a rise in

UASC, and the Department is preparing for these numbers to increase further during the year.

49.3 The Panel sought clarification on whether East Sussex County Council are accepting UASC from Kent County Council. In response, the Panel were informed that East Sussex have only accepted children from Kent where there has been capacity to do so.

49.4 The Panel also discussed the impact of the easing of Covid-19 lockdown restrictions. In particular, Members asked the Department for detail about its plans for working with its partners to ensure it is well-placed to respond effectively to the developing situation. In response the Panel were informed that a virtual working group has been formed to help deliver a smooth transition, with the membership including representatives from schools, mental health teams and voluntary sector organisations.

49.5 RESOLVED: to note the report.

50 UPDATE ON RESIDENTIAL HOMES

50.1 The Panel considered a report by the Director for Children's Services updating members on how Residential Homes in the county have responded to the Covid-19 pandemic and the support provided by the Department.

50.2 The Panel thanked the Registered Homes Managers and all staff at the homes for coping so well in response to the unprecedented circumstances presented by the national emergency.

50.3 RESOLVED: to note the report.

51 ANY OTHER EXEMPT ITEMS CONSIDERED URGENT BY THE CHAIR.

51.1 There were none.

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Report to:	Corporate Parenting Panel
Date:	30 October 2020
Title of Report:	Annual Report of Services for Looked After Children 2019-20
By:	Director of Children's Services
Purpose of Report:	To update the Panel on achievements and challenges for services for Looked after Children in 2019-20

Recommendations:

The Corporate Parenting Panel is recommended to comment on and note the report.

1. Background and supporting information

1.1 Services for Looked After Children (LAC) are predominantly funded from the Children's Services base budget with some additional smaller funding streams supporting specific activity e.g. Virtual School activity from the Pupil Premium Grant.

1.2 Attached as Appendix 1 is the report of performance and outcomes in 2019-20 for services for Looked After Children in East Sussex, for whom the Council acts as Corporate Parents.

2. Conclusion and recommendations

2.1 The service performed well in 2019-20 with good outcomes for children in the care of East Sussex County Council.

2.2 The Corporate Parenting Panel are recommended to comment on and note the report.

STUART GALLIMORE
Director of Children's Services

Contact:
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Appendices
Appendix 1 - Annual Report of Services for Looked After Children 2019-20

East Sussex
County Council

East Sussex
Looked After Children Services
Annual Progress Report 2019/20

Sally Carnie, Head of Service

Appendix 1

Who did we look after?

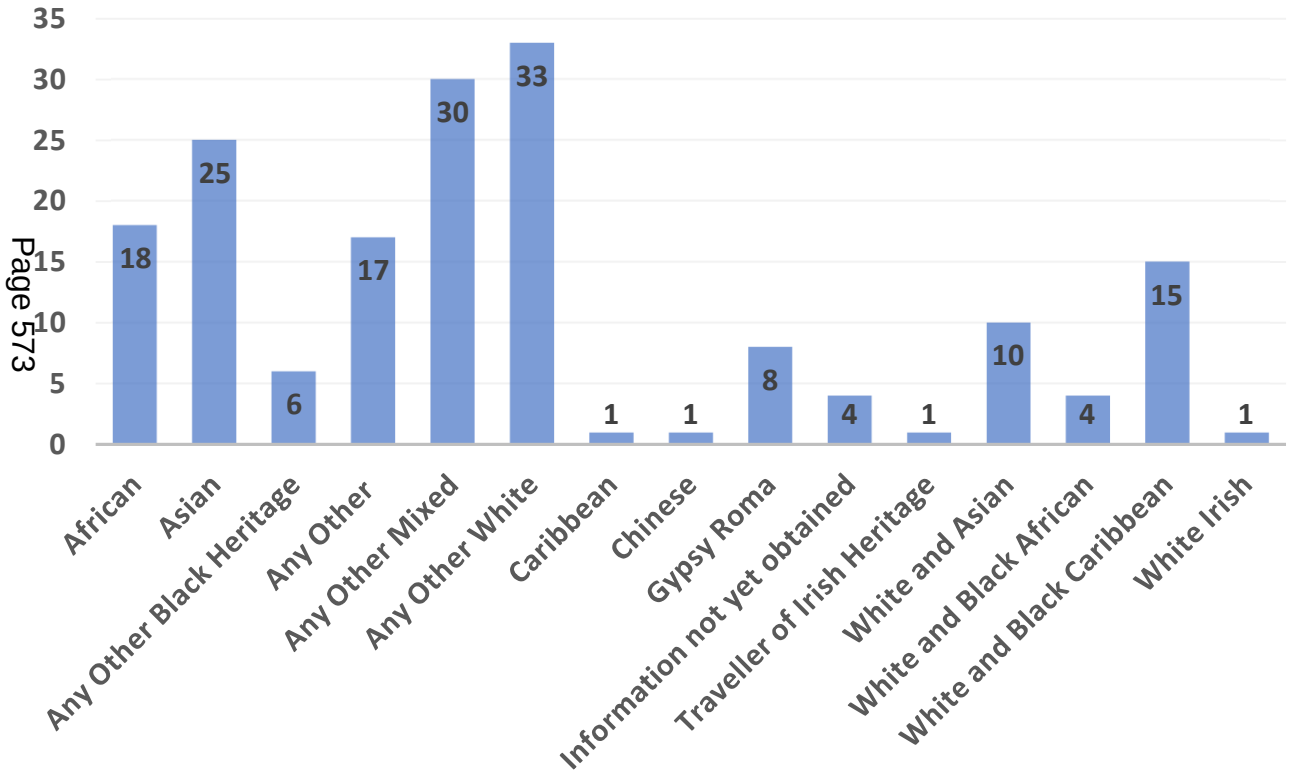
- **The data below is a snapshot as of 31st March 2020.**

Statistics	2018-2019	2019-2020
Looked After Children (LAC)	**600**	**592**
Children coming in to care	**195**	**179**
0-5 year olds admitted to care	**87**	**75**
6-12 year olds admitted to care	**38**	**38**
13+ year olds admitted to care	**70**	**66**
Children leaving care	**197**	**177**
0-12 year olds leaving care	**72**	**64**
13+ year olds leaving care	**107**	**105**

- We looked after 311 boys and 281 girls.
- Overall there were fewer children in care during this period
- This figure is made up of fewer admissions to care but also fewer discharges from care
- In addition the ‘churn’ figure, which is made up of the number of children moving in and out of care during the annual cycle, when added to the year end figure shows a reduction by **20** overall. In total there were **760** children in care allocated to Social Workers and worked with during the year 19/20

23% of LAC in ESCC identify as being minority ethnic or mixed heritage.

Who did we look after?



* Numbers of BAME children within the LAC population across 2019/20

Unaccompanied Asylum Seeking Children (UASC)

- ESCC was caring for **32** UASC under 18 during 19/20 (plus 48 care leavers).
- Our UASC cohort were mainly male and over 16 years old, although 25% of this group were under 16 years and our youngest child was only 12 years old and female.
- In the last year, 2 children have come via The Vulnerable Children's Resettlement Scheme and the remainder have been spontaneous arrivals, found either by the Police or at Newhaven Port or transferred via the National Transfer Scheme mostly from arrivals at Dover.
- The majority of these children came from Vietnam and Iran followed by Sudan, Iraq, Albania and Afghanistan with one child each from Ethiopia, Mali, Kuwait and Kurdistan.

This data is a snapshot as of 31st March 2020.

Statistics	2018-2019	2019-2020
UASC in care	40	32

Children with Disabilities

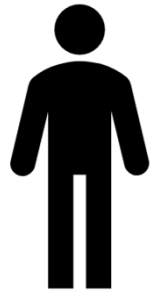
- The number of our LAC with disabilities remains similar to previous years.
- At 31 March 2020 there were **27** LAC with disabilities, with similar age distribution to previous year (19 aged 15 or less and **8** aged between 16 and 19)
- 8 of these children were placed with ESCC foster carers and 2 with independent agency foster carers. 6 were placed in ESCC Childrens Homes and **5** in independent Childrens Homes. **4** children were placed in residential schools to meet their medical needs, joint funded with health and **2** were placed in residential schools due to behavioral needs arising from their ASD diagnosis.
- The disability homes have managed a variety of young people with differing needs from behaviours that challenge, to vulnerable young people with complex medical needs.
- Going forward there are plans to create more capacity and flexibility into the structure of the homes to safely manage the needs of any disabled child requiring respite or accommodation

Where our children are living

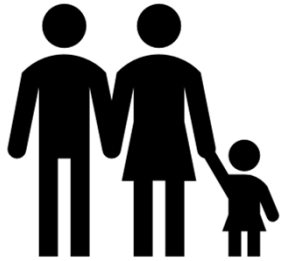
. Placement Type	2018-2019	2019-2020
With foster carer	473	447
Of these; in house carers	327	293
Kinship carers	49	62
Agency carers	97	92
Placed for Adoption	21	30
In Supported Lodgings	33	30
ESCC children's homes	18	19
Agency children's homes	27	38
Agency special schools	1	0
Placed with parents	23	20
Independent living	0	3
Youth custody/secure unit	2	4
Hospital/NHS establishment	2	1
Absconded	0	0

The data below is a snapshot as of 31st March 2020.

Increase in Kinship placements



Increase in children placed for Adoption



Increase in Independent living

Increase in children living in agency children's homes

Decrease in children living in ESCC Foster placements & Supported Lodgings

How well did we do in 19/20?

- Overall performance in relation to our LAC indicators remained strong and stable with very small % variations in most areas. The impact of Covid 19 on performance will need careful review going forward.
- The rate of LAC per 10,000 population under 18 years **reduced** from **56.6%** (18/19) to **55.7%** (19/20) against a national England rate of 65%
- More challenging has been timely placements for children with a plan for adoption (adoption scorecard), children with 3 or more placement moves (N162), children in permanent placements (N163) and children placed outside ESCC boundaries. Whilst the performance in these areas remains comparatively high, our local dip in performance reflects the wider national picture in terms of sufficiency of placements across all areas of placement planning
- Latterly some of our health indicators have been adversely affected by Covid such as access to dentistry and timely review health assessments
- The emotional and behavioural health of children in care (SDQ) has dipped slightly by 0.1% but this is consistent with the pattern over previous years
- There has been a real improvement in the accommodation options for LAC and Care Leavers under 18. However, Care Leavers aged19-21years in suitable accommodation has fallen by 1.1% from 18/19, and 6.2% against the national average
- Care Leavers 19-21years in education employment and training has shown a real improvement this year and is above the national average

Adoption Recruitment

Adoption South East(ASE) Developments:

ASE went live on 1 April 2020. Managers and staff were actively involved in the recruitment work stream, developing common practice, shared resources, and in the final quarter of the year processed all recruitment enquiries for Brighton and Hove.

Despite high levels of recruitment activity, the number of adopters approved continued to fall compared with previous years. This reflects the national position on adopter sufficiency.

Recruitment	2016-2017	2017-2018	2018-2019	2019-2020
Total No. of adopters approved	30	25	33	22
No of 2nd time Adopters	0	0	4	3

Family Finding and Linking

- Those children approved for adoption have complex backgrounds and needs
- Large sibling groups may have a different plan for individual children e.g. a mixture of long term fostering and adoption and may need to be separated, as it is difficult to place them altogether
- Children of mixed heritage tend to be placed out of county in areas reflecting greater ethnic diversity
- Complex health and genetic conditions, together with protracted care proceedings, contribute to delay in family finding and placement
- Early permanence meetings continue with locality teams to promote timely planning and family finding.
- There has been an increase in the number of children placed for Fostering to Adopt and this continues to be keenly promoted, especially for young children.

Family finding and linking	2019-2020
No. of children adopted (AO's)	32
Number of children approved for adoption	29
No. of relinquished children	2
Total No. of children matched	31
No. of 2 sibling groups matched	7
No. of 3 sibling groups matched	0
No. of 4 or more siblings groups matched	0
No. of children matched (outside of ASE)	7
No. of children matched within ASE	4
No. of children placed for Fostering to Adopt	6

Adoption - Support

Within Adoption Support we have a range of services which include:

- Adoption Support Fund applications
- Adopted Families Group
- Throughcare pathway for Adopted adolescents
- Letterbox & Direct Contact Service
- ADCAMHS
- Services to Adopted Adults

ADOPTION SUPPORT 2019/20	2019-2020
Post Adoption Support Assessments carried out; statutory responsibility to assess and provide coordinated package of support or sign post	56
No. of open cases, including therapeutic interventions, parent consultations, respite, education & virtual school advice and family social work	152

Fostering: Recruitment and Retention

- There were 22 foster households approved during 2019/20 – this means that ESCC has held steady in the context of a national shortage of foster carers.
- The conversion rates from enquiry to approval have continued to increase annually.
- The fostering service's recruitment strategy and advertising has been successful in targeting potential foster carers.
- The fostering service experienced a small increase in enquiries compared to 2018-19.
- At the close of 2019/20, the fostering service had 254 approved foster homes and 451 approved foster carers with all households having a supervising social worker who provides intensive support.

Retention	Households		
	2017-2018	2018-2019	2019-2020
Approvals ending Retirement	22	10	8
Approvals ending Change in circumstances	9	3	9
Approvals ending Terminated at panel	1	4	3

Recruitment	Households		
	2017-2018	2018-2019	2019-2020
Enquiries	346	266	268
Screening calls	157	118	114
Initial visits	86	70	71
Skills to foster training (STF)	43	29	21
Applications for assessment	31	35	35
Closed	5	3	7
Withdrew	7	11	6
Total allocated but did not progress	12	14	13
Approvals	19	21	22
Placements	37	36	39
Conversion rate Enquiry to approval	5.5%	7.9%	8.2%
Conversion rate Screening call to approval	12%	17.8%	19.2%
Conversion rate Initial visit to approval	22%	30%	31%

Supported Lodgings:

Supported Lodgings: Approvals

- There were 11 supported lodgings households approved during 19/20 offering 14 placements.
- NET gain of +3 Supported Lodgings households.

Placements

- **61** young people were placed with supported lodgings providers during 19/20.

Young people placed:

- **57** Looked After Children (LAC) **93.44%**
- **1** Homeless **1.64%**
- **3** Unaccompanied Asylum Seeking Children (UASC) **4.91%**

Placement Support Service

The placement support service delivered 143 packages of individual support during 2019/20.

PSS support includes:

- Foster carers - 75 child support packages
- Children In Care Council (CICC) - 10 child support packages
- Special Placement Scheme (SPS) - 6 child support packages
- Through Care Team - 50 young person's support packages
- Attachment Project (SWIFT) - 1 family supported
- Foster Care Agency - 1 child support package

Evaluations of PSS support packages are undertaken annually:

25% of all support packages "I would not have continued this placement without Placement Support"

95% of carers noted that the placement support service resulted in a positive impact on the placement.

60% of carers would prefer more hours of placement support.

Our Children's Homes

Brodrick House in Eastbourne

- Continuing good work with challenging group of young people.
- Outreach embedded for those that move on.
- New bathrooms at last.
- Continuing 'Outstanding' judgement by Ofsted.
- Manager & deputy resign & are replaced .

Lansdowne Secure Children's Home

- Re-designed to improve the existing accommodation and increase capacity from 7-12 beds.
- The new fully furbished home will be complete in early 2021.
- Ofsted inspection (February 2020) judged as 'good' in all areas (inspection included education and CQC for health services within the home).
- Lansdowne has continued to work creatively with all residents during this period of change.

Homefield Cottage in Seaford:

- Settled group of young people.
- Re-modelling of study and decoration throughout.
- Young people enjoy a holiday in Dorset.
- Thrive model of care embedded in the home as staff trained.
- Judged as "good" by Ofsted.

Acorns in Bexhill:

- Continued to provide regular respite care for some of the highest need disabled children aged 7 - 19.
- A full time emergency placement was made for a few months until the beginning of 2020, and another young person's respite became a full time placement whilst awaiting a residential school place.
- Acorns received an Ofsted judgement of 'Good' in October 2019

Hazel Lodge in Hastings:

- Move on of long-term resident to Supported Lodgings.
- New residents achieving positive outcomes.
- Judged as "Outstanding" by Ofsted June 2019.

The Bungalow in Eastbourne:

- Registered for 7 children aged 7-19 and has provided full-time accommodation to some of our disabled children who are unable to live in a family setting.
- All children attended local schools and all maintained contact with their families, facilitated on site.
- The Bungalow received an Ofsted judgement of 'Good' in January 2020

Initial Health Assessment

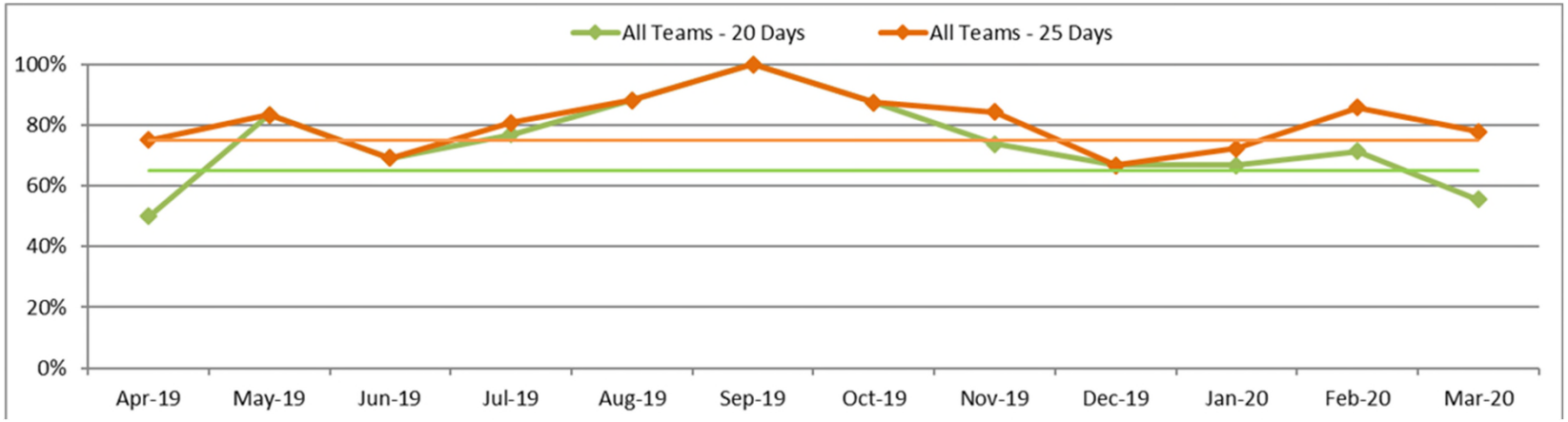
Steps taken to improve performance in Initial Health Assessments (IHA)

- Robust IHA tracking system now embedded.
- Partnership with East Sussex Health Care Trust colleagues has led to improved communication between social care and health staff at both the operational and strategic levels.
- Significant improvement in performance, routinely monitored by ESHT and ESCC together.
- **75%** of IHAs were completed within 20 days against a target of 65%, and **81%** within 25 days against a target of 75% in 2019-20.

Successes in 2019/20

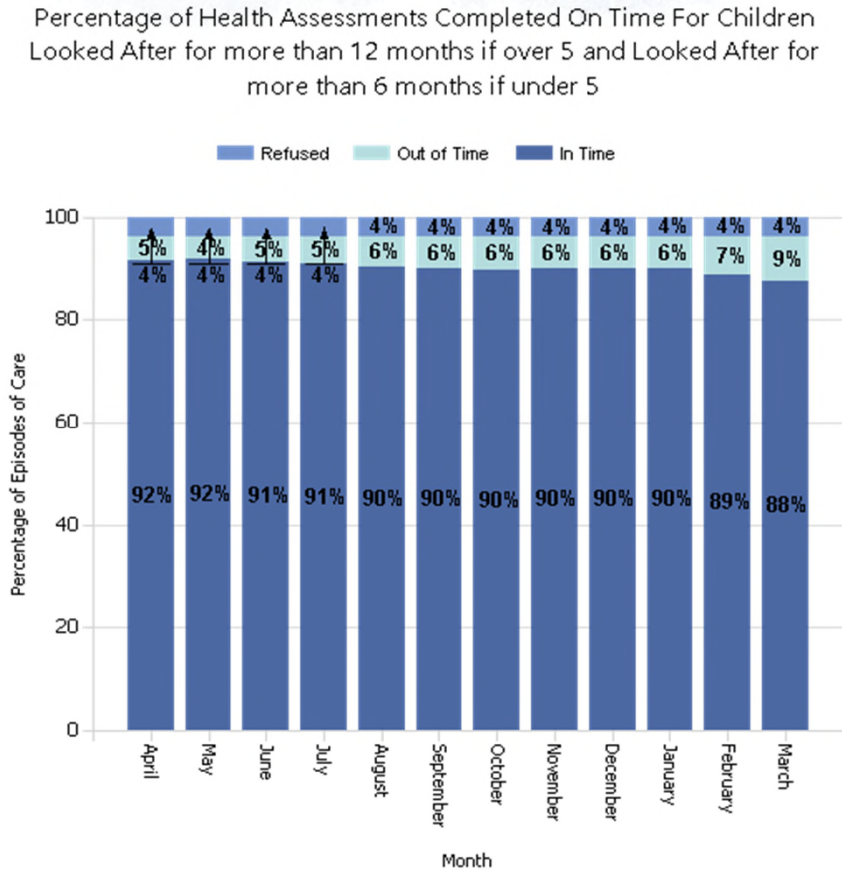
- Exceeded target for IHAs within statutory timescales
- Improved timeliness and reporting of RHAs
- Improved quality of health passports for care leavers
- Improved pathways into mental health services for LAC and Care Leavers

Initial Health Assessment (IHA) Monthly Performance Summary 2019-20



Review Health Assessments

- Performance has remained largely stable and good throughout the year except for February and March.
- These months were impacted by the combination of a systems error and Covid. This has been rectified for 2020/21.



Mental Health and Emotional Wellbeing of our LAC

- JTAI Ofsted multi-agency inspection in February 2020 focussed on the mental health of Children and Young People in East Sussex
- A Sussex wide review of emotional wellbeing services was completed and taken through governance structures over the summer of 2020.
- East Sussex Health and Social Care plan has identified that mental health services for LAC should be prioritised in that:
- looked after children's needs are prioritised across health, social care and education to enable the best outcomes
- and mental health services are commissioned to optimise the emotional wellbeing of looked after children and previously looked after children
- ADCAMHS and LACAMHS continue to work exclusively with LAC and children who were previously LAC. ADCAMHS have worked with 60 families and LACCAMHS have worked with 143 children plus running Therapeutic Parenting Groups for carers and residential teams.

Education of Looked After Children

- The Department for Education (DfE) announced on the 8th April that school or college performance data based on summer 2020 tests, assessments and exams at any phase would not be published. Schools and colleges should not be held to account by Ofsted or the DfE through the publication of performance tables on the basis of exams and assessment data from summer 2020.
- The National LAC dataset for 2020 will not be published by the DfE or issued to NCER to populate the Local Authority reporting tool for Virtual Schools.
- While there is no ESCC or national data available we can see that individual pupils have performed in line with or above expectations.

Education for Looked After Children- What we have achieved in 2019/20

- All year 13 students who applied to University have been accepted. This is 11% of the year 13 students who are eligible for University.
- Improvement in the quality of teaching and learning and development of on line teaching
- In total, 77 CYP received one to one tuition in March and 24 took part in group interventions.
- The 2019/20 national attendance data will not be reported due to COVID and regional comparisons will be difficult.

Education for Looked After Children – Future Developments

- Development of teaching and learning including an online offer and focus on Key Stage 2 phonics
- Delivery of training on attachment and trauma as part of a wider ESCC offer
- Development of joint working with Adoption Support services across the region
- Promotion of the work of the Virtual School and share information and resources with Schools, Carers and Social Workers on line

The Through Care Team (TCT): What we have achieved in 19/20

- The Published Local Offer is now available in leaflet form designed by our young people
- Our most isolated young people accessed weekly groups in Eastbourne and Hastings, these groups provided opportunities for social interaction with their peers.
- Young people not in education or training attended weekly sessions with our Participation Worker, Virtual School Case Worker and the Youth Employability Service representative.
- Care Leavers who are parents had access to a parent and baby group which encouraged positive parenting strategies alongside social engagement.
- Social activities took place throughout the year, including a trip to London to see the sights, a Halloween party planned by the young people, a summer picnic and sports event and the annual Christmas party.

The Through Care Team (TCT): What we have achieved in 19/20 (continued)

- Our care Leavers were involved in providing their views in a number of forums including National Leaving Care Benchmarking Forum events, a Care Leaders film regarding fostering and a CYPT partnership day.

- Tenancy support remained a high priority with Placement Support Workers providing individual support to those struggling to maintain their placements or homes.

- We used the newly commissioned highly intensive support placements for our most vulnerable young people.

- The Team continued to support young people with highly complex behaviors from the age of 14 to 25. A flexible approach to working with these young people including joint working between Social Workers, Personal Advisors and Placement Support Workers ensured a high level of support and engagement using relationship-based practice . A significant number of these young people were struggling with trauma related mental health issues, others had been exposed to exploitation including county lines.

- The Through Care / Adult Social Care Panel made plans for young people who required support from Adult Social Care post 18, ensuring the relevant support was identified to enable a smooth transition at 18.

The Through Care Team – Future Developments

Work with local businesses and other agencies to improve our Local Offer to young people to include:

- Cheap / free access to leisure activities including local gyms.
- Subsidised travel on public transport.
- Work with CAMHS and Adult Mental Health Services to provide therapeutic intervention to our older teenagers, particularly those who are experiencing the impact of trauma, require tier 4 services and our young people who entered care late.
- Establish our Care Leavers council, a pilot is underway.
- Establish a Peer mentoring scheme, with a particular focus on our young people who are now parents.
- Put on an Art Exhibition to show case the work of our Care Leavers.
- Develop an opportunity to provide a care experienced young person with an Apprenticeship in the Through Care Service.
- Create a specific Placement Support Case Worker role with a focus on homelessness and the hardest to reach young people, funded by DfE grant.

Unaccompanied Asylum Seeking Children (UASC)

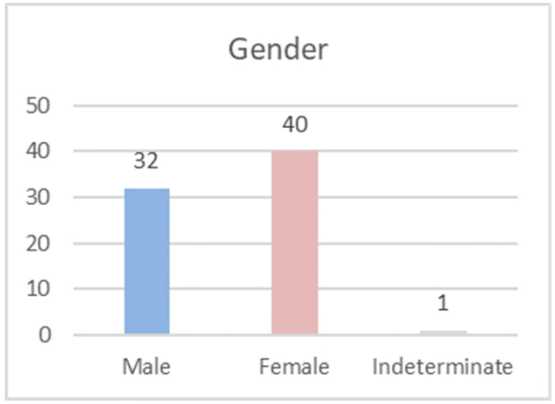
What we have achieved in 19/20

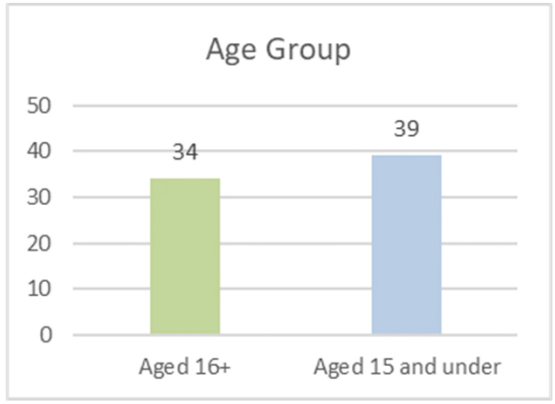
- Improved education offer to UASC including access to English Lessons on electronic devices.
- The recruitment of a social worker to increase the UASC Team.
- Successful UASC social drop in (monthly) with representatives from health, Sussex Police and The Refugee Council regularly attending.
- Specialist UASC training provided to foster carers and social workers
- Training delivered to young people to support them to understand and adjust to life in the UK.
- Continued improvement in relationship with specialist accommodation providers to better respond to the needs of young people.

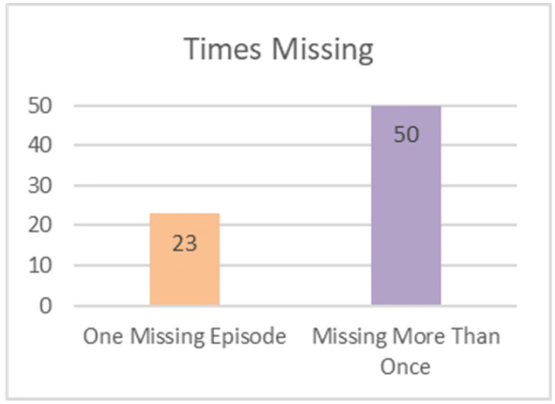
Future Developments

- Mentoring for UASC by young people who are already looked after
- Keywork tools for accommodation providers to better support UASC to understand life in the UK
- Vocational courses for UASC in addition to traditional classroom based learning.
- Service provision to better respond to the specific mental health needs of UASC.
- Improved accommodation offers for UASC including step down accommodation to enable our care leavers to develop independent living skills
- Service provision to better respond to the specific mental health needs of UASC.

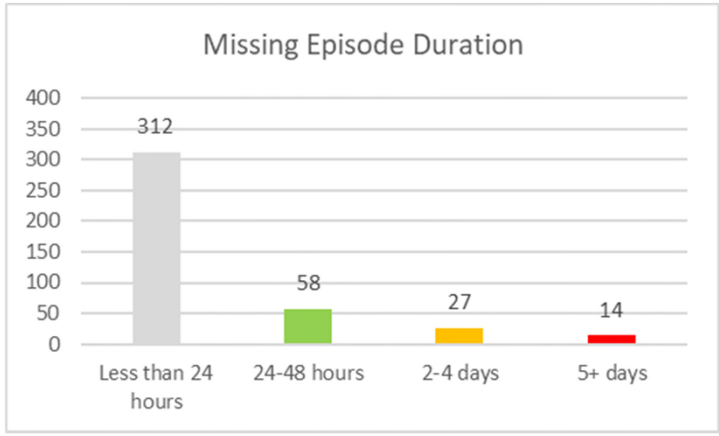
Our children who went missing







- In **2019/20,** **73** LAC went missing, of these, **32** were males, **40** were females and **1** was indeterminate.
- **34** of the **73** missing LAC were aged 16 and over, while the other **39** were aged 15 and under.
- **50** of the **73** missing LAC were missing more than once.
- In 2019-20 there were **411** missing episodes, of these, **312** episodes of children being missing for less than 24 hours, **58** episodes when they were missing between 24-48 hours, **27** episodes when they were missing between 2-4 days and **14** episodes when they were missing for 5 days or more. All these children were actively tracked by Sussex Police and by Children Services staff. Risk assessments were regularly reviewed on high profile children who went missing and, where necessary, formal multi agency strategy discussions were held in line with Safeguarding Procedures.



Our Children who who are at risk of Criminal Exploitation

- The MACE Operational Group continued to meet monthly each side of the county to consider the referrals of all exploited children identified in East Sussex who were deemed to be at highest risk. Referrals to the group were screened through a multi-agency screening hub with processes tightened in line with feedback from the JTAI.

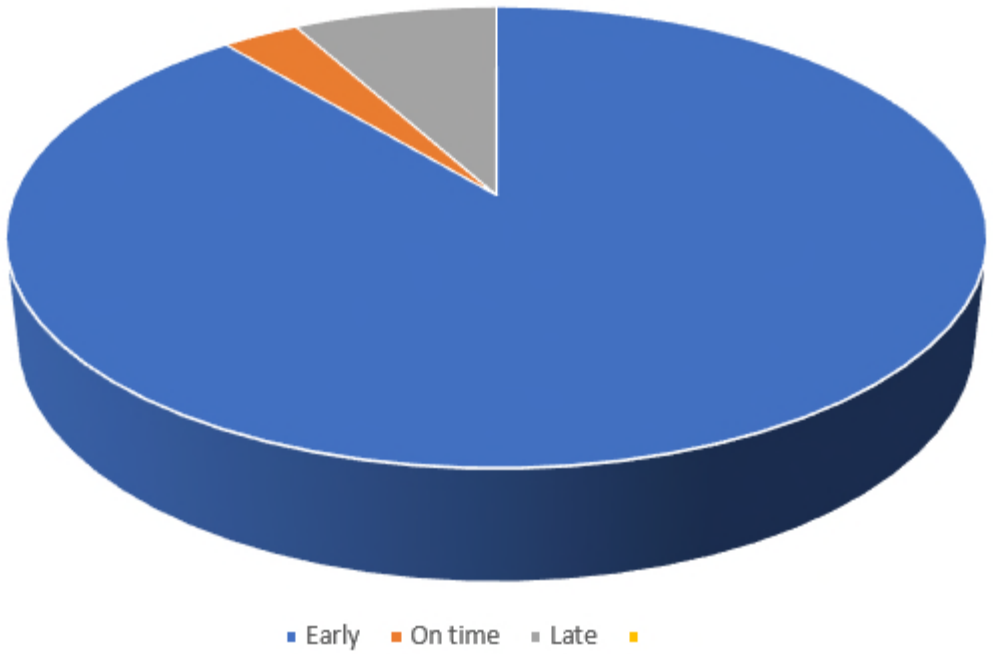
- As of March 2020 there were **25** children subject to East Sussex MACE Bronze panel oversight and therefore categorised as being at high risk of exploitation. 5 of these children were East Sussex LAC (**2** male and **3** female). One of these young people was deemed to be at risk of criminal exploitation, two of sexual exploitation and two deemed to be at risk of both criminal and sexual exploitation.

- The MACE strategic group met bi-monthly to consider the issues raised in relation to safeguarding this group of children. The criminal exploitation of children connected to 'County Lines' activity remained a significant issue in East Sussex, with changes during Covid to criminal exploitation in the Hastings area. In response the YOT led on a contextual peer group assessment in Hastings/St Leonards. This was one of a number of contextual safeguarding responses that East Sussex delivered over the past 18 months. This approach was supported by a growing body of research and evidence in effective multi agency safeguarding practice, particularly focusing on older children and place-based interventions

Looked After Young People Who Offend

- The YOT worked with **26** looked after children in 2019/20.
- **11** of those were subject to care orders, **13** were s.20.
- **2** young people became LAC as a result of being securely remanded.
- A snapshot of the Looked After status of open cases showed that the YOT were working with **5** Looked After Children on March 31st 2020 which equates to **5%** of the YOT caseload. Looked After Children aged 10-17 represent less than 1% of the total population of this age group across the county therefore they are over-represented within the YOT cohort. There is an agreed protocol in place which focuses on decriminalizing LAC where appropriate.

Timeliness – LAC Reviews



92% of all LAC Reviews were held early or on time in 2019/20.

The majority of late reviews were delayed in the child's best interests or because an essential party was unable to attend.

Capacity issues and unexpected long term absence in the Safeguarding Unit during Quarters 3 and 4 resulted in a decision to prioritise Safeguarding. Some LAC Reviews were pushed back to make way for ICPCs and others postponed to preserve the existing IRO relationship. These Reviews were only postponed where the child was settled and in discussion with their social worker.

Meetings continue to be scheduled well in advance which contributes to a high level of compliance.

Participation

Children and Young People make their voices heard in lots of different ways.

In 2019/20 91% of Young People and Children aged 4+ participated in some way in their Review. New processes in 2020 will ensure that this involvement is increasingly meaningful and held at the centre of the Review.

The role of our elected members

The Corporate Parenting Panel met quarterly during 2019/20 to scrutinize the performance of all services in relation to LAC and Care Leavers, paying particular attention to outcomes. It also received presentations from the Children in Care Council and from the East Sussex Foster Care Association. The reports set out below were presented and considered:

April 2019

- Ofsted Inspection report for the Bungalow, Sorrell Drive
- Bright Spots Survey highlights
- LAC Statistics
- Children's Home Regulations 2015, Regulation 44: Inspection reports for January 2019 to March 2019 for the following children's homes: Acorns at Dorset Road, Brodrick Road , Hazel Lodge, Homefield Cottage, Lansdowne Secure Unit, The Bungalow, Sorrel Drive

July 2019

- Annual progress report of the East Sussex Fostering Service
- Annual progress report of the East Sussex Adoption and Permanence Service
- Independent Reviewing Officer Annual Report 2018/19
- LAC Statistics
- Children's Home Regulations 2015, Regulation 44: Inspection reports for April 2019 June 2019 for the following children's homes:- Acorns at Dorset Road, Brodrick Road , Hazel Lodge, Homefield Cottage, Lansdowne Secure Unit, The Bungalow, Sorrel Drive

October 2019

- LAC Annual Report
- LAC Statistics
- Virtual School Annual Report
- Coram Voice Bright Spots Survey of Care Leavers
- Unaccompanied Asylum Seeking Children Update
- Ofsted Inspection reports for Brodrick House, Hazel Lodge, and Homefield Cottage
- Childrens' Home Regulations, Regulation 44: Inspection reports for July 2019 - September 2019 for the following children's homes: Acorns at Dorset Road, Brodrick Road , Hazel Lodge, Homefield Cottage, Lansdowne Secure Unit, The Bungalow, Sorrel Drive

January 2020

- East Sussex Foster Care Association (ESFCA) Annual Report
- Health of LAC Annual Report
- LAC Statistics
- Children's Home Regulations 2015, Regulation 44: Inspection reports for October 2019 to December 2019 the following children's homes:- Acorns at Dorset Road, Brodrick Road , Hazel Lodge, Homefield Cottage, Lansdowne Secure Unit, The Bungalow, Sorrel Drive

Priorities for 2020/21

Continue to improve the timeliness of return home interviews for LAC and Care Leavers

Improve the mental health pathways for our LAC and Care Leavers

Complete the extension of Lansdowne Secure Children's Home

Learn from Serious Case Reviews and consider development of our Corporate Grandparenting Role

Continue to focus on equality data informing practice with a particular focus on the MACE cohort

Explore and develop No Wrong Door strategy

Improve sufficiency of placements through Fostering, Adoption and Residential provision

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Report to:	Corporate Parenting Panel
Date:	30 October 2020
By:	Director of Children's Services
Title of Report:	Independent Reviewing Service Annual Report
Purpose of Report:	To update the Corporate Parenting Panel on the contribution of the Independent Reviewing Service to Quality Assuring and Improving Services for Looked After Children

Recommendations:

The Corporate Parenting Panel is recommended to comment on and note the report.

1. Background

1.1 This Annual Independent Reviewing Service report provides quantitative and qualitative evidence relating to the Independent Reviewing Services in East Sussex as required by statutory guidance.

2. Support information

2.1 The Independent Reviewing Service Annual Report 2019 - 2020 is attached as Appendix 1.

3. Recommendations

3.1 The Corporate Parenting Panel is recommended to comment on and note the contents of the report.

STUART GALLIMORE
Director of Children's Services

Contact
Fiona Lewis – Operations Manager, Safeguarding Unit
Tel. No. 01323 464106
Email: Fiona.lewis@Eastsussex.gov.uk

Appendices
Appendix 1 - The Independent Reviewing Service Annual Report 2019 – 2020

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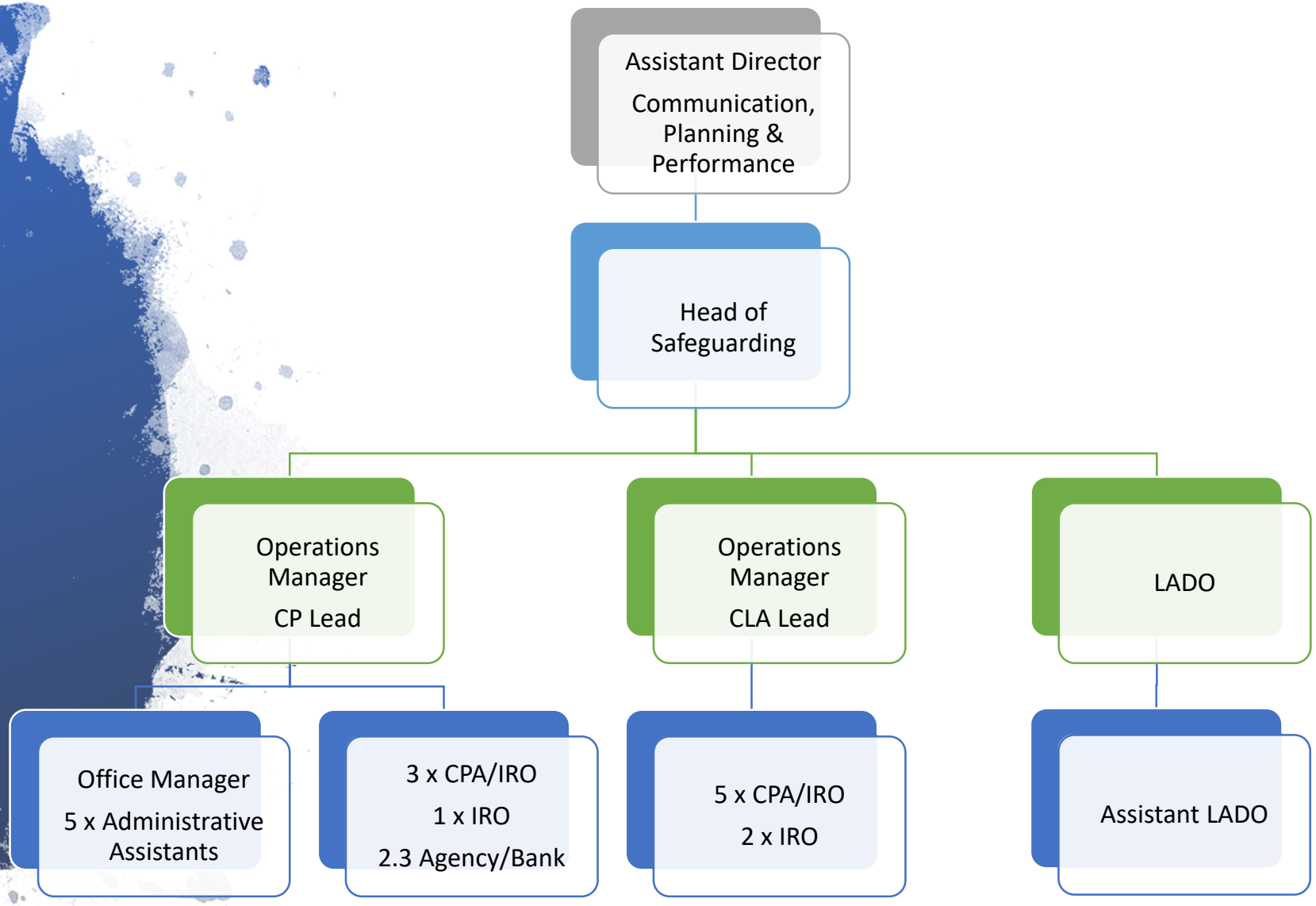
East Sussex County Council

East Sussex Independent Reviewing Service Annual Report 2019/2020

Fiona Lewis Operations Manager

This Annual IRO report provides quantitative and qualitative evidence relating to the IRO Services in East Sussex as required by statutory guidance.
The IRO Annual Report must be presented to the Corporate Parenting Panel.

Children's Safeguarding Unit



Please see Glossary for definitions

Professional Profile of the Unit

IRO/CPAs are registered social workers with extensive experience. They have the confidence and knowledge to bring a critical perspective to plans for the most vulnerable children in our county.

IROs chair statutory Looked After Children review meetings whilst CPAs chair Child Protection Conferences; the two roles are separated by different legislation and regulatory protocols which each require a depth and breadth of expertise. In ESCC and in common with much of England and Wales, most staff operate a dual role; this ensures that Chairs retain a sense of the child's holistic experience. The separate management streams ensure a focus on legislative / practice developments and quality assurance of each function.

The Unit has a diverse staff group who bring a wealth of personal and professional skills and experiences to their role.

Role of the IRO

> The Independent Reviewing Officer must be the visible embodiment of our commitment to meet our legal obligations to this special group of children. The health and effectiveness of the IRO service is a direct reflection of whether we are meeting that commitment, or whether we are failing.
> Mr Justice Peter Jackson 2014

It is a legal requirement for every Looked After Child to have a named IRO

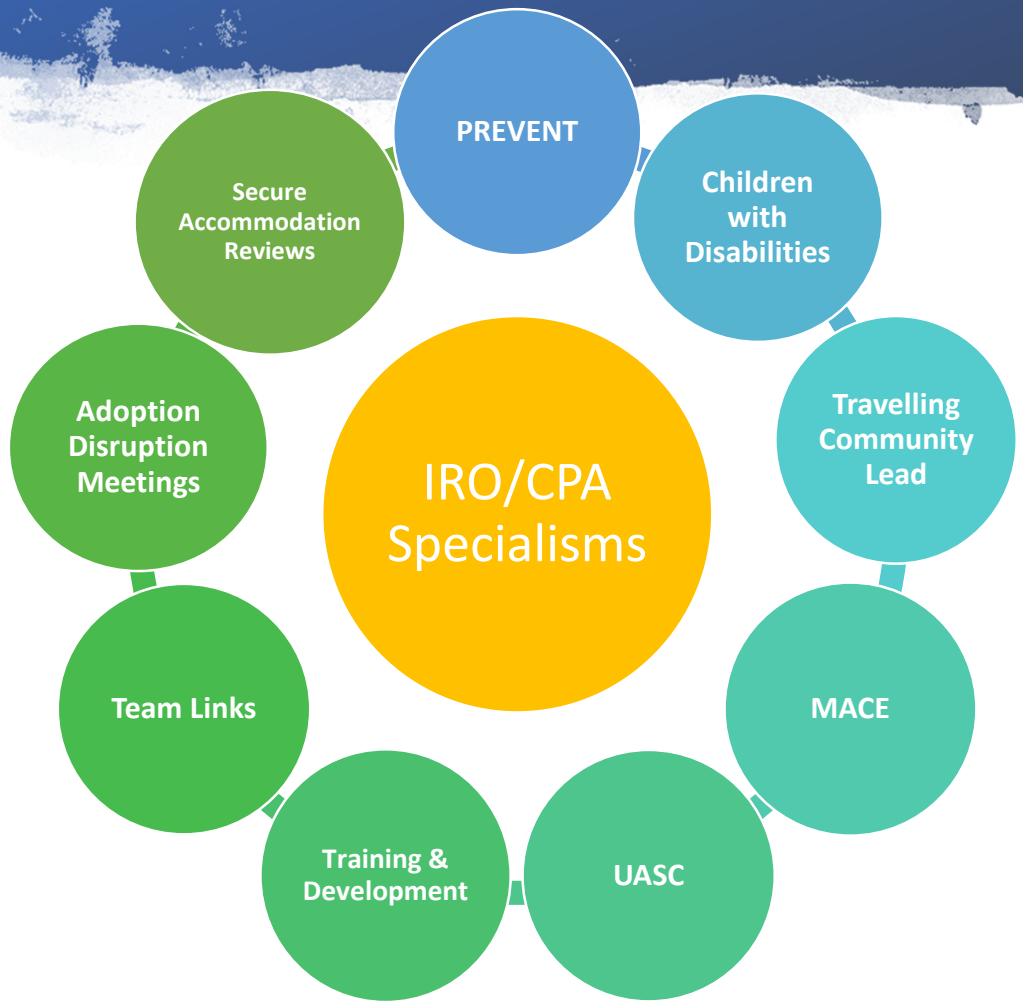
IROs quality assure the Care Planning process for Looked After Children and ensure that their wishes and feelings are understood.

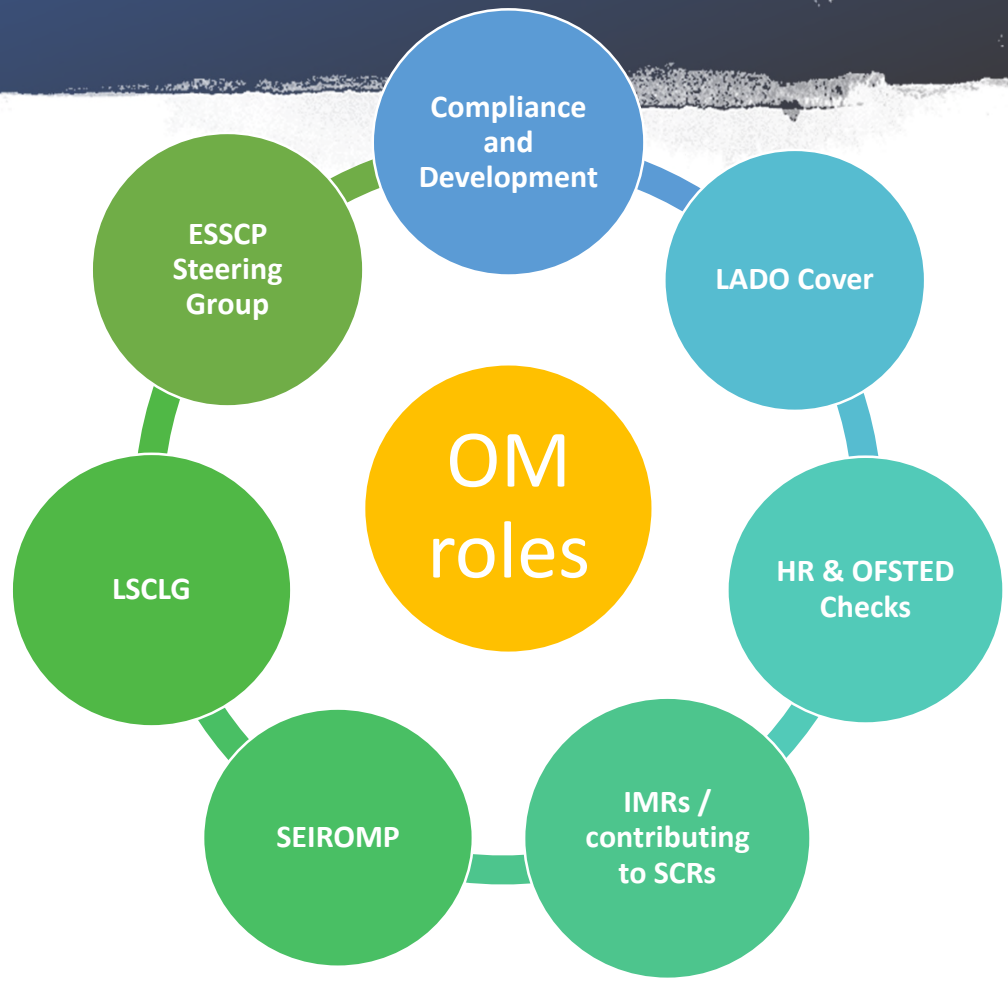
The statutory duties of the IRO are to:

- Monitor the Local Authority's performance of its functions in relation to the child's case.
- Participate in any review of the child's case.
- Ensure that any ascertained wishes and feelings of the child are given due consideration by the appropriate authority.
- Perform any other function as prescribed in the regulations.

The Independent Reviewing Service contributes to East Sussex's Core Offer for Children's Social Care: Provide care and support for children and young people where there is evidence that they have suffered significant harm or are at immediate risk of significant harm and provide an alternative home for children who are unable to live with their parents or in their extended family.

Additional Unit Responsibilities





Quality Assurance Monitoring and Audits

Strategy Discussion to ICPC	ICPC not leading to CP Plan	Repeat Plans within 2 years	Health Plans Audit
Ethnicity and Diversity Data on Child's Record	SAB Multi-Agency Audit: Young People at Risk of Exploitation	CLA Participation	QA of IRO Outcomes
CLA Reviews out of timescales	Issues Resolution themes and compliance	CLA Placement Stability	Short Breaks

Continuing Professional Development

IROs have engaged with CPD across the year, cascading learning in Unit Meetings including:

- Quality Justice Circle
- Community Care Conference
- Effective Challenge and Participation Development Day
- Recurrent Removals:Contemporary issues in research and practice
- OM Action Learning and Development
- PM Action learning and Development
- NAIRO – cascade
- The MIRRA (Memory – Identity – Rights in records – Access) study
- Prevent/Channel
- Black History Month
- Equality Issues for our LAC
- Reducing Parental Conflict
- Managing Mental Health

Caseloads

- The majority of LMG2's in the Safeguarding Unit hold a dual role; reviewing both Child Protection and Looked After Child plans. CPA caseloads are not legislated; however the government has set statutory guidance for IROs: a caseload of 50 to 70 looked after children for a full time equivalent IRO, would represent good practice. (The IRO Handbook DfE). At the end of March 2020 CPA/IRO combined caseloads averaged 97 children.
- In common with other Authorities ESCC operates a weighting system recognising that whilst IROs have additional responsibilities for LAC; Child Protection caseloads can be more dynamic, meetings can involve multiple children and may involve a higher level of risk. Covering both roles necessitates an advanced depth and breadth of professional knowledge.
- Highly successful recruitment across Quarter 4 will reduce reliance of Agency/Bank staff and allow for reduced caseloads going into 2020/2021

2725 Reviews

Conferences and LAC Reviews* are usually held as a single meeting involving all relevant family and professionals. However meetings may be held in two or more parts to ensure that they are effective and safe.

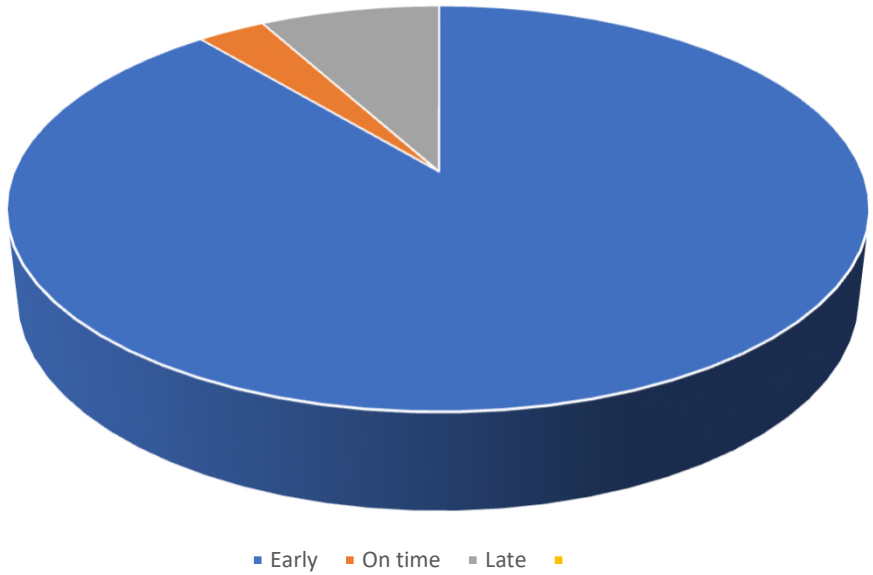
Chairs are also responsible for preparation work with parents and carers, pre-meets with social workers and meeting with children who are Looked After, as well as completing QA and Outcome documents.

Over the year the Unit chaired:

- 1113 Conferences concerning 2244 children
- 1612 individual LAC Reviews
- Equating to 215 meetings/303 Plans per chair

*LAC Reviews in ESCC are now 'My Voice Matters' Meetings; this change came into effect in March 2020 so the term was not used during the 2019/20 reporting cycle. Please see details of My Voice Matters Development later in this report.

Timeliness – LAC Reviews



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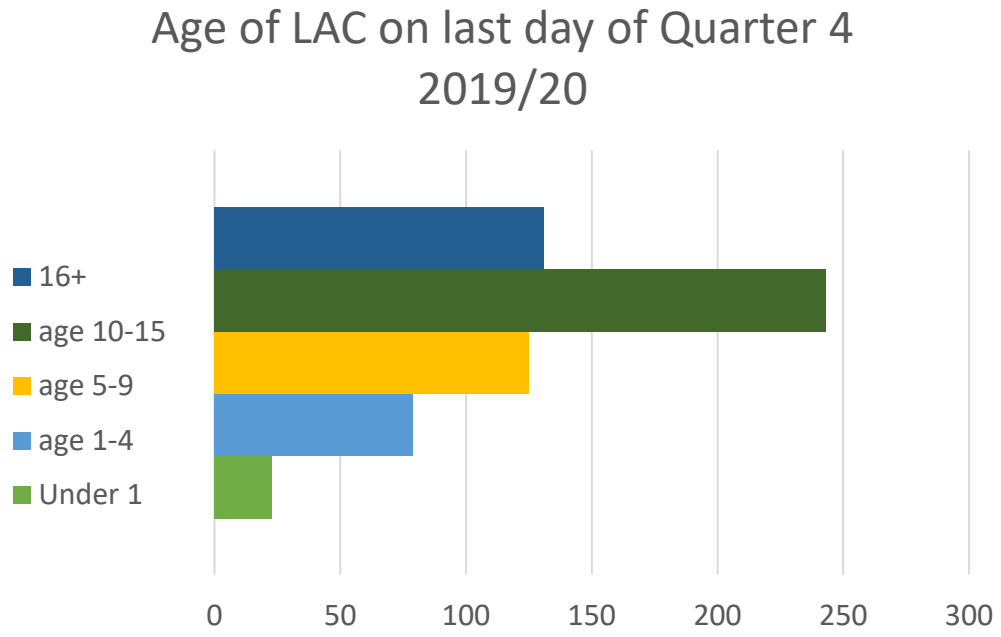
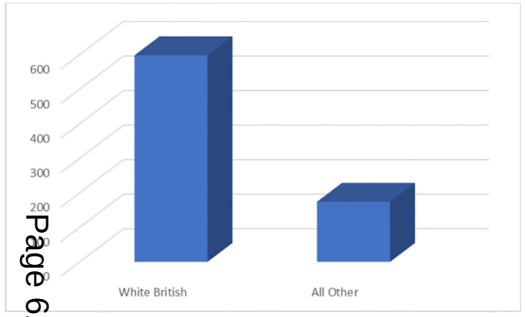
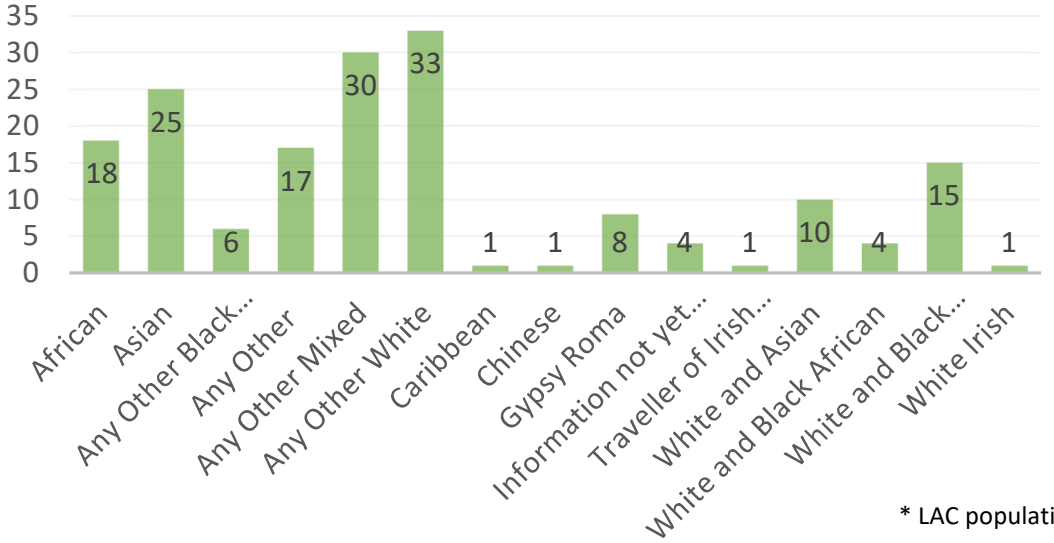
Knowing our LAC - Demographics

- At the end of March 2020 ESCC was looking after 601 children and young people, equivalent to 56.5 per 10000.
- This was a slight decrease on the previous year and sits below IDACI.
- The number of LAC was relatively stable throughout the year.



23% of LAC in ESCC identify as being minority ethnic or mixed heritage.
38% of ESCC IROs identify as being minority ethnic or mixed heritage.





* LAC population across 2019/20

Unaccompanied Asylum Seeking Children

- 48 UASC were Looked After by ESCC across 2019/20; the majority of these children came from Vietnam and Iran followed by Sudan, Iraq, Albania and Afghanistan with one child from each of Ethiopia, Mali, Kuwait and Kurdistan.
- 25% of UASC were aged less than 16 years old

Where do Children and Young People live whilst in our Care?

The majority of LAC in ESCC are in foster care.

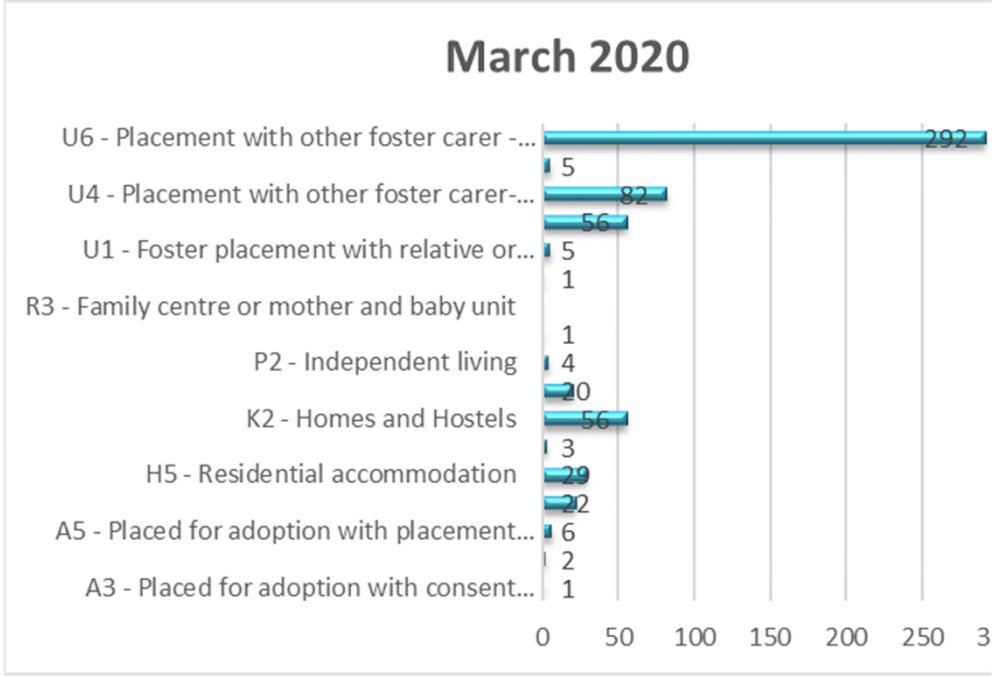
42% of LAC in ESCC had been accommodated for 2.5+ years and of those 61% had been in the same placement for at least 2 years. This is slightly lower than the National average but higher than statistical South East neighbours.*

12% of LAC had 3 or more placements across the year.*

IROs particularly scrutinise those plans where children have had a series of moves or where their placement appears insecure.

ESCC continues to promote children having long term relationships with the same IRO and ensuring that brothers and sisters have the same IRO wherever possible.

*As at last day of Quarter 4 2019/20



Legal status and Care Plans

- Care Proceedings for East Sussex sit slightly below IDACI and statistical neighbours.
- IROs generally report constructive discussions with social work teams and with some Children's Guardians during Care Proceedings.
- The IRO must be consulted in respect of the final Care Plan and their views provided to the Court. There is a significant tension in the time available within court schedules for IROs to fully consider all documents in order to provide a balanced, informed analysis. This is a potential risk for the service; with 2019/20 seeing an increased scrutiny of the IRO's position both Nationally and Locally.
- IROs have been reminded of the need to address children's legal status at all stages of their journey through care to ensure that it remains the most appropriate plan.

Issues Resolution

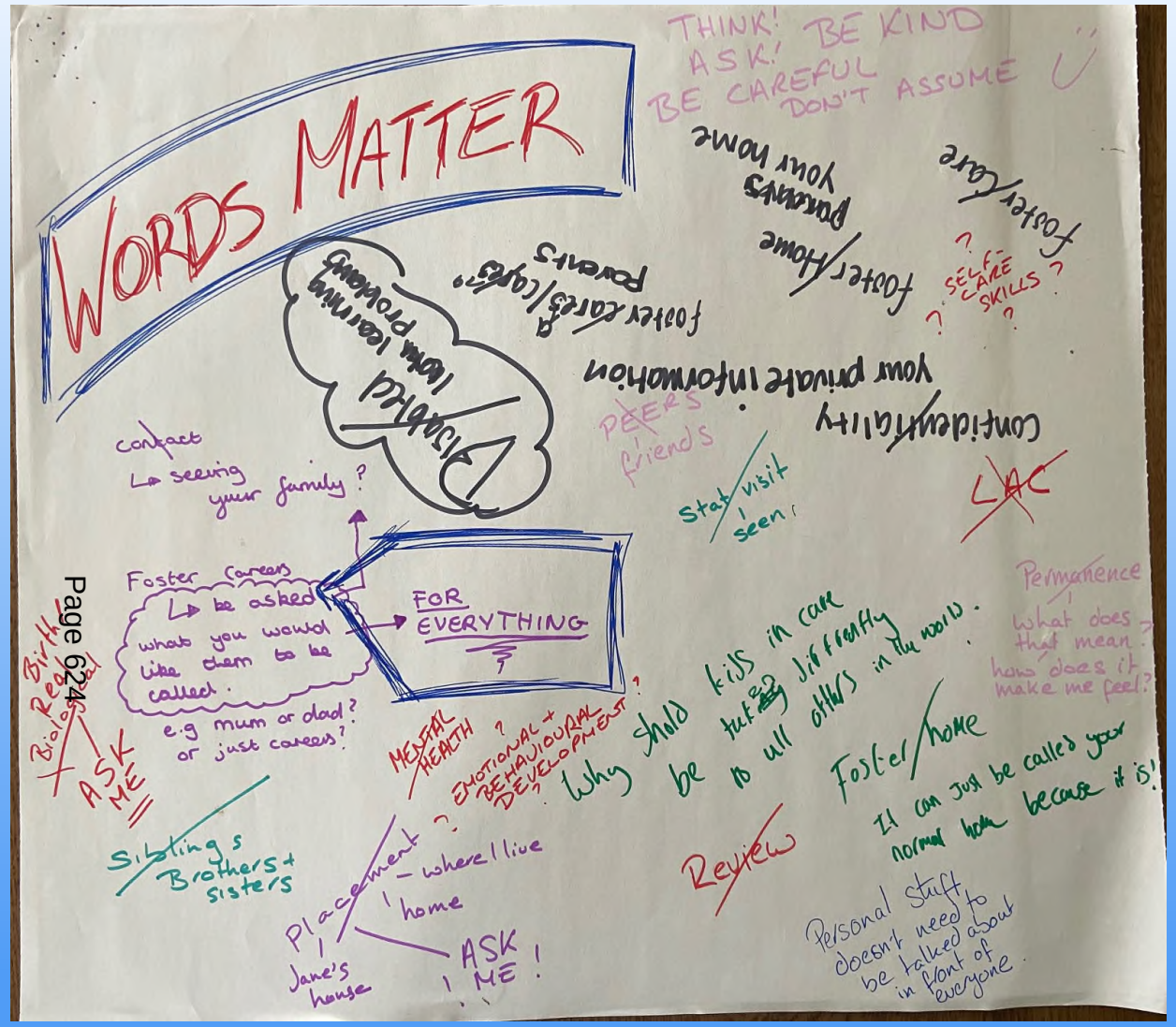
- Quality Monitoring of Child Protection Plans and evidence of independent challenge is required under Working Together to Safeguard Children 2018 (DfE) and Local Safeguarding Protocols.
- A ‘local dispute resolution process’ is a statutory requirement of the Independent Reviewing Service.
- OFSTED and Government require evidence of effective challenge by CPAs and IROs to be visible on children’s files. This was an area for improvement in our most recent inspection.
- The Safeguarding Unit operates a consistent approach to challenge across Child Protection and the Independent Reviewing Service.
- This approach was reviewed in 2019/20; a new electronic form now sits on the child’s file which requires compliance with timescales and ensures visible professional debate.

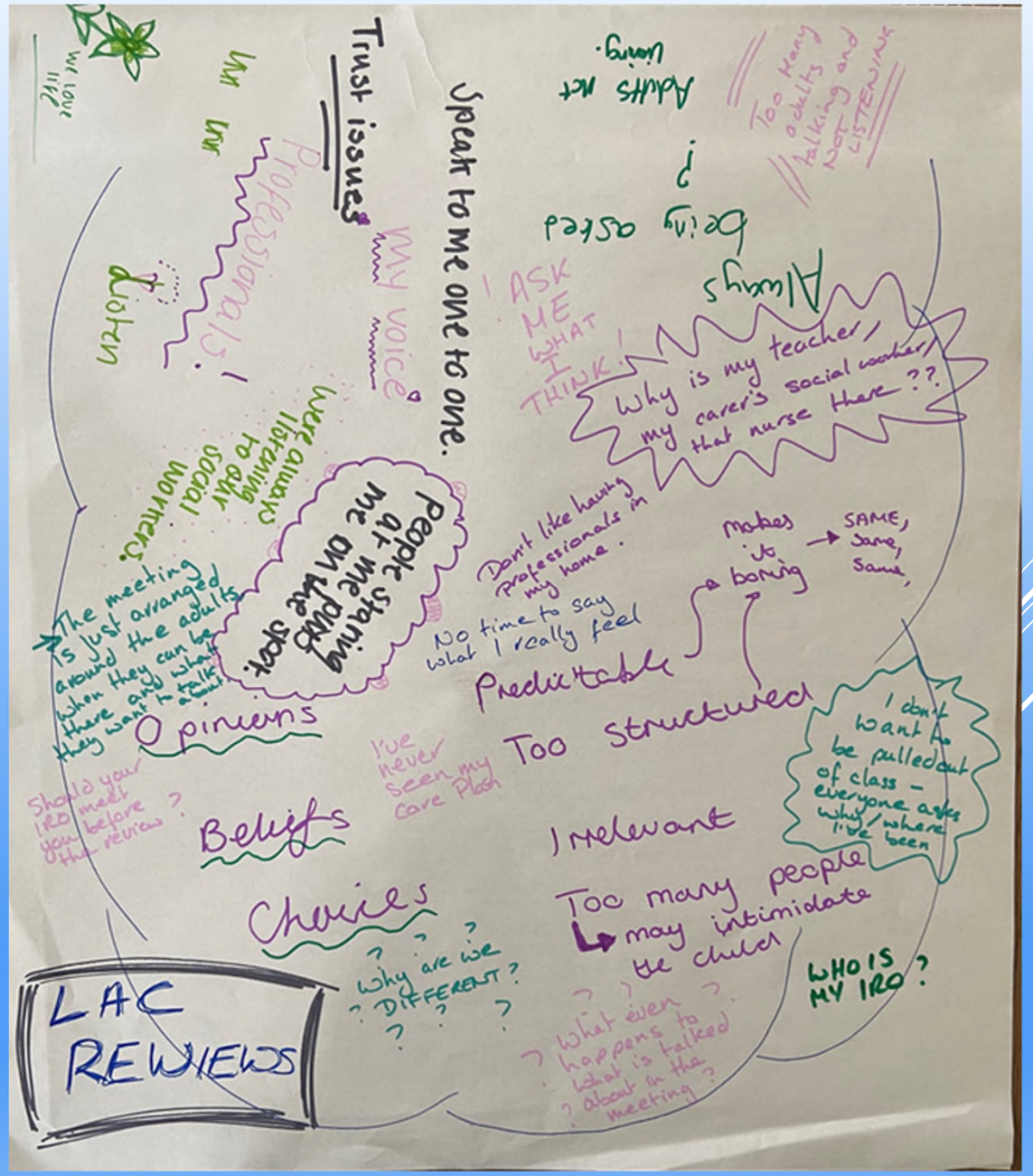
Themes from Issues Resolution 2019/20

The majority of Issues Resolutions across both CP and CLA related to delay or non-compliance with statutory documentation	• Impacts on fair, effective meetings • Blocks electronic workflow • Results in an incomplete record
Visits or other statutory tasks not visible on child's file	• Practice Requires Improvement • Recording / Administration Requires Improvement
Concerns regarding the Child Plan / Care Plan	• Dispute about the direction / quality of the plan • Drift / Delay • Impact of resources on Plan

Progress on Priorities for 2019/20

Participation:	•The child's views are now a mandatory part of the electronic record •Children and Young People are now prioritised in the organisation of their review •Development of Parent/Carer Information and digital feedback is an ongoing piece of work with Business Support
Improving the quality and depth of Care Plans:	•My Voice Matters meetings focus on the child's experience and use language that is appropriate for the child •The new IRO Outcome document focuses on the impact of the Care Plan and the Placement •The revised process will enable better use of translation services to ensure that children are able to access their Plan •The Issues Resolution Process has been revised with improved tracking and a focus on consistency between IROs
Children with Disabilities – status and Care Plans:	•Social Workers from the Children with Disabilities team played an integral part in the development My Voice Matters •The new documentation allows for better accessibility options e.g. converting letters into the child's preferred communication style •CLA CWD were included in the Health Audit with the team performing consistently well •An Audit of Short Breaks children / children potentially eligible for Short Breaks helped to clarify process
Improved Data Monitoring:	•LCS continues to present challenges in terms of Review data however these are now better understood and a number of errors have been corrected. •CLA documents have been streamlined to focus on what is important for individual children and to enhance QA function
Improved compliance with documentation / data to ensure effective meetings	•The Independent Reviewing Service now proactively tracks and prompts social workers to ensure that monitoring undertaken by the IRO is focussed on the quality of the Care Plan and the child's experience rather than paperwork. •Midway Reviews will allow formal monitoring and QA





Changing the Way We Think and Talk About Reviews

Children and Young People asked us to rename the LAC Reviewing process. They suggested 'My Voice Matters'. They asked us to keep meetings small, to use careful, child friendly language and to focus on what was most important to them. So from 2020 we've done just that.

We have reduced paperwork to free up time for Social Workers to spend with the child, to build relationships and understand their world.

A My Voice Matters page within the Review document has replaced consultation forms; ensuring the child's voice is central to their meeting and cannot get lost.

IRO outcomes will focus on the child's experience, celebrating their achievements and identifying any changes needed.

Children will receive a letter from the IRO following their My Voice Matters Meeting. This letter will be shared with the team around the child and will form the record of the meeting.

My Life

My Plan

My Voice Matters

My Voice Matters:

Informed by Key Learning from The Care Experienced Conference April 2019 and 'Language that Cares' TACT March 2019 and the CICC!

Improves compliance with statutory requirements and with the philosophy of being 'Corporate Parents'

Removes unnecessary duplication, unhelpful language, confusion and bottlenecks in the electronic record

Increases the 'footprint' of the IRO on the child's file

Ensure that the Care Plan is clear and up to date

Return the child to the centre of the process

My Life

My Plan

My Voice Matters

IRO Service Priorities for 2020/21

- Elevate the Child's Voice
- Embed My Voice Matters
- Digital Feedback and Consultation for Parents /Carers
- Increase use of Midway Reviews
- Develop IRO Lead Areas
- Improve quality and compliance through consistent monitoring

Glossary

CP – Child Protection
CPA – Child Protection Advisor
ESSCP – East Sussex Safeguarding Children Partnership
HR – Human Resources
IMR – Independent Management Review
IRO – Independent Reviewing Officer
LAC/CLA – Looked After Child
LADO – Local Authority Designated Officer
LSCLG – Local Safeguarding Liaison Group
MACE – Multi Agency Child Exploitation
OM – Operations Manager
SCR – Serious Case Review
SEIROMP/NAIROMP – South East / National IRO Managers' Partnership
UASC – Unaccompanied Asylum Seeking Child

Report to:	Corporate Parenting Panel
Date of meeting:	30 October 2020
Report by:	Director of Children's Services
Title:	Virtual School Annual Report - 1 April 2019 - 31 March 2020
Purpose of report:	To outline the performance of the Virtual School between 1 April 2019 to 31 March 2020

Recommendations:

The Corporate Parenting Panel is recommended to comment on and note the report

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1. Background

1.1 The Virtual School Report is contained within Appendix 1.

2. Budget Implications

2.1 The Virtual School is funded via a combination of grants and will continue to direct the Pupil Premium to interventions which will have the best possible educational outcomes for Looked After Children.

3. Recommendations

3.1 The Corporate Parenting Panel is recommended to comment on and note the contents of the report.

STUART GALLIMORE
Director of Children's Services

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Appendices

Appendix 1 – Virtual School Report 2019/20

Appendix 1

Virtual School Report 2019/2020

1. Introduction

1.1 During this period the Virtual School (VS) focused on the delivery of support to Schools, Carers and Social Workers to ensure the best possible outcomes for children who were looked after (CLA), previously looked after children (PCLA) and care leavers (CL). All interventions were designed to meet this overriding objective and used an evidence-based approach, incorporating national research and local quantitative and qualitative data.

1.2 The VS supported 358 CLA in schools and 606 children and young people (CYP) when care leavers were included. 23.7% of the CLA cohort had an Education Health and Care Plan, 17% were on the special needs register at SEN support level and 17% were in Special Schools. In March 2020, there were 44 Unaccompanied Asylum-Seeking Children in years 7 to 13, 15 of whom were of school age. Caseworkers in the VS had an average caseload of between 80 and 100 CLA. The higher number occurred between January and March when one Caseworker had left, and another had been appointed but was unable to take up the post until April.

1.3 This academic year was obviously a highly unusual one. The Department for Education (DfE) announced on the 8 April that school, college or multi-academy trust (MAT) level performance data based on summer 2020 tests, assessments and exams at any phase would not be published. Schools and Colleges should not be held to account for exam and assessment data from summer 2020 and data would not be used by others, such as Ofsted and Local Authorities, to hold Schools and Colleges to account.

1.4 For 2020, pupils were awarded the higher outcome between centre assessed grades or an algorithm that incorporated centre assessed grades but considered school and pupil prior performance. Because of this change in methodology, trend comparisons between years should be treated with extreme caution.

1.5 The current indication is that National and Local Authority data will not be published by the DfE. It will therefore not be possible to issue a further briefing note outlining East Sussex's performance compared to Statistical Neighbours, Core Cities and National performance for 2020.

1.6 Our current understanding is that a National CLA dataset for 2020 will not be published by the DfE or issued to NCER to populate the Local Authority reporting tool for VS's.

1.7 Primary Phase end of Key Stage tests were cancelled and grades were not awarded.

1.8 The VS was responsible for the management and administration of the Pupil Premium Grant (PPG) for CLA. In the financial year 2019- 2020 each CLA was allocated £2,300. Funding from the PPG was pooled to ensure the best outcomes for our children as outlined in 1.1 and according to the priorities set out in the VS Development Plan as described below. Pupil Premium funding for PCLA was also £2,300 but was held by their individual School. The VS advised Schools on the appropriate spend for this grant allocation for this cohort.

2. Virtual School Structure

2.1 During this period the VS employed a Head Teacher, two Education Officers (Caseworkers with supervisory and additional responsibilities), an Advisory Teacher, 7 Caseworkers (fte) and a Teaching Assistant. The VS also employed 12 casual Intervention Teachers. In addition, two Personal Advisers (PAs) were funded to work within the Through Care Service. One PA focused on working with young people who were not in education, employment or training (NEET) and on

increasing youth participation in local and national issues; the other on supporting the education of Unaccompanied Asylum-Seeking Children (UASC). In addition, a VS Extended Support Assistant was appointed to work within the East Sussex Behaviour and Attendance Team (ESBAS). This has enabled the VS to respond to children in crisis, in their individual school environment, more quickly. This structure also ensured that the support offered was incorporated into the wider package of intervention delivered to schools.

3. Key Developments

3.1 The quality of teaching and learning continued to be the VS's key focus. The VS's team of Teachers delivered interventions across all age ranges. Literacy and numeracy remained the main areas for intervention and included phonics intervention at Key Stage 2 to improve reading. In addition, the VS embedded an assessment and reporting policy to evaluate the impact of this work, to be assured of the effective assessment, planning and delivery of each intervention. The VS also used tutors from private agencies to deliver face to face and online lessons, and the year 11 cohort participated in on-line maths revision lessons as part of a Local Authority pilot project.

3.2 Teaching and learning since the middle of March 20 was adapted to be delivered in a virtual format. VS teachers worked hard to use digital technology for teaching and several on-line lesson products were purchased to assist. The VS provided both individual and group sessions, which focussed initially on year 11s and year 6s. In total, 77 CYP received one to one tuition in March, and 24 took part in group interventions. Results show that 75% of year 11 students achieving a level 4 and above had received additional tuition.

3.3 Partnerships between the VS and local providers were developed to deliver services to young people who were not engaging with school**.** Eggtooth and the Education Futures Trust, both based in Hastings, provided educational and therapeutic interventions to CLA in the Hastings area. Develop Outdoors worked with our young people across the Authority. The VS also started to work with Jamie's Farm, an organisation that offers disadvantaged young people a programme, combining farming, family and therapy**.**

3.4 Over the past 6 months, alternative providers continued to work face to face with individuals where possible, and provided virtual support based on a range of creative activities including the use of a therapeutic dog. This has been an area of challenge during COVID. The Youth Employability Scheme, YES, offered a universal service to all young people from year 10, and worked intensively with those who required more support in identifying future pathways. As a result of these partnerships there has been an increase in the levels of engagement of CLA in education and in post 16 pathways.

3.5 Personal Education Plans (PEPs) remained critical in raising educational outcomes for our children. Any applications for Pupil Premium funding to support CLA and their learning continued to be made via the PEP. Last year the VS developed its in-house PEP auditing system which was successful and will replace the need to purchase a commercial E PEP programme. There has been a significant increase in the completion rates of PEPs and the VS will continue to work with schools to ensure that they are of a high quality.

3.6 In March, a VS writing competition was launched based on a book of pictures by Chris Van Allsburg. The entries were all made into a book, participants received a certificate and the winners a book token.

"*The children really enjoyed the task, even those that did not submit stories have loved working on them from home". (Teacher)*

"X said he could never write 500 words but with the carers support and nudging he did it. He was very pleased to receive a winners' gift token and certificate. His carer has now challenged him to write a 1000-word story which he was working on each morning". (Social Worker)

"This comes at a perfect time for D. I have informed her that she is a winner. I have printed out the certificate on fancy paper and shared your email". (Head Teacher)

3.7 The preparation of CLA for key educational transitions remained a focus during 2019/20. A summer school for pre-reception children and Spring School for years 8,9 and 10 was held. However, the year 11 revision school had to cancelled because numbers were affected by a train strike.

3.8 Unfortunately, the planned 2020 transition events had to be cancelled due to COVID, but Caseworkers worked with schools to offer virtual support. The VS sent regular information and resources to Carers, Social Workers and Designated Teachers on preparing for transition from home. This included running a workshop on Using Pupil Passports to share information about a CLA and the importance of involving them in the process. The YES Service continued to work with CLA re post 16 planning.

3.9 The VS continued to work closely with Bede's school to further develop the Springboard boarding project and plan placements for the next academic year. Four additional students were offered residential places and one student a day place to start in September 2020. Bede's also hosted the Children in Care Awards and VS Governor meetings, but a planned event for younger children involving a visit to their zoo had to be cancelled due to COVID. The VHT met with the Buttle Trust and Eastbourne College to explore placements and partnership working and there are plans to meet with Christs Hospital in the near future.

3.10 The Children in Care Awards held in October 2019 to celebrate the achievements of our children and young people was again a success. The children's author, Jacqueline Wilson produced a filmed message for the nominees and award winners. Plans are currently underway to deliver a virtual awards ceremony for 20/21.

3.11 The VS has continued to work closely with other services to develop support for Social and Emotional Health across the Authority. Regular messages were sent out to Carers and Designated Teachers during lockdown, sharing strategies and resources to support mental health. The VS jointly ran a virtual summer conference on Mental Health with Judy Perraton, Mental Health Co-ordinator and the Educational Psychology Service. In total, 650 staff attended the ten workshops which were very well received. The VS also funded 50 places on an extended course in Attachment and Trauma.

3.12 More recent information sent to schools, social workers and carers has focussed on supporting children and young people back into school.

3.13 The VS will be involved in the STrAWB (Shared Training and Assessment of Well-Being for Looked-After Children) project feasibility study. This project will deliver a training and assessment package for foster carers and schools, designed to identify and support those children who are at greatest risk of developing mental health difficulties, as well as those who are most resilient following maltreatment. It is led by researchers from the Universities of Oxford and Sussex.

4. National Agenda for Virtual Head Teachers

4.1 The Virtual Head Teacher (VHT) worked collaboratively with the national cohort of VHT's on a range of national priority areas.

4.2 The VS continued to work to develop better communication with local authorities across the country where CLA were placed out of the county. This remained an area of key challenge, particularly for those children with an Education Health and Care Plan (EHCP) or those awaiting assessment for an EHCP. The VS worked closely with ISEND to develop policies and procedures to address this issue and continued to reduce the timescales for school admissions. This year some highly personalised and creative educational packages for young people with the highest level of

need were successfully put together. The VS also worked with the English as an Additional Language Service and Post 16 providers to develop provision for Unaccompanied Asylum Seekers.

4.3 The exclusion of CLA from school has been a significant national issue during this period and is one that is being reviewed in relation to post COVID policies in school. This year the VS worked with all schools to support children who were in crisis, to avoid exclusion where possible. Fixed term exclusion for 2018-19 was 10.11% (National 11.67%)

4.4 The admission and attendance of CLA continued to be a key issue nationally with significant numbers having poor attendance. The VS tracked the attendance of all ESCC CLA educated both in and outside East Sussex and intervened as early as possible. The 2019/20 national attendance data has not been collected due to COVID and the partial closure of schools.

4.5 The VS has been tracking attendance for CLA since lockdown. Attendance during lockdown was monitored as part of the vulnerable children group and support was given to ensure that all CLA were offered school places. The VS Headteacher was also part of the Vulnerable Children Risk Assessment Group who met weekly to ensure that adequate safeguarding was in place for vulnerable groups of children including CLA.

4.6 When year groups returned to school, the attendance of CLA was in line with or above the attendance of all children.

4.7 A very small number of children have not returned to East Sussex schools since September and are being supported to get back into education by VS Caseworkers as well as by ESBAS.

4.8 VS's receive no funding for Post 16 provision. This is a key issue for all VS's and as such the DfE announced a pilot for funding Post 16 provision but unfortunately, due to COVID, this has not progressed.

5. Governor priorities for the Virtual School 2020/21

Outcome	Subsidiary	Tasks
Improve KS2 progress outcomes, particularly in reading, writing and Maths	**To ensure high quality intervention through support, training, monitoring and evaluation**	Embed teacher induction, training and supervision Provide guidance for schools on high quality planning and review Monitor quality of PEPs and send regular feedback to schools Work with CLASS to develop a KS2 phonics intervention project Develop policy to promote use of technology to support development of literacy skills and removal of barriers arising from literacy difficulties
To improve progress outcomes at KS4	**To ensure high quality intervention through support, training, monitoring and evaluation**	Embed teacher induction, training and supervision Work with a range of Alternative providers to expand options available to CYP.

	To develop a range of high-quality alternative provisions for young people out of school **To ensure that Alternative Provision supports academic and wider outcomes and supports transitions into post 16 pathways**	Work with providers to produce information on their provision Ensure that AP interventions include appropriate assessment, planning and review to ensure positive impact Work with residential homes, placement support and Alternative Providers to train staff in delivery of ASDAN courses. Virtual School to become a registered ASDAN centre Support staff from residential homes, placement support and Alternative Providers to identify appropriate ASDAN courses for CYP out of school or on part time timetables, to plan sessions and to carry out and mark assessments.
To develop inclusive practice re CLA in all schools – academic and pastoral differentiation so that all CLA have access to good and better schools and enjoy going to school	**To support the transition of CLA and PCLA on their return to school after absence due to COVID related issues.** **To improve enjoyment of school and confidence in school for CLA with specific reference to changes in response to COVID** **To work with other services and schools to improve understanding and support for mental health and emotional wellbeing (MHEW) and of the needs associated with attachment and trauma.** **To work with education, care and health partners to support schools in developing MHEW policies and practices including whole school policies and interventions.**	Work with LA services to support co-ordinated develop of whole school practices and interventions re MHEW Work with SIP and ISEND to promote inclusive practice and use of the Inclusion Quality Mark Support the development of high quality MHEW interventions through joint working with mental health practitioners in schools and LACAMHs Develop VS training offer to schools and carers within a wider East Sussex offer. Roll out Beacon House training offer to Designated Teachers Produce and share information promoting inclusive practice through an online presence. Share information and strategies/resources with foster carers Explore reasons that some CYP felt they had learnt more at home

		and use information to inform practice in schools. Develop use of ELSA strategies and resources within schools Contribute to planning and delivery of the DFE's Wellbeing for Education Return Project Work with academic teams from Sussex and Oxford on the 'Shared Training and Assessment of Well-being Project (STrAWB)
To reduce exclusions – both fixed term and permanent	**To work with schools to develop differentiated behaviour policies particularly within organisational changes created because of COVID.** **To work as part of the LA team that promotes Therapeutic Thinking and other complementary approaches** **To support schools to develop more inclusive behaviour policies**	Participate in the 'whole school programmes for emotional well-being working group' – looking at a range of inclusive approaches Challenge exclusions and work with schools to put in an alternative plan VS team to receive training in Therapeutic Thinking
To increase the participation of all CLA and care leavers in opportunities that will raise aspiration and prepare them for the challenges of an independent future (Extra Curricular activities, Work experience, CICC developments)	**To ensure high quality IAG for care leavers e.g. University, apprenticeships** **To ensure engagement of CYP in WP activities** **To develop YP participation in local and national initiatives** **To use care leavers views to inform practice** **To embed the use of SEND Vocational Profiles and other SEND Community of Practice interventions within VS practice**	Involve care leavers in Local Offer and run dissemination event – suspended because of COVID Develop 16 plus meetings to involve WP co-ordinators in colleges and schools and ensure a coordinated approach Work with Universities to develop their Widening Participation programme and ensure engagement by involving CYP in programme planning Explore development of year 6 and 11 transition events to ensure maximum impact To develop online communication re extra curricula

		events for pre and post 16 students To pilot an adapted PEP for post 16 students – informed by the SEND Vocational Profiles
To develop high quality advice and support re Previously Looked After Children	**To develop knowledge and understanding of team** **To work with post adoption team to develop understanding of VS role and key educational issues** **To work with Amaze to share support offer parents of PCLA**	Increase staff knowledge, understanding of issues specific to PCLA via input from Adoption Team Create a VS link staff member within the Adoption team. Hold regular drop-in sessions with Adoption social workers Work in partnership with Adoption South East to develop practise re PCLA
To increase attendance rates overall and reduce persistent absence	**To reduce amount of time CLA are out of school when they move in or out of county** **To develop range of Alternative Provision to encourage engagement of CYP who have become disengaged from school (see above)**	Embed policies and procedures re CLA with EHCPs moving in or out of county – adapt policy to take account of children who are granted an EHCP after they have moved out of East Sussex
To improve the quality of Personal Education Plans		To develop a robust for monitoring quality of PEPs To further develop a robust and staged system for ensuring timely completion of PEPs
To ensure clear and effective educational pathways for UASC	**To develop EAL provision for all new and existing UAS** **To increase staff knowledge, understanding of issues specific to UAS**	Work together with EALs to develop a clear policy re EAL delivery to UAS CLA and care leavers – to include online teaching Regular UASC updates at team meetings Work with East Sussex College group to identify a choice of ESOL pathways for UASC

To ensure that all young people are engaged in education and aspire for their futures	**To develop links with a range of independent schools so able to offer residential and day school places and extracurricular support.**	Work with YES and Enterprise team to develop Information, advice and guidance from start of year 10 and with a focus on students likely to be NEET To develop work experience and volunteering opportunities for CLA and ensure CLA are included in schools' work experience offers To work with Springboard to share boarding school experience with VSs across the country. To develop links with Eastbourne College, Christ Hospital and Cranbrook re educational provision and extra curricula activities Hold a raising aspirations' event/s using outside speakers to inspire CYP.
To promote the work of the VS and share information and resources with schools, carers and social workers.	**To develop our online presence** **To enable VS users to interact with the school through an online platform/s.**	Meet with comms manager to plan online presence Plan and develop online presence Ensure quality and updated content and opportunities for interaction with users

5.1 The VHT, together with the national group of Virtual Head Teachers, to contribute to the national debate regarding the ongoing DfE commitment to funding Pupil Premium Plus for CLA and PCLA and issues impacting CLA such as admissions and exclusions.

5.2 The VS to review priorities above on an ongoing basis in response to the impact of COVID 19 on education.

6 Recommendations

6.1 The Corporate Parenting Panel are recommended to comment on and note the report

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Report to:	Corporate Parenting Panel
Date of meeting:	30 October 2020
By:	Director of Children's Services
Title:	Looked After Children Health Report
Purpose:	To provide assurance to the Corporate Parenting Panel on how, as part of the wider system, the Clinical Commissioning Groups (CCGs) and East Sussex Health Care Trust (ESHT) are fulfilling their statutory duties under the guidance 'Promoting the health and well-being of Looked After Children' (2015).

RECOMMENDATIONS:

The Corporate Parenting Panel is recommended to comment on and note the contents of this report

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1. Background and Supporting information

1.1 Clinical Commissioning Groups (CCGs) are the main commissioners of health services and the purpose of this report is to provide assurance to the Corporate Parenting Panel on how, as part of the wider system, the CCGs and East Sussex Health Care Trust (ESHT) are fulfilling their statutory duties under the guidance 'Promoting the health and well-being of Looked After Children' (2015) which is available as Appendix 1.

1.2 The panel is asked to comment on and note the priorities for 2020-21, including taking forward good practice from the Covid-19 response, implementation of the Sussex-wide service specification and the focus on the mental health and emotional wellbeing of Looked After Children.

1.3 The Pan Sussex Annual report is attached as Appendix 2 and the East Sussex/ESHT specific report is attached as Appendix 3.

2. Key achievements:

- **Initial Health Assessment (IHA) process and timescales for statutory health assessments** - Improvement to pathways for initial and review health assessments achieved by the CCG, health providers and the Local Authority (LA) working closely together. This has resulted in significant improvement in meeting statutory timescales for health assessments. Regular Audit of health assessments has been undertaken to ensure quality.

- **Joint Targeted Area Inspection (JTAI)**- the inspectors commented on the high quality of the IHA and Review Health Assessments (RHA) assessments that were reviewed.

- **Section 11 audit re-design** – The re-design includes specific sections on Looked After Children for the first time, which goes to all providers across the Local Safeguarding Children Partnerships.

- **Transition**- There is a strong focus on supporting young people to make the huge transition to independence. The Specialist Health Team, in conjunction with the Brighton and Hove and West teams, have developed a young person's Personal Health Summary document. This Summary provides the young person with their own 'health facts', information about the health service and how to access it and guidance on staying healthy

3. Key Performance Data from East Sussex Health Care Trust

3.1 The performance data below demonstrates the clear improvement in timeliness of health assessments in response to improved pathways and reporting:

Initial Health Assessments IHA 2019-20	IHA should be completed and report distributed within 20 days of child entering care	
	Within 20 days of entering care	Within 16 days of complete paperwork being received by ESHT
Q1	20%	7%
Q2	24%	33%
Q3	43%	64%
Q4	25%	100%

Review Health Assessments RHA 2019-20	RHA should be completed and distributed before expiry of the previous report (6 monthly under 5 years of age, annually between 5-18 years of age)	
	Under 5 years of age	**5-18 years of age**
Q1	19%	29%
Q2	61%	75%
Q3	71%	65%
Q4	100%	62%

Leaving Care Health Summary 2019-20	All eligible children between 16-18 years of age leaving care should be provided with a health summary
Q1	62%
Q2	100%
Q3	100%
Q4	100%

4. Impact of Covid-19

4.1 During quarter 4, the Specialist Health Team adjusted the delivery of IHAs and RHAs due to Covid-19 in line with CCG and Government guidance. Appointments were undertaken by phone consultation initially, triangulating information by speaking to the child/ young person (where age appropriate), carers, social workers and other agencies involved in order to inform the Health Care Plan and report.

5. Identified risks

- The main priority, to fully implement the Pan Sussex service specification has been delayed meaning that the expected outcomes have not been fully realised.

- Health data for the year evidences clear progression in the health pathway however, timeliness for health assessments continues to be impacted by delay in referral from LA and highlights where there needs to be further sustainable improvements.

- Impact of pandemic restrictions and lockdown

- Need for clear pathways and reporting relating to emotional and mental health for this group of children and care leavers

6. Priority work streams identified for 2020-21

- **Emotional Wellbeing and Mental Health** - The formal evaluation of the Sussex wide review, the East Sussex Joint Targeted Area Inspection (JTAI) and the national Anna Freud pilot to be used by CCG, designates and commissioners to inform development of services.

- **Reporting and Governance** - Strengthen reporting across the integrated care system from to inform a health of Looked After Children dashboard which will inform commissioning decisions going forward. This will include a strong focus on emotional wellbeing and mental health.

- **Transition** - Increased oversight of offer to all Looked After Children across Sussex irrespective of placing authority, and to children placed out of Sussex.

- **Workforce Development and Training** - Develop a multi-agency Looked After Children training that is accessed via LSCP as a Pan Sussex offer.

- **Specialist commissioning and Quality -** Supporting commissioners of all health services to have appropriate arrangements and resources in place to meet the physical and mental health needs of looked-after children and improve health outcomes.

7. Recommendations

7.1 The Corporate Parenting Panel is recommended to comment on note the contents of the report.

STUART GALLIMORE
Director of Children's Services

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APPENDICES

Appendix 1 – Promoting the health and well-being of looked-after children, Statutory guidance for local authorities, clinical commissioning groups and NHS England, March 2015

Appendix 2 – Pan-Sussex Report on the Health of Looked After Children

Appendix 3 – East Sussex Healthcare NHS Trust (ESHT) Report on Health of Looked After Children in East Sussex

Department for Education

Department of Health

Promoting the health and well-being of looked-after children

Statutory guidance for local authorities, clinical commissioning groups and NHS England

March 2015

Contents

Summary

About this guidance

This is joint statutory guidance from the Department for Education and the Department of Health. It is for local authorities, clinical commissioning groups (CCGs) and NHS England and applies to England only.

This guidance is issued to local authorities, CCGs and NHS England under sections 10 and 11 of the Children Act 2004 and they **must** have regard to it when exercising their functions.

It is also issued under section 7 of the Local Authority Social Services Act 1970. This requires local authorities in exercising their social services functions to act under the general guidance of the Secretary of State. Local authorities **must** comply with this guidance unless there are exceptional reasons that justify a departure.

This guidance replaces the *Statutory Guidance on Promoting the Health and Well-being of Looked After Children*, which was issued in November 2009 to local authorities, Primary Care Trusts and Strategic Health Authorities. The guidance published in 2009 has been updated to reflect reforms to the National Health Service following the Health and Social Care Act 2012. It also takes account of other reforms such as changes to the special educational needs legislative framework and the cross-Government mental health strategy, which emphasises that mental health is as important as physical health.

This guidance should be read in conjunction with:

- The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review
- The Children Act 1989 Guidance and Regulations Volume 3: Transition to Adulthood
- The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services
- Guide to the Children's Homes Regulations, including the Quality Standards
- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
- Who Pays? Determining responsibility for payments to providers
- National Tariff Payment System

Terms used in this guidance

There is a glossary of technical terms used in this guidance. This can be found at Annex D.

How to use this guidance

The main points summarise the high level information local authorities, CCGs and NHS England need to know. More details about each point and further guidance are set out in the rest of this document.

Expiry or review date

This guidance will be reviewed in 2020 or sooner if deemed to be necessary.

What legislation does this guidance refer to?

- The Children Act 1989 and associated regulations[1]
- The Children Act 2004
- The Mental Capacity Act 2005 – Deprivation of Liberty Safeguards
- The National Health Service Act 2006
- The Mental Health Act 2007
- The Health and Social Care Act 2012
- The Care Act 2014
- The Children and Families Act 2014.

Who is this guidance for?

This guidance is for:

- all local authority managers and staff who have responsibilities for looked-after children, including Directors of Public Health, commissioners of placements, and staff who support and supervise carers
- commissioners of health services for children
- NHS England
- designated and named professionals for looked-after children
- GPs, optometrists, dentists and pharmacists
- Lead Members for Children's Services in local authorities
- managers and staff of services for care leavers, and Personal Advisers
- teachers
- health visitors, school nurses and any other professional who is involved in the delivery of services and care to looked-after children.

[1] The Care Planning, Placement and Case Review (England) Regulations 2010.

Main points

- 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, including eligible children and those placed for adoption, 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.
- 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*.
- 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.
- 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.
- When a child starts to be looked after, changes placement or ceases to be looked after, the responsible local authority should notify, among others, the CCG – or, in the case of a placement out of authority, both the originating and the receiving CCG (or local health board in the case of a child looked after by a local authority in England but living in Wales) – and the child's GP. If the child is moved in an emergency, the notifications should happen within five working days. Prompt notifications are essential if initial health assessments are to be completed in good time.[2]
- Looked-after children should never be refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.
- CCGs and NHS England have a duty to cooperate with requests from local authorities to undertake health assessments and help them ensure support and services to looked-after children are provided without undue delay.
- Local authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area.
- The health needs of looked-after children should be taken into account in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).
- Every local authority should have agreed local mechanisms with CCGs to ensure that they comply with NHS England's guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for looked-after children and to resolve any funding issues that arise.[3]

[2] The person to notify in the CCG could be the designated nurse, who should in turn inform the named professional and the local looked-after health team.

[3] Who Pays? Determining responsibility for payments to providers.

- If a looked-after child or child leaving care moves out of the CCG area, arrangements should be made through discussion between the “originating CCG”, those currently providing the child’s healthcare and the new providers to ensure continuity of healthcare. CCGs should ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care for the child.
- Local authorities, CCGs and NHS England should ensure that plans are in place to enable children leaving care to continue to obtain the healthcare they need.
- Looked-after children should be able to participate in decisions about their health care. Arrangements should be in place to promote a culture:
    - where looked-after childen are listened to
    - that takes account of their views according to their age and understanding, in identifying and meeting their physical, emotional and mental health needs[4]
    - that helps others, including carers and schools, to understand the importance of listening to and taking account of the child’s wishes and feelings about how to be healthy.[5]

[4] Local authorities have a duty to (i) agree the child’s care plan with parents or others with parental responsibility, unless aged 16 or 17 (in which case they can agree it themselves) [Care Planning Regulations 2010, Regulation 4]; (ii) ascertain and give due consideration to their wishes and feelings when making decisions for looked-after children [Children Act 1989 s22(4) and (5)].

[5] In this guidance the term ‘carer’ means foster carer or residential care worker.

Supporting all looked-after children: joint responsibilities

Context

1. Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.

Overarching principles

2. Parents want their children to have the best start in life, to be healthy and happy and to reach their full potential. As corporate parents, those involved in providing local authority services for the children they look after should have the same high aspirations and ensure the children receive the care and support they need in order to thrive.

3. Local authorities have a duty under the Children Act 1989 to safeguard and promote the welfare of the children they look after, wherever they are placed. Directors of Children's Services, Directors of Public Health and Lead Members for Children's Services have a responsibility to ensure there are systems in place so that this duty is properly discharged.

4. This must be done in accordance with the relevant Regulations.[6] These Regulations set out the requirements governing the development and review of a looked-after child's care plan. That plan includes their health plan.

5. The NHS has a major role in ensuring the timely and effective delivery of health services to looked-after children. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and The NHS Constitution for England make clear the responsibilities of CCGs and NHS England to looked-after children (and, by extension, to care leavers). In fulfilling those responsibilities the NHS contributes to meeting the health needs of looked-after children in three ways: commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child.

6. Under the Children Act 1989, CCGs and NHS England have a duty to comply with requests from a local authority to help them provide support and services to looked-after children.

[6] The Care Planning, Placement and Case Review (England) Regulations 2010.

7. Local authorities, CCGs and NHS England can only carry out their responsibilities to promote the health and welfare of looked-after children if they cooperate. They are required to do so under section 10 of the Children Act 2004.[7]

8. The Health and Social Care Act 2012 places a legal duty on CCGs to work with local authorities to promote the integration of health and social care services.[8] The Government's Mandate to NHS England includes an explicit expectation that the NHS, working together with schools and children's social services, will support and safeguard looked-after children (and other vulnerable groups) through a more joined-up approach to addressing their emotional, mental and physical health needs.

9. Effective channels of communication between all local authority staff working with looked-after children, CCGs, NHS England and health service providers, as well as carers – along with clear lines of accountability – are needed to ensure that the health needs of looked-after children are met without delay. Looked-after children themselves (according to age and understanding) should also have the information they need to make informed decisions about their health needs.

10. Staff working with looked-after children who are delivering health services should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different. They should in particular:

- ensure looked-after children are able to access universal services as well as targeted and specialist services where necessary
- receive supervision, training, guidance and support.

11. Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning of child and adolescent mental health services (CAMHS). They should also plan for effective transition and consider the needs of care leavers.

Planning health services for looked-after children

12. The starting point for planning health services for looked-after children should be the statutory Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). The statutory guidance on JSNAs and JHWSs states that health and wellbeing boards will need to consider the needs of vulnerable groups such as

[7] Under the Children Act 1989 'relevant partners', which are required to cooperate with local authorities in making arrangements to improve children's well-being in their area, are: district councils, where there are two-tiers of local government, clinical commissioning groups, NHS England, Young Offenders Institutions, police and probation services, schools, further education colleges and sixth form colleges.

[8] Section 14Z1(2) of the National Health Service Act 2006 inserted by section 26 of the Health and Social Care Act 2012.

looked-after children and adopted children.[9] The information gathered as part of that process should be used to identify gaps in provision to meet the physical and mental health needs of looked-after children and inform strategic commissioning priorities.

13. CCGs and the officers in the local authority responsible for looked-after children's services should:

- recognise and give due account to the greater physical, mental and emotional health needs of looked-after children in their planning and practice
- give equal importance (parity of esteem) to the mental and physical health of looked-after children and follow the principles in the national document Mental *Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*
- agree multi-agency action to meet the health needs of looked-after children in the area
- ensure that sufficient resources are allocated to meet the identified health needs of the looked-after children population, including those placed in their area by other local authorities, based on the range of data available about their health characteristics
- take into account the views of looked-after children, their parents and carers, to inform, influence and shape service provision, including through Children in Care Councils and local Healthwatch where they are undertaking work in this area
- arrange the provision of accessible and comprehensive information to looked-after children and their carers.

14. Understanding the emotional and behavioural needs of looked-after children is important. Local authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional well-being of individual looked-after children.[10] SDQ scores can be aggregated to help quantify the needs of the local looked-after children population and should be used by local authorities and CCGs as they develop their JHWSs.[11] More information about the use of the SDQ for individual looked-after children can be found in Annex B. If they wish, local authorities may use other tools to supplement the SDQ.

[9] Health and wellbeing boards comprise: a representative from each CCG whose area falls within or coincides with the local authority area, the Director of Children's Services, the Director of Public Health, the Director of Adult Social Services and a representative from the local Healthwatch organisation.

[10] The SDQ is an internationally validated brief behavioural screening questionnaire about 4-16 year olds. It exists in three parts: one for the carer, another for the child's teacher and a third part for the child. While the Department for Education requires local authorities to provide SDQ data to be completed for looked-after children by their foster carer or residential care worker, local authorities should not see this as purely a data collection exercise by central government with which they must comply.

[11] The NSPCC/Rees Centre University of Oxford report in the Impact and Evidence Series, *What Works in Preventing and Treating Poor Mental Health in Looked-After Children?*, found that 'Use of the Strengths and Difficulties Questionnaire (SDQ) with looked-after children has been shown to provide a good estimate of the prevalence of mental health conditions…'

Commissioning health services

15. CCGs are the main commissioners of health services, with the exception of:

- certain services commissioned directly by NHS England (primary care, high secure psychiatric services, highly specialist in-patient mental health services, other specialised services and the majority of health services for prisoners and members of the armed forces)
- health improvement services commissioned by local authorities; and
- health protection and promotion services provided by Public Health England.

16. All commissioners of health services should have appropriate arrangements and resources in place to meet the physical and mental health needs of looked-after children.

17. Services for individual children placed out of the CCG area should be consistent with the responsible commissioner guidance *Who Pays? Determining responsibility for payments to providers* (see pages 12 and 13 of that guidance).

18. CCGs should ensure:

- they can access the expertise of a designated doctor and nurse for looked-after children (see page 13). Where a designated professional is employed by a different NHS organisation, this will need to be set out in a local agreement
- when looked-after children move placement or move into another CCG area and are currently receiving, or on a waiting list for, health services, their treatment continues uninterrupted. Looked-after children should be seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service. The length of a placement should not affect a child's access to services
- arrangements are in place to ensure a smooth transition for looked-after childen and care leavers moving from child to adult health services.

19. NHS England should ensure:

- looked-after children are always registered with GPs and have access to dentists near to where they are living. This is a shared responsibility with the local authority for the children it looks after
- when looked-after children need to register with a new GP (e.g. when they enter care or change placement), the transfer of GP-held clinical records is 'fast-tracked'.

20. Commissioners, whether they sit within the responsible local authority, CCGs or NHS England, should commission services which meet the following requirements:

- health professionals contributing to the care planning cycle for looked-after children should have the appropriate skills and competences and receive continuing professional development[12]
- providers have arrangements in place for relevant training and clinical supervision of professionals contributing to the healthcare of looked-after children, including those who are employed by the local authority
- clinical governance and audit arrangements are in place to assure the quality of health services for looked-after children.

The responsible commissioner

21. NHS England guidance *Who Pays? Determining responsibility for payments to providers* provides the framework for establishing responsibility for commissioning an individual's care within the NHS.[13] Local authorities and CCGs should have agreed local mechanisms to ensure this guidance is followed when making placement decisions for looked-after children and for resolving any funding disputes that may arise. This is essential to avoid delays in looked-after children being assessed for, and accessing, the services they need.

22. NHS England expects that any disputes will be resolved locally, ideally at CCG level, with reference to the guidance in *Who Pays?* In cases that cannot be resolved at CCG level, NHS England should be consulted and should arbitrate where necessary.

23. When a child is first placed, the local authority looking after them has a shared responsibility with the relevant CCG to ensure that a full health assessment takes place and that a health plan is drawn up and implemented.

24. The local authority should inform, among others, the relevant responsible CCG in writing of its intention to place a child in its area and advise whether the placement is intended to be long or short-term. Some placements need to be arranged urgently and prior notification will not always be possible. In these cases, in accordance with Regulation 13(3)(f) of the *Care Planning, Placement and Case Review (England) Regulations 2010*, the local authority is expected to notify the relevant responsible CCG within five working days or as soon as reasonably practicable.

25. Out of authority placements of looked-after children are dealt with in a different way. Where a CCG or a local authority, or both where they are acting together, arrange accommodation for a looked-after child in the area of another CCG, the "originating CCG" remains the responsible CCG for the services that CCGs have responsibility for commissioning. That is the case even where the child changes his or her GP practice.

[12] See the Royal Colleges' intercollegiate framework, *Looked-after children: knowledge, skills and competences of health care staff.*

[13] The sections of that guidance of particular relevance to looked-after children are paragraphs 29-31 and paragraphs 71-75.

26. The originating CCG is responsible for commissioning the child's statutory health assessment(s).

27. Arrangements for primary healthcare are determined by GP registration.

28. CCGs and NHS England should ensure that a child is never refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.

The role of the designated doctor and nurse

29. Designated doctors and nurses have a very important role in promoting the health and welfare of looked-after children. The role is:

- to assist CCGs and other commissioners of health services in fulfilling their responsibilities to improve the health of looked-after children
- intended to be strategic, separate from any responsibilities for individual looked-after children (although the professionals in these posts may also provide a direct service to children outside their designated role).

30. Any job description should be jointly agreed by the CCG as commissioner of the local service for looked-after children, the health organisation from which the designated doctor or nurse is employed, if different, and the relevant local authority. Model job descriptions and person specifications can be found in the *Royal Colleges' intercollegiate framework*.

31. In line with *Working Together to Safeguard Children* and NHS England's *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework*, CCGs should have appropriate systems in place for discharging their responsibilities for safeguarding. That includes securing the expertise of designated doctors and nurses for looked-after children. There is unlikely to be a single model, and local CCGs should consider the range of duties for any post, whilst ensuring that the workload is realistic.

Planning and providing services to promote the health of individual looked-after children

The care planning framework

32. As an integral part of care planning, social workers must make arrangements to ensure that every looked-after child has:

- their physical, emotional and mental health needs assessed
- a health plan describing how those identified needs will be addressed to improve health outcomes
- their health plan reviewed in line with care planning requirements, or at other times if the child's health needs change.

33. This must be done in accordance with *The Care Planning, Placement and Case Review (England) Regulations 2010.*

Notification of placement

34. When a child starts to be looked after or changes placement, the local authority must, before the placement is made, notify the child's GP, parents (except where clearly inappropriate) and those caring for the child. When a child starts to be looked after, changes placement or ceases to be looked after, the local authority must also notify in writing:

- the CCG for the area in which the child is living
- the CCG and the local authority for the area in which the child is to be/ has been placed.[14]

35. Prompt notification by local authorities and appropriate information sharing will enable CCGs to fulfil their duties and meet timescales for health assessments.

36. If placements are made in an emergency, written notification must be provided within five working days of the start of the placement unless not reasonably practicable to do so.

Information sharing

37. Local authorities, CCGs and NHS England as well as providers of services should ensure that there are effective arrangements in place to share information about a child's health. These arrangements should balance the need to know with the sensitive and

[14] The person to notify in the CCG could be the designated nurse, who should in turn inform the named professional and the local looked-after children health team.

confidential nature of some information. Fear about sharing information should not get in the way of promoting the health of looked-after children.[15]

38. The lead health record for a looked-after child should be the GP-held record. The initial health assessment and health plan, and subsequent review assessments and plans, should be part of that record.

39. Information on the principles of confidentiality and consent is at Annex C.

Health assessments, plans and reviews

Health assessments and plans

40. 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.

41. 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.[16]

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

- the child's state of health, including physical, emotional and mental health
- the child's health history including, as far as practicable, his or her family's health history
- the effect of the child's health history on his or her development
- existing arrangements for the child's health and dental care appropriate to their needs, which must include
    - routine checks of the child's general state of health, including dental health
    - treatment and monitoring for identified health (including physical, emotional and mental health) or dental care needs
    - preventive measures such as vaccination and immunisation[17]
    - screening for defects of vision or hearing

[15] NHS organisations and local authorities should have in place information sharing protocols that reflect the HMG guidance *Information sharing: guidance for practitioners and managers*. The Health and Social Care Information Centre brings together helpful resources and guidance on information governance.

[16] Regulation 33(1) of the Care Planning, Placement and Case Review (England) Regulations 2010.

[17] Gov.uk: Comprehensive information on immunisation, including the current routine childhood vaccination schedule; and an algorithm that is helpful where either children born overseas arrive in the UK and need further immunisation, or UK-born children have missed some or all of their routine immunisations.

    - advice and guidance on promoting health and effective personal care
- any planned changes to the arrangements
- 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.

43. CCGs, NHS England and NHS service providers have a duty to comply with requests from local authorities in support of ther statutory requirements.[18] Where a looked-after child is placed out of area, the receiving CCG is expected to cooperate with requests to undertake health assessments on behalf of the originating CCG. For guidance on who pays for assessments, see the section in this guidance on the responsible commissioner.

The principles of a good health assessment and planning

44. Health assessments should:

- not be an isolated event but, rather, be part of the dynamic and continuous cycle of care planning (assessment, planning, intervention and review) and build on information already known from health professionals, parents and previous carers, and the child himself or herself. That includes routine health checks received through the universal healthy child programme 0-5 years and 5-19[19]
- focus on emotional and mental well-being as well as physical health
- inform other aspects of care planning, such as the impact of a child's physical, emotional and mental health on his or her education
- be undertaken with the child's informed consent, if he or she is 'competent' to give it[20]
- be child-centred and age-appropriate (further information about the content of age-appropriate assessments is at Annex A) and carried out with sensitivity to the child's wishes and feelings and fears, so that the child feels comfortable. Health assessments, including reviews, should also be carried out as far as possible at a time and venue convenient to the child, their carers and parents. They should take account of any particular needs, including attention to issues of disability, race, culture and gender and if they are unaccompanied asylum seekers.[21]
- give the child clear expectations about any further consultations, support or treatment needed. Explanations should include the reasons for this and the

[18] Section 27 of the Children Act 1989.

[19] The outcomes of these checks are normally notified to parents. For looked-after children they should be notified to the main carer and the child's social worker. For children accommodated under section 20 of the Children Act 1989 the child's parents should also be notified by the child's social worker.

[20] NSPCC factsheet on Gillick competency and Fraser Guidelines. For further information on consent, see Annex C.

[21] Expert paper: The health needs of unaccompanied asylum seeking children and young people.

choices available, and the appropriateness of plans kept under review as necessary
- pay particular attention to health conditions that may be more prevalent in looked-after children (such as foetal alcohol syndrome or attachment difficulties) and which may otherwise have been misdiagnosed.

45. To ensure the child's health plan is of high quality, the health assessment should use relevant information drawn together beforehand and fast-tracked by all involved to the health professional undertaking the assessment. This will include information in the GP-held record[22] and also, if not in that, the additional information held:

- by children's social services and derived from an assessment undertaken in accordance with *Working Together to Safeguard Children*. This includes the child's personal and family history if known
- by community dental services and family dentists
- on the Child Health Information System (CHIS), especially immunisation status to date
- on any parent-held or child-held record, or school health record
- within any database in local hospital emergency departments or within other local hospital record systemns, especially where the child is known to have been in contact with services
- on any contact with child and adolescent mental health services (CAMHS)
- on any contact with a Youth Offending Team (YOT) where appropriate.

46. The health assessment should:

- be integrated with any other assessments and plans such as the child's Core Assessment or an Education, Health and Care Plan where the child has special educational needs
- involve birth families as far as possible, so that an accurate picture of the child's physical, emotional and mental health can be built up
- involve a named health professional to coordinate the health assessment and the actions set out in the health plan developed from that assessment.

47. Local authorities should ensure that, as a minimum, the child's main carer completes the carer's two-page version of the SDQ for the child in time to inform his or her health assessment. Further information about the requirement to use the SDQ can be found at Annex B.

48. The health practitioner carrying out the assessment has a duty of clinical care to the child. That includes making the necessary referrals for investigation and treatment of conditions identified at the assessment. Even if the placement is brief, the practitioner

[22] In the case of GP-held records, a summary report should be requested from the GP holding them. Steps should be taken to fast-track the records to any GP with whom the child is known to have subsequently become registered.

should follow up concerns and if the child returns home, every effort should be made to continue to implement the health plan.

Who should carry out the health assessment?

49. It is the responsibility of the local authority that looks after a child to arrange their health assessment in partnership with health professionals. The responsible CCG and, if different, the CCG in the area where the child is placed should reach agreement without delay as to which CCG's service will carry out the health assessment.

50. Factors that should determine any decision about which CCG's commissioned service undertakes the health assessment are:

- the distance at which the child is placed. If a child is placed far from home, the responsible CCG should consider if it is more practicable, and will lead to the child receiving a better healthcare experience, to commission health professionals in the area of the receiving CCG
- the need to ensure they are satisfied with the quality of health assessment and follow-up to the actions that are identified
- knowledge about the availability of local services that can meet the child's needs.

51. The Department of Health, with NHS England, Monitor, the Royal Colleges and other partners, has developed a mandatory national currency and tariff for statutory health assessments for looked-after children placed out of area. Details are set out in the current National Tariff Payment System.[23]

Reviews of the health plan

52. The local authority that looks after the child must make arrangements for a registered medical practitioner or a registered nurse or registered midwife to review a looked-after child's health needs and provide a written report for each review addressing the matters specified in section 1 of Schedule 1 of the Care Planning, Placement and Case Review (England) Regulations 2010 (see pages 16-17 of this guidance).[24]

53. The review of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months after the child's fifth birthday. The child's social worker and IRO have a role to play in monitoring the implementation of the health plan, as part of the child's wider care plan.

54. The local authority that looks after a child must take all reasonable steps to ensure that the child receives the health care services he or she requires as set out in their health plan. Those services include mental health services, medical and dental care

[23] National Tariff Payment System 2014/15 (see sections 4.4.4 and 5.6.5 of the main document, along with the checklist tool at pp95-97 of Annex 4A).

[24] Regulation 7 of the Care Planning, Placement and Case Review (England) Regulations 2010.

treatment and immunisations, as well as advice and guidance on personal health care and health promotion issues.

Mental health services

55. Child and adolescent mental health services (CAMHS) play a crucial role in assessing and meeting any needs identified as part of the SDQ screening process.

56. CCGs, local authorities and NHS England should ensure that CAMHS and other services provide targeted and dedicated support to looked-after children according to need. This could include a dedicated team or seconding a CAMHS professional into a looked-after children multi-agency team. Professionals need to work together with the child to assess and meet their mental health needs in a tailored way.

Special educational needs (SEN)

57. Two-thirds of looked-after children have special educational needs (SEN)[25]. Of those, a significant proportion will have a statement or a learning difficulties assessment. From 1 September 2014 statements were replaced by Education, Health and Care (EHC) plans, with the transition process to be complete by 2016.

58. To support children and young people with SEN or disabilities, including those who are looked after or leaving care, local authorities and CCGs must commission services jointly. This SEN provision applies to children and young people from birth to age 25.

59. Local authorities are also placed under a duty to publish a Local Offer, which sets out in one place all information about provision across education, health and social care, for children and young people with SEN or disabilities. Local authorities which place looked-after children in another authority need to be aware of that authority's Local Offer if the child has SEN or disabilities.

60. Local authorities and health professionals should ensure that:

- they follow the requirements set out in the *Special educational needs and disability code of practice: 0 to 25 years*[26]
- the looked-after child's EHC plan works in harmony with their care plan to tell a coherent and comprehensive story about how the child's health needs in relation to accessing education are being met. Health and education professionals should consider how to co-ordinate assessments and reviews of the child's care plan and EHC plan to ensure that, taken together, they meet the child's needs without duplicating information unnecessarily.

[25] *Outcomes of children looked after by local authorities in England as at 31 March 2014* (page 11).
[26] Information about looked-after children who have SEN is included in chapter 10.

61. Further information can be found in the Code itself and in the *Guide for health professionals on the support system for children and young people with special educational needs and disabilities*.

The role of social workers in promoting health

62. Social workers have an important role in promoting the health and welfare of looked-after children. In particular they should:

- work in partnertship with carers, looked-after children, their birth parents where appropriate and health professionals to contribute to the formulation of the health plan
- ensure that all the necessary consents and delegated authority permissions have been obtained so that decisions are not delayed
- take action to liaise with relevant health professionals if actions identified in the health plan are not being followed up. Given the impact that poor physical, emotional and mental health can have on learning, they should also ensure the child's virtual school head is involved in resolving any health care needs that impact on the child's education
- ensure the child has a copy of the care plan and the health plan
- support foster carers, or the appropriate person in the children's home where a child is placed, to promote the child's physical and emotional health on a day-to-day basis. That should include providing them with information on the child's state of health, including a copy of the child's latest health plan[27]
- ensure that there is clarity for carers, GPs and dentists, and for the child, about what health care decisions have been delegated to carers.

63. Social workers and health professionals should give carers information on how to contact designated and named health professionals for looked-after children and the looked-after children team, and on how to access services, including CAMHS consultations, that the child needs. Supervising social workers should also support and give information to carers about managing their own health.

64. Social workers and carers require regular training to understand their roles in identifying and responding to the emotional and mental health needs of looked-after children.

65. Social workers should also ensure:

- that foster carers and residential care staff know it is their responsibility to make sure a child attends their health assessment and all other medical, dental and optical appointments, and facilitate any required treatment regimes

[27] Where the child is 'competent' in line with Fraser Guidelines, their consent should be obtained. NSPCC factsheet on Gillick competency and Fraser Guidelines. For further information on consent, see annex C.

- that the children their authority looks after, including teenage parents, have access to available positive activities such as arts, sport and culture, in order to promote their sense of well-being.

66. Social workers and other local authority professionals should ensure that information about any health needs or behaviours which could pose a risk of harm to the child, the carer or members of his or her family or household is passed to the carer (or residential care worker) at the time of the placement. At the same time, the carer should receive information about the support that will be available to the child and carer to address or manage these difficulties.

The roles of Virtual School Heads (VSHs) and designated teachers

67. Every local authority in England is required to appoint an officer (called a Virtual School Head) to discharge the local authority's duty to promote the educational achievement of the children it looks after, regardless of where they are placed. Maintained schools and academies are required to have a designated teacher for looked-after children. Given the interrelationship between health and education outcomes, social workers should ensure that the authority's VSH and the designated teacher for looked-after children are aware of information about the child's physical, emotional or mental health that may have an impact on his or her learning and educational progress.

The role of Independent Reviewing Officers (IROs)

68. The IRO should, as part of the child's case review, note any actions and updates to ensure that the health plan continues to meet the child's needs. The IRO should be proactive in bringing any deficiencies in the quality of the health plan or its delivery to the attention of the appropriate level of management within the local authority, using the local dispute resolution process if necessary. The local authority should, in turn, discuss any concerns with the designated nurse, so that outstanding issues are addressed without unnecessary delay. IROs should always ensure that looked-after children are involved in the review of their care plan and its component parts, and have their wishes and feelings heard and respected. Further information relating to the statutory requirements of the IRO's role can be found in the *Independent reviewing officers' handbook*.

The contribution of primary care teams

69. Primary care teams have a vital role in identifying the individual health care needs of looked-after children. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions. They may also have continuing responsibility for the child when he or she returns home.

70. From 1 April 2015, all patients (including children) should have a named GP at the practice with which they are registered, who is responsible for the coordination of services provided under the GP contract.

71. GP practices should:

- ensure timely access to a GP or other appropriate health professional when a looked-after child requires a consultation
- provide summaries of the health history of a child who is looked after, including information on immunisations and covering their family history where relevant and appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments
- maintain a record of the health assessment and contribute to any necessary action within the health plan
- make sure the GP-held clinical record for a looked-after child is maintained and updated and that health records are transferred quickly if the child registers with a new GP practice, such as when he or she moves into another CCG area, leaves care or is adopted.

72. Treating a patient as a temporary resident should be avoided if possible, as the medical record is not available to the treating medical practitioner. If it cannot be avoided, the treating practitioner will normally wish to talk to the child's named GP to avoid treating the patient "blind". Temporary registration is for those who intend to be in an area for more than 24 hours but less than three months, and where there is any doubt over the potential length of stay the GP practice should opt for full registration.

Health professionals and the role of named health professionals for looked-after children

73. All healthcare staff who come into contact with looked-after children should work within the Royal Colleges' intercollegiate framework. This framework identifies the competences that enable healthcare staff to promote the health and well-being of looked-after children. They are a combination of the skills, knowledge, values and attitudes that are required for safe and effective practice.

74. All staff should have access to appropriate continuing professional development opportunities, clinical supervision and support to facilitate their understanding of the clinical aspects of child welfare and information sharing in relation to looked-after children.

75. Named nurses and doctors for looked-after children have an important role in promoting good professional practice within their organisation and providing advice and expertise for fellow professionals. The named health professional will work in (and usually be employed by) a health provider organisation. He or she will act as a principal

health contact for children's social care and should have up-to-date specialist knowledge of the health needs of looked-after children or know how to access it.[28]

76. Working with the designated professionals for looked-after children, named health professionals should:

- coordinate the provision of local health services for individual looked-after children and the input into health assessments and their reviews for individual looked-after children
- ensure the timeliness and quality of health assessments for looked-after children and ensure actions taken to implement the health care plan are tracked
- act as a key conduit and contact point for the child and their carer, where they have difficulties accessing health services.

Placement out of authority

77. Social workers must notify the relevant CCG, in accordance with Regulations, when a child is placed out of authority.[29] They should ensure that arrangements are made to secure health provision for the child.

78. In making a judgement about the suitability of an out of authority placement for a child, the responsible authority should assess, with input from health services, the arrangements which it will need to put in place to enable the child to access services such as primary and secondary health care.

79. Where the child will require specialist health services such as child and adolescent mental health services (CAMHS), the CCG (or local health board in Wales) that commissions secondary healthcare in the area authority should be consulted, so that the responsible authority can establish whether the placement is appropriate and able to meet the child's needs. The designated nurse and doctor for looked-after children in the area authority will also be a valuable source of advice and information.

80. When a looked-after child or child leaving care is moved out of a CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing healthcare and new providers to ensure continuity of healthcare. CCGs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care. The needs of the child should be the first consideration.

81. *The Care Planning, Placement and Case Review (England) Regulations 2010* require local authorities making distant placements to consult with children's services in the area of placement. They also require the Director of Children's Services of the

[28] A model job description and person specifications for specialist looked-after children health professionals can be found in the Royal Colleges' intercollegiate framework.
[29] Regulation 13, The Care Planning, Placement and Case Review (England) Regulations 2010.[30] The following must also be consulted: the child's IRO, the child's relatives and parents where appropriate, the CCG (or local health board in Wales) that commissions secondary health care if the child requires secondary health services, and the Virtual School Head.

responsible authority to approve these placements.[30] The process for making distant placements and who should be consulted is described in *Statutory guidance on out of authority placements of looked-after children.*

Supporting foster carers and children's homes to promote health

82. Fostering service and children's homes providers should work respectively with foster carers and residential care staff to promote a child's health and well-being. Carers should be given information about the child's health needs as they have day-to-day responsibility for making sure those needs are met.

83. Standard 12 of the National Minimum Standards for fostering services and the Fostering Services Regulations 2002 must be adhered to at all times.

84. The Children's Homes Regulations 2015 set out the Quality Standards that must be met by children's homes providers. They describe the outcomes that children must be supported to achieve. One of the Quality Standards is about health and well-being.

85. Where a local authority commissions a children's home or, via the home, a practitioner or non-NHS service to deliver care to meet a specific health or developmental outcome outlined in the child's care plan, they should be confident that the professional care provided will meet the assessed health needs of the individual child. The local authority must give agreement for such care and be involved in its ongoing review.

86. The local authority, as a corporate parent, the child's social worker and health professionals should work with children's home staff to secure and facilitate access to the health services that each child needs. In particular, social workers and other relevant officers in the authority responsible for a looked-after child should ensure the necessary health outcomes are clear in the child's relevant plan and then work with the home to:

- agree the specific responsibilities of the home towards supporting the health needs of each child at the time the placement is made
- ensure that these responsibilities are recorded in the child's placement plan. This must include recording permission from a person with parental responsibility for the child for staff to administer first aid and non-prescription medication, and clearly agreed responsibilities for the administration of prescription medication
- be confident that staff in the home have sufficient understanding of relevant local health provision, including the functions of the designated doctor and nurse for looked-after children in their area, and can support children to navigate these services, advocating on their behalf where necessary and appropriate.

[30] The following must also be consulted: the child's IRO, the child's relatives and parents where appropriate, the CCG (or local health board in Wales) that commissions secondary health care if the child requires secondary health services, and the Virtual School Head.

Children detained under the Mental Health Act or in custody

87. The legal status of children who are the subject of a care order is not affected by detention under the Mental Health Act or in custody. The responsibility of the local authority to promote the welfare of looked-after children who are so detained remains. That includes its responsibilities to maintain and review the child's health plan as part of his or her care plan.[31]

88. Every effort should be be made, working in partnership with CCGs, NHS England and the institutions in which the children are detained, to ensure these children's health needs are identified and met, wherever they are living. To support the assessment process, the National Child and Maternal Health Intelligence Network (which is part of Public Health England) has developed a standardised and validated Comprehensive Health Assessment Tool (CHAT) for young people in the youth justice system.

Transitions from care

89. Some children who cease to be looked after – whether returning home, adopted or with a Special Guardianship Order or making the transition to adulthood – will have continuing health needs that require ongoing treatment. Health professionals and social workers should ensure that there are suitable transition arrangements in place so that the child's health needs continue to be met. In particular, they should ensure that prospective adopters and care leavers have, or know how to obtain, the information they require about what health services, advice and support are available locally to meet their needs.

Children placed for adoption

90. Children placed for adoption remain looked after until the adoption order is made. Research shows that their needs do not change overnight once they are adopted. Local authorities should ensure there is consistent and sustained health care in place to support each child during the transition from care to a permanent home. This will help inform post-adoption support for the child and the child's new parents and enable continuity of services.

91. At a strategic level:

- local authorities should have robust arrangements in place for the commissioning of timely health assessments so that prospective adopters have the information they need to support the child placed with them

[31] Children remanded to youth detention accommodation under section 104(1) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 become looked-after children. The requirements in the Care Planning, Placement and Case Review (England) Regulations 2010 for them to have a health assessment and plan are disapplied.

- local authorities and CCGs should cooperate to make sure adoption agencies and panels secure access to timely medical advice and comprehensive information about a child's health so as to avoid unnecessary delays
- local authorities and health service providers should work together to ensure that information in health records is not lost once the child ceases to be looked after.

92. At an operational level, at an early stage where adoption is the planned permanence option for a looked-after child, social workers should:

- comply with the requirements for health assessments and reviews set out in the Adoption Agencies Regulations 2005
- build on the health assessments and information already included in the child's health plan.
- request adoption medicals that include the requirements for any further medical reports necessary for the purposes of placement order proceedings, for example, in relation to any on-going mental health needs and therapeutic services that need consideration to support bonding and attachment with the child's prospective new parents.

93. The local authority should be ready to file the medical (and other) reports required under Rule 29 of the Family Procedure (Adoption) Rules 2005 and Annex B of the Practice Direction which supplements Rule 29(3).

Care leavers

94. Local authorities, CCGs and NHS England should ensure that there are effective plans in place to enable looked-after children aged 16 or 17 to make a smooth transition to adulthood, and that they are able to continue to obtain the health advice and services they need. In particular:

- there should be an emphasis on partnership working between the young person and their personal adviser, and the doctors and nurses involved in their health assessments[32]
- personal advisers should have access to information and training about how to promote physical and mental health
- transitions should be planned as early as possible, and certainly at least six months in advance of a transition to adult services, so that social workers, personal advisers, commissioners and providers of children's and adult services can manage transitions smoothly and ensure that young people are clear about expectations.

95. Care leavers should be equipped to manage their own health needs wherever possible. They should have a summary of all health records (including genetic

[32] From their 16th birthday, the authority responsible for looking after the child must appoint a personal adviser for eligible children to work with them and prepare a pathway plan.

background and details of illness and treatments), which suggests how they can access a full copy if required. Information needs to be given to care leavers sensitively and with support, with an opportunity to discuss it with health professionals. Young people leaving care should be able to continue to obtain health advice and services, and know how to do so.

96. Personal advisers should work closely with looked-after children's health teams involved in health assessments. Leaving care services should ensure that health and access to positive activities are included as part of the young person's pathway planning. They should also ensure that care leavers have the information they need to be able to manage their health when living independently.

97. Care leavers with complex needs, including those with disabilities, may transfer direct to adult services and the pathway plan will need to ensure that this transition is seamless and supported. For care leavers who do not meet the criteria for support by adult services, their personal adviser should ensure that all possible forms of support, including that offered by the voluntary sector, are identified and facilitated as appropriate.

Annex A: Age-appropriate health assessments

Recommended content

The content of the health assessment should be age-sensitive and developmentally appropriate. The recommended content for the different stages of childhood is outlined below. There may be other aspects of health care that are also relevant. This will depend on the individual child. Practitioners should not, therefore, confine themselves to assessing only the areas identified below if there are other matters that are relevant.

Under-5s

For under-fives, the focus will be on:

- attachment behaviour and emotional health
- physical health
- growth
- diet and nutrition
- screening and immunisations
- dental health
- considering the impact on the child of parental substance misuse
- monitoring developmental milestones, in particular the development of speech and language, gross and fine motor function, vision and hearing, play and pre-literacy skills, social skills.

Ages 5-10

For primary school age children, the focus will be on:

- physical health and management of specific health conditions eg asthma
- communication skills
- ability to make relationships and to relate to peers
- mental and emotional health, including depression and conduct disorders
- progress at school
- exercise and diet and understanding of a healthy lifestyle
- maintenance of personal hygiene
- awareness of basic safety issues, including road safety
- provision of a healthy balanced diet
- ability to recognise and cope with the physical and emotional changes associated with puberty
- access to accurate simple information about sexual activity
- considering the impact on the child of parental substance misuse
- screening and immunisation

- dental health
- attachment behaviour
- social and self-help skills
- assessment of the risks of child sexual exploitation, antisocial or youth offending behaviour, bullying, domestic abuse or sexually harmful behaviour.

Adolescents and those leaving care (11-18)

For secondary school age children, the focus will be on:

- ability to take appropriate responsibility for their own health, including the management of specific health conditions, e.g. asthma, diabetes
- communication and interpersonal skills
- educational and social progress
- lifestyle, including diet and physical activity
- ensuring that immunisations are up to date
- dental and skin health
- mental and emotional health, including depression and conduct disorders
- understanding of issues relating to healthy relationships, including sexuality and sexual activity, contraception, sexually transmitted infection and the particular risks of early sexual activity
- access to sources of information and advice about a range of health issues, including the risks of alcohol, tobacco and other substance use, and access to sources of advice on modifying health risk behaviours. Assessment should be made of whether referral to specialist treatment for substance misuse is appropriate
- assessment of the risks of child sexual exploitation, antisocial or youth offending behaviour, bullying, domestic abuse or sexually harmful behaviour.

Annex B: Strengths and Difficulties Questionnaire (SDQ)

It is important to have some means of measuring on a regular basis the emotional and behavioural difficulties experienced by looked-after children at a national level. The way in which that is currently done is through the Strengths and Difficulties Questionnaire (SDQ). This was introduced into the Department for Education's data collection for children looked after at 31 March in 2008 and is the outcome measure used for tracking the emotional and behavioural difficulties of looked-after children at a national level.

The SDQ is a clinically validated brief behavioural screening questionnaire for use with 4-17 year olds or 2-4 year olds. It is internationally validated and simple to administer. It exists in three versions: for parents or carers, teachers and children aged 4-17, and can be used to screen for any problems related to a child's emotional well-being. The SDQ comprises a series of statements that require a jugement on how well it describes the child by ticking one or three or four boxes for each question.[33]

The SDQ provides information to help social workers form a view about the emotional well-being of individual looked-after children.

For the purpose of the Department for Education's SSDA903 data collection, the requirement is that local authorities must ensure that the looked-after child's main carer (a foster carer or residential care worker) completes the two-page questionnaire for parents and carers. This is a simple questionnaire that does not require any training to interpret and can be completed in between five and ten minutes.

If the SDQ completed by the carer suggests that the child's total difficulties score is outside the normal range (i.e. a borderline score of 14-16 or a score of 17+, considered as giving cause for concern), the child may benefit from triangulating the scores from the carer's SDQ with those of his or her teacher and (if he or she is aged 4 to 17) the self-evaluation. Social workers and Virtual School Heads should consider arranging for this to be done in order to provide more comprehensive information for the health assessment. If triangulation of those scores confirms the carer's score, consideration should be given to using a diagnostic tool to enable an appropriate intervention to be identified.

Other validated screening tools may be used in addition to the SDQ.

The questionnaire can be completed at any point during the year, but to reduce the administration required it is recommended that it is completed around the time of a child's health assessment. Local authorities, usually through the child's social worker, should ensure that:

- SDQ questionnaires are given to carers to complete. This should be done well ahead of the child's health assessment so that the completed SDQ informs the health assessment. Ideally, it should be completed one month before the health

[33] Further information on the SDQ.

check is due. For those young people who have recently come into care, the carer will need to establish a relationship with the child before they are in a position to carry out the assessment. If the child has recently moved to a new placement, social workers will need to judge if the child's previous carer is better placed to complete the questionnaire

- carers are given an explanation of how it should be completed and that they understand why it is important to complete the SDQ (and that it is about the child and not a reflection on their ability to care for him or her). Carers should know to whom the completed SDQ should be returned and by when
- information in the completed questionnaires is collected by the local authority and the child's total difficulties score is worked out and available to inform the child's health assessment. This should help the social worker and health professionals to decide whether to triangulate the scores with an SDQ completed by the child's teacher and (if the child is in the relevant age bracket) the child, and whether the child needs to be referred for further diagnostic assessment of their mental health
- if the child's SDQ scores suggest there are underlying problems, this should trigger consideration of a fuller diagnostic assessment. The SDQ should be used as evidence to support a referral to local targeted or specialist mental health services, where appropriate.

When decisions about placement choices are being made and where changes of placement occur, social workers, working in partnership with health professionals, should consider referral for specialist mental health assessment and treatment where it is appropriate. The SDQ should help inform these decisions. Professionals should ensure this information is shared securely and appropriately where changes of placements, including from care to adoption, occur.

The data return for the Department for Education relates only to the part completed by the carer.[34]

[34] Further information on the SSD903 Data Collection.

Annex C: Principles of confidentiality and consent

NHS organisations and local authorities should have in place protocols which establish the framework for information sharing at an intra- and inter-agency level. These should reflect the *HM Government guidance on information sharing*.

Children who become looked after may not return to their birth families but will become permanently part of new foster or adoptive families, or may move into independence without retaining links with birth families. The transfer of information about a child's health status and history becomes very important. Accurate information about health history, and any current/ongoing medical conditions, may be vital to securing the right placement for a looked-after child.

For this reason, obtaining consent to information sharing is a vital first principle to promoting the health of looked-after children. The person or third party will need to understand the reasons why particular information needs to be shared, so that they can give **informed** consent.

Where disclosure of a child's information might reveal information about other individuals (e.g. parents, family), consent should be sought from these individuals as well. Where it is not practicable to seek consent or where the individual is not competent to give consent, it is important to consider whether disclosure would be justified in the 'public interest' (e.g. to protect others from a risk so serious that it outweighs the individual's right to privacy). Decisions to disclose information in the public interest must be taken on a case by case basis, and should always be fully documented.

In obtaining consent to seek information from other parties or to disclose information about the child, a key consideration will be determining whether the child is competent to give consent or whether consent should be sought from a person with parental responsibility.

The same issues arise in relation to consent to information sharing as in consent to treatment, namely:

'Young people aged 16 or 17 are regarded as adults for the purposes of consent to treatment and are therefore entitled to the same duty of confidence as adults. Children under 16 who have the capacity and understanding to take decisions about their own treatment are entitled also to decide whether personal information may be passed on and generally to have their confidentiality respected… In other instances, decisions to pass on personal information may be taken by a person with parental responsibility in consultation with the health professionals involved.'

Children aged 16 and 17

Once young people reach the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care. This means that in many respects they should be treated as adults – for example if a signature on a consent form is necessary, they can sign for themselves.

However, it is still good practice to encourage competent children to involve their families in decision making. Where a competent child does ask for their confidence to be kept, it must be respected unless disclosure can be justified on the grounds of 'public interest' e.g. that there is reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm.

Efforts should be made to persuade the child to involve their family, unless it is believed that it is not in their best interest to do so. If a decision is taken to disclose, the justification should be noted in the child's records.

Children aged 15 and under

Unlike 16 or 17 year olds, children under 16 are not automatically presumed to be legally competent to make decisions about their healthcare. However, the courts have stated that under 16s will be competent to give valid consent to a particular intervention if they have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (sometimes known as "Gillick competence"). In other words, there is no specific age when a child becomes competent to consent to treatment: it depends both on the child and on the seriousness and complexity of the treatment being proposed.[35]

'Competence' is not a simple attribute that a child either possesses or does not possess: much will depend on their relationship and trust between doctors, other health professionals and the child and their family or carer. Children can be helped to develop competence by being involved from an early age in decisions about their care.

If a child under 16 is competent to consent for himself or herself to a particular intervention, it is still good practice to involve the family in decision making, unless the child specifically requests that this should not happen and cannot be persuaded otherwise. As with older children, a request for confidentiality must be respected unless the child is suffering or likely to suffer significant harm without disclosure.

[35] Gillick competency and Fraser Guidelines.

Annex D: Some terms used in this guidance

Designated professional: CCGs are required to have access to the expertise of a designated doctor and nurse for looked-after children, whose role is to assist commissioners in fulfilling their responsibilities to improve the health of looked-after children. The Royal Colleges' intercollegiate framework includes model job descriptions.

Designated teacher: all maintained schools and academies are required to have a designated teacher for looked-after children. Their role is to act as a source of advice and expertise and to champion the needs of looked-after children within the school as well as work with the local authority that looks after the child to ensure his or her personal education plan (PEP) is developed and implemented.

Distant placement: Regulation 11(5) of the Care Planning, Placement and Case Review Regulations (England) 2010 as amended defines a distant placement as meaning 'a placement outside the area of the responsible authority and not within the area of any adjoining local authority'. Distant placements must be approved by the responsible authority's Director of Children's Services (DCS).

Eligible child: a looked-after child who is aged 16 or 17 and has been looked after by a local authority for a period of 13 weeks, or periods of 13 weeks, which began after he or she reached 14 and ended after he or she reached 16.

Former relevant child: a former relevant child is a young person aged 18 or above who either has been a relevant child and would be one if under the age of 18 or who, immediately before he or she stopped being looked after at the age of 18, was an eligible child.

Looked-after child: a child who is looked after by a local authority (referred to as a looked-after child) is defined in section 22 of the Children Act 1989 and means a child who is subject to a care order (or an interim care order) or who is accommodated by a local authority.

Named health professional: providers of health services are expected to identify a named doctor and nurse for looked-after children. As well as coordinating the provision of services for individual children, named professionals provide advice and expertise for fellow professionals. The Royal Colleges' intercollegiate framework includes model job descriptions for this and other specialist health professional roles.

Originating authority (sometimes called the responsible or placing authority): the local authority that looks after the child.

Originating CCG (sometimes called the home or responsible CCG): when a looked-after child is placed out of authority, the originating CCG is the CCG in whose area the child is placed before that move. The originating CCG remains the *responsible commissioner* for CCG-commissioned services.

Placement out of area (sometimes referred to as an out of authority placement): a placement out of the local authority's area is one that is a placement in foster care, a residential children's home or in 'other arrangements' located outside the boundary of the responsible authority. An out of authority placement could be in an adjoining local authority or in a more distant area

Primary care team: typically includes GPs, practice nurses, community nurses, midwives, health visitors, the GP practice manager and support staff

Receiving authority: the local authority area in which the local authority that looks after a child places him or her.

Receiving CCG: in the case of a placement out of authority, the receiving CCG is the CCG to whose area the looked-after child is moved.

Registered medical practitioner: any doctor who treats patients in NHS or private practice must be registered with the General Medical Council and hold a licence to practise.

Relevant child: a child who is not looked after, is aged 16 or 17 and was an eligible child before he or she stopped being looked after.

Virtual School Head (VSH): an officer employed by a local authority in England whose job is to ensure that the authority's duty to promote the educational achievement of the children it looks after is properly discharged.

Further information

Useful resources and external organisations

The following list, though not comprehensive, is intended to highlight some of the main resources that local authorities, CCGs, NHS England and health providers should find useful.

- Attachment Aware Schools project
- British Association for Adoption and Fostering Resources
- Comprehensive Health Assessment Tool (CHAT)
- Inspecting local authority childrern's services: the framework
- Intercollegiate role framework. Looked-after children: Knowledge, skills and competences of health care staff
- National Tariff Payment System
- NSPCC Face to Face service
- Strengths and Difficulties Questionnaires
- NICE pathways: looked-after babies, children and young people: an ovrview
- NICE local government briefings: Looked-after children and young people (June 2014)
- NICE Quality Standard for the health and well-being of looked-after children
- NICE public health guidance 28: Looked-after children and young people
- Research in practice: Fostering and adoption learning resources
- The Children's Food Trust Learning Network website
- The United Nations Convention on the Rights of the Child (UNCRC): Articles 12, 13, 24, 39
- Young Minds
- What works in preventing and treating poor mental health in looked-after children? (August 2014). This is part of NSPCC's Impact and Evidence series co-produced with the Rees Centre, University of Oxford
- Who Pays? Determining responsibility for payments to providers

Other relevant departmental advice and statutory guidance

- Adoption statutory guidance
- Gov.UK: looked-after children's services
- Gov.UK: safeguarding children
- Care Leaver Strategy: a cross departmental strategy for young people leaving care
- Children's Homes Guide and Quality Standards
- Fostering Services (England) Regulations 2011
- Fostering Services: national minimum standards

- Mental health and behaviour in schools: departmental advice
- Out of authority placement of looked-after children – statutory guidance
- Outcomes of looked-after children: statistical first release
- Promoting the education of looked-after children: statutory guidance for local authorities
- Public Health Outcomes Framework
- Special educational needs and disability code of practice: 0 to 25 years
- Safeguarding children and young people from sexual exploitation
- Working Together to Safeguard Children

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Looked After Children Annual Report 2019-20

Date:	July 2020
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Contents

1.0 Introduction

"If we were to truly replicate what a family is for the child who's being Looked After by the state, if the state was truly to provide that, it would give them the best of everything."

Lemn Sissay - Poet and Care Leaver

Sussex is made up of the city of Brighton and Hove and the counties of East and West Sussex. The CCGs serving these areas have a statutory duty to comply with requests from local authorities (LAs) for help to provide support and services to their Looked-After Children. They have a countywide Looked After Children team that comprises of Designated Professionals (Doctors and Nurses), Business Support and placed based and pan-Sussex commissioners. The Chief Nursing Officer holds executive responsibility, supported by the Deputy Director and Head of Safeguarding & Looked After Children, who provide the strategic lead. This report highlights how the CCGs ensure the timely and effective delivery of health services to Looked After Children and contribute to meeting their health needs by commissioning effective services and collaborating with Local Safeguarding Children's Partnerships and key stakeholders.

2.0 Statutory and Legislative Background

Statutory responsibilities are clearly outlined in national legislation and guidance. Alongside this statutory obligation sits compliance with the Care Quality Commission regulatory requirements. There has been no significant update to the two main documents:

- *'Promoting the health and wellbeing of Looked After Children'* published by the Department of Health and Department of Education in March 2015. This guidance is issued to local authorities, CCGs, and NHS England under sections 10 and 11 of the Children Act 2004 and lays out the joint responsibilities for supporting all Looked After Children. This guidance is due to be reviewed in 2020 and should be read in conjunction with:
- *2015 intercollegiate document: Looked After Children, knowledge, skills and competence of healthcare staff.* This document outlines the competency framework, and skills, knowledge, attitudes, values and training for staff. This document is scheduled for an update and consultation has commenced

Other publications informing commissioning and delivery of services for Looked After Children:

- The Children Act 1989 Guidance and Regulations Volume 2- 4: Care Planning, Placement and Case Review, Transition to Adulthood and Fostering Services
- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
- Who Pays? Determining responsibility for payments to providers
- National Tariff Payment System Care Planning, Placement and Case Review (England) Regulations (2010)

3.0 Strategic roles

The roles of the designated nurse and designated doctor are statutory strategic roles, who have specific roles and responsibilities as set out in the Royal Colleges' Intercollegiate Framework Document (ICF). The roles include strategic advice and guidance to assist service planning and to advise clinical commissioning groups in fulfilling their responsibilities. Named Doctors, Nurses and Leads for Looked After Children in provider organisations are also detailed in this document and designates have highlighted deficits leading to a gradual increase in the number and sessions of these key roles. NHS Looked After Children Professionals Meetings and individual supervision by designated professionals have been set up to support them.

Designated Nurses for Looked After Children: Following recommendations of an external review and TIAA audit there has been an increase of 80% in capacity to meet ICF recommendations, from 2.5 Whole Time Equivalents (WTE) Designated Nurses to 4.5. Interviews have taken place and all roles will be filled by July 2020. From 1st April job descriptions will be aligned and all posts will be Sussex-wide.

Designated Doctors for Looked After Children: As part of the significant investment into the team, and in line with the ICF there will also be an increase in Designated Doctor hours, as part of the new operating model. Sessions will be increased to eight PAs pan-Sussex and recruitment will take place in the autumn.

4.0 Update from Previous 18/19 Annual Report

- Alignment of Looked After Children service specification to reduce variation.
- Improvement of reporting across Sussex including alignment of provider reports
- Commencement of Anna Freud emotional wellbeing project
- Increased Designated Nurse capacity commensurate with the intercollegiate framework.
- Increased Designated Doctor provision agreed and recruitment process to start Summer 2020
- Update to Sussex Safeguarding Standards with additions relating to Looked After Children added into contracts from April 2019 and audited in February 2020.
- Improvement to pathways for initial and review health assessments achieved by CCG, health providers and LA working closely together.
- Key developments added to level 3 training delivered by safeguarding and Looked After Children designates, including addition of Adverse Childhood Experiences research and delivery of trauma informed healthcare
- Partnership working with Named Professionals to ensure that key principles relating to adoption and changing the NHS number are followed and that when a child is adopted all health records held by their organisation are managed appropriately.

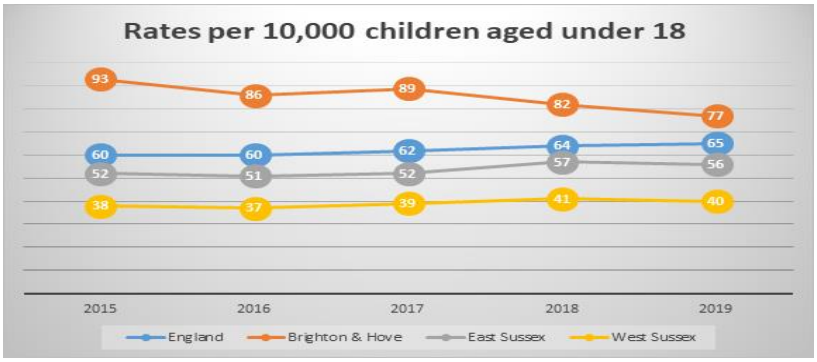
5.0 Pandemic-Covid-19

On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in China. In response to the impending pandemic UK Government published coronavirus action plan on 3rd March 2020 and the CCGs entered Command and Control, with a specific Safeguarding and Looked After Children work stream. Operational planning, the mechanism by which agreements with health care providers are brought into contract, was suspended alongside many business as usual activities. Resources were redirected to support the COVID-19 effort. Chief Executive Letter and Annex dated 17th March 20 set out how providers of community services were to release capacity to support the COVID-19 preparedness and response. Arrangements apply until 31 July 2020. Initial assessments for Looked After Children were identified as priority and to continue. Lockdown measures announced on 23rd March will impact on service delivery as face to face assessments will need to be adjusted to being virtual by telephone and video.

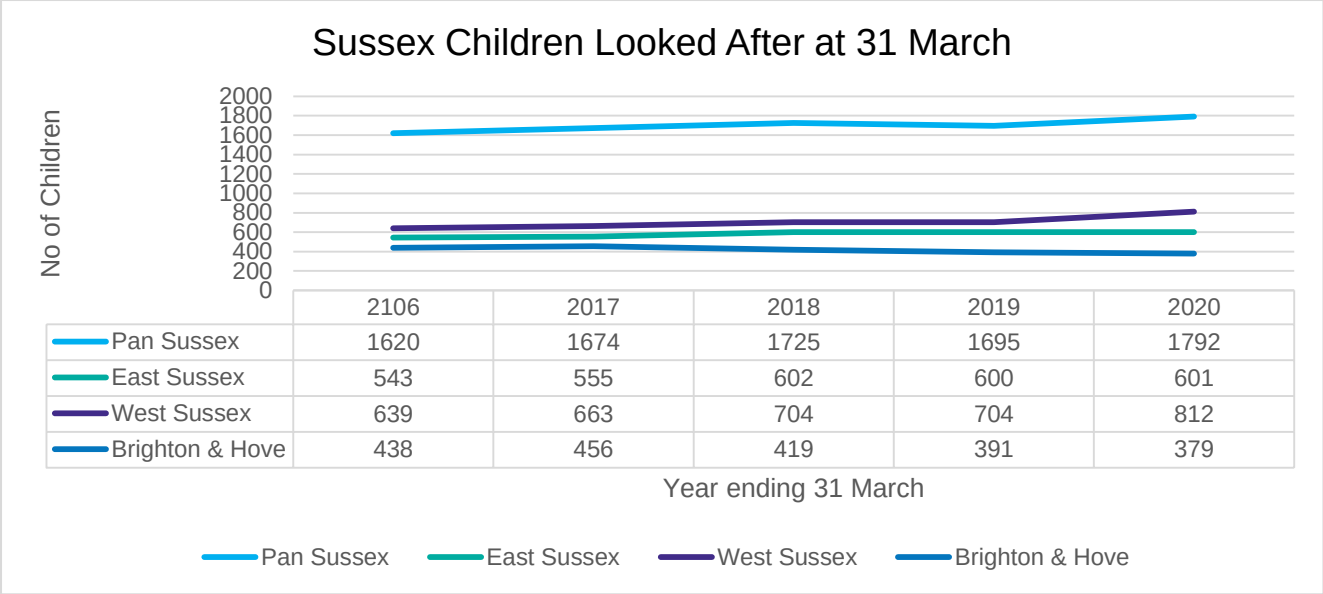
6.0 2019/20 Profile

Nationally the number of Looked After Children continues to rise and adoptions from care continue to fall. At 31 March 2019, the number of Children Looked After by LAs in England increased by 4% since 2018, from 75 420 to 78 150 - continuing increases seen in recent years. Abuse and neglect remain the primary reason for becoming a Looked After child at 63%.

Sussex has a population of over 380,000 children under the age of 19 years, comprising approximately 21% of the population. Rates of Looked After Children are calculated per 10 000 of child population and vary significantly across the three LA areas. The Brighton and Hove rate of 77 is relatively high to England rate of 65 leading to the city accommodating 379 children. In West Sussex the rate is low and if aligned to the national trend would result in a higher looked after children population closer to 1145.

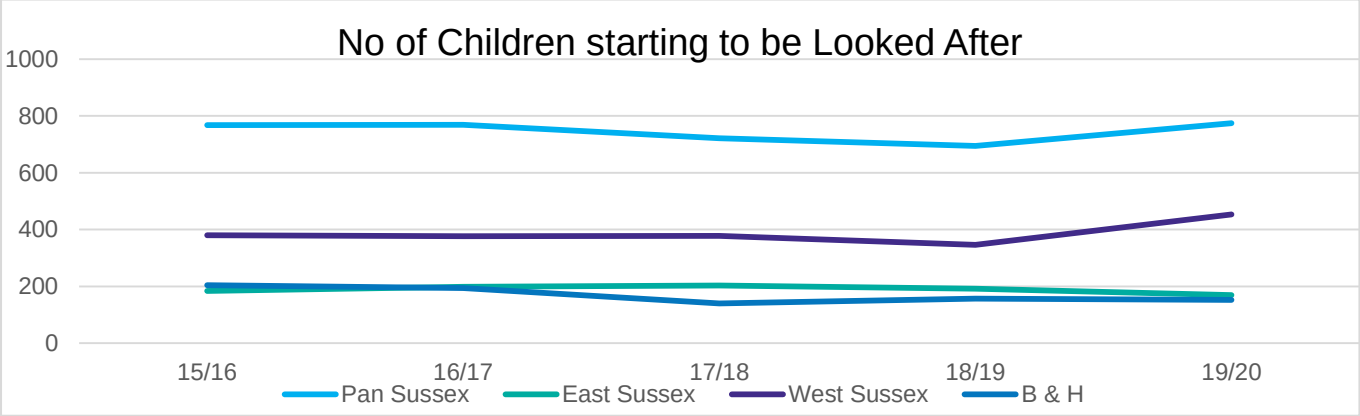


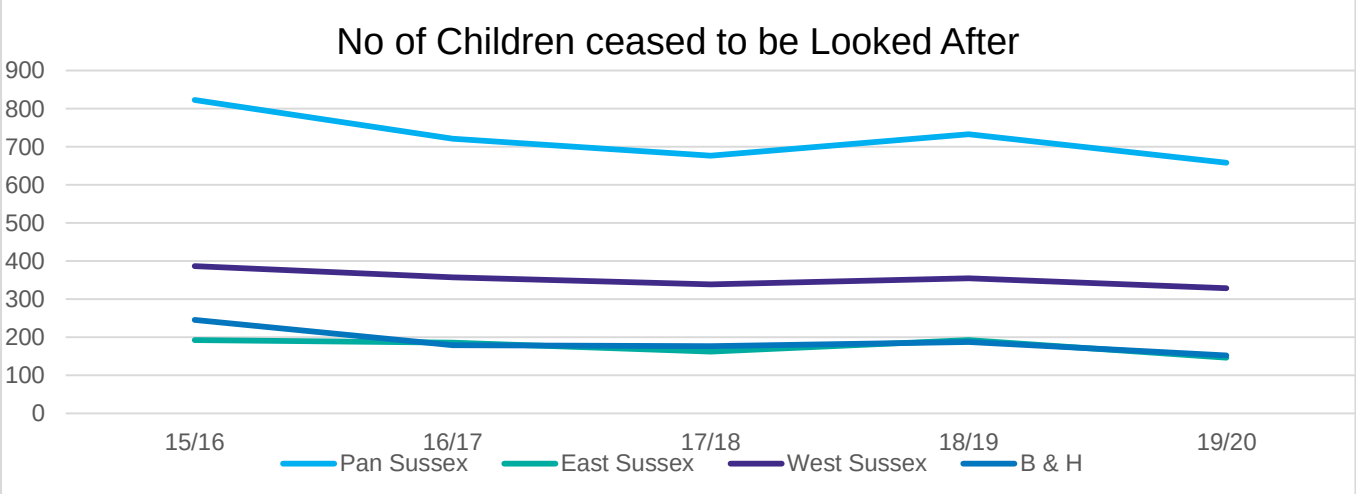
At 31 March 2020, the number of Children increased by 6% since 2019. Whilst East Sussex and Brighton and Hove have not followed the national trend and seen a decrease, the number of Looked After Children overall in Sussex has risen due to a significant increase above the national rate in West Sussex of 16%. This has not been reflected in staff numbers and has resulted in capacity issues due to increased demand.



	2106	2017	2018	2019	2020
Pan Sussex	1620	1674	1725	1695	1792
East Sussex	543	555	602	600	601
West Sussex	639	663	704	704	812
Brighton & Hove	438	456	419	391	379

Numbers of children in care at any one point does not reflect all of the children during the year. Children return home or leave care for reasons such as age or adoption. Therefore, the data only ever gives a snapshot of children moving in and out of the system at a fixed date each month/year, but considerable activity sits beneath it and this is increasing. Children will come in and out of the system within the year, some may come in and stay whilst others can leave quite quickly. The number of children starting to be Looked After in Sussex this year has risen by 11% to 774. The number ceasing has fallen by 10% to 658 and much lower than the high of 823 in 2016.



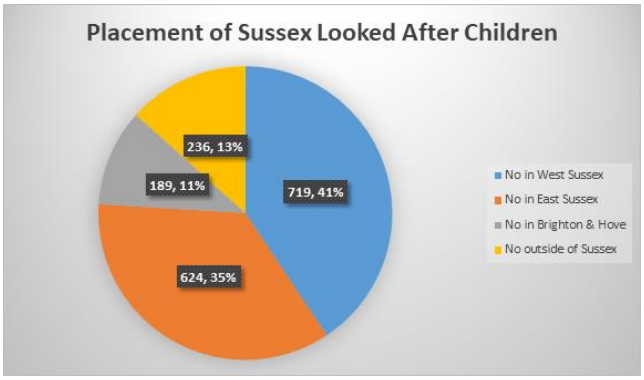


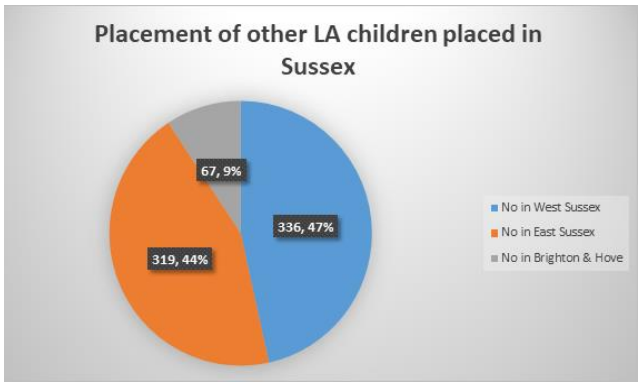
Placement

LAs have a general duty to provide accommodation that is within the local area and allows the child to live near their home. Profiling over the last two years has identified that whilst Sussex Children may not be in placement within their own LA or city boundary the significant majority (89%) do continue to reside within Sussex. There are 188 children in placement outside of Sussex. The main reason being that specialist placements are required that are not available within Sussex or children move to live in kinship care or are matched to an adoptive family outside of the counties.

Designated professionals, commissioners and providers promote equal access to services for all children moving placement into or across Sussex. An understanding of where children live is important when commissioning health services to ensure sufficient capacity in the right area. The three Sussex LAs provide CCG with information.

Accuracy of numbers of children placed cross boundary into Sussex by other LAs is more difficult to confirm as reliant on timely LA to CCG notification. As of 31st March 2020, estimate is approximately 722 children, an increase of 56% from 461 reported in the previous year. The total number of children in placements in Sussex is up 14% from 1977 to 2254, which has led to an increased demand on services. Thirty children's homes are reported in West Sussex but changes as homes open and close. Most are managed by private providers; some of these market themselves with a particular focus and tend to accommodate high risk-taking children from other counties.





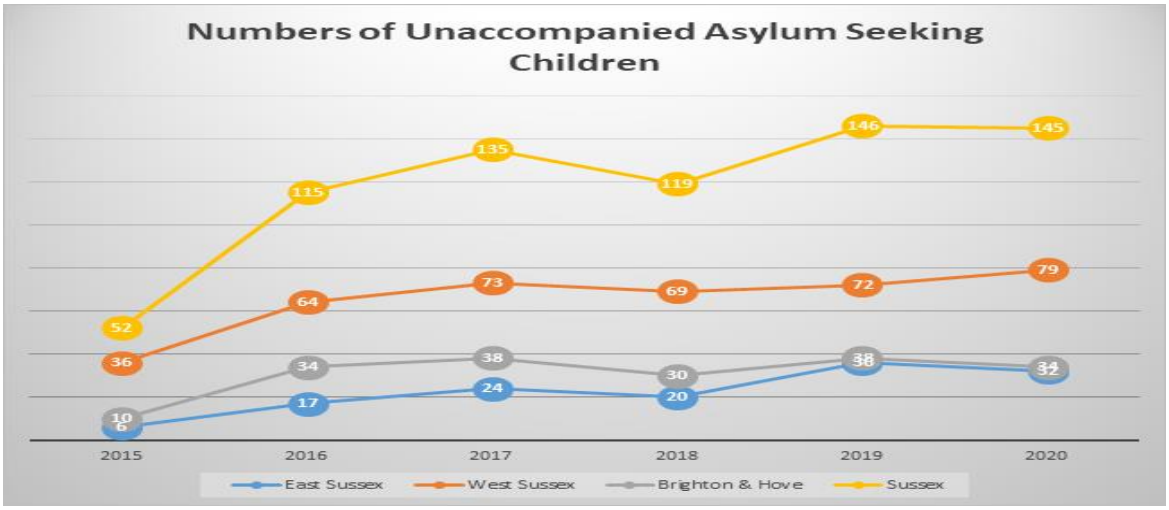
West Sussex 812 Children were Looked After, up from 704 the year before. Of these, 79 were Unaccompanied Asylum-Seeking Children (UASC), 10% of the total. The rate per 10 000 population aged 0-17 years in West Sussex was 47. The corresponding rates in March 2019 were 65 for England and 51 for Statistical Neighbours. Most Children (37%) were aged 10-15 years, followed by 29% in the 16+ age group. All Data March 31 2020

East Sussex 601 Children were Looked After, very little difference from the two preceding years. Of these, 32 were UASC, 5% of the total. The rate per 10 000 population aged 0-17 years in East Sussex was 52. Most Children (40%) were aged 10-15 years, followed by 38% in the 0-9 age group and 22% in the 16+ age group. All Data March 31 2020

Brighton & Hove 379 Children were Looked After, slightly down from 391 the year before. Of these, 34 were UASC, 9% of the total. The rate per 10 000 population aged 0-17 years in Brighton and Hove was 77. Most Children 42% were aged 10-15 years, followed by 29% in the 16+ age group. All data March 31 2020

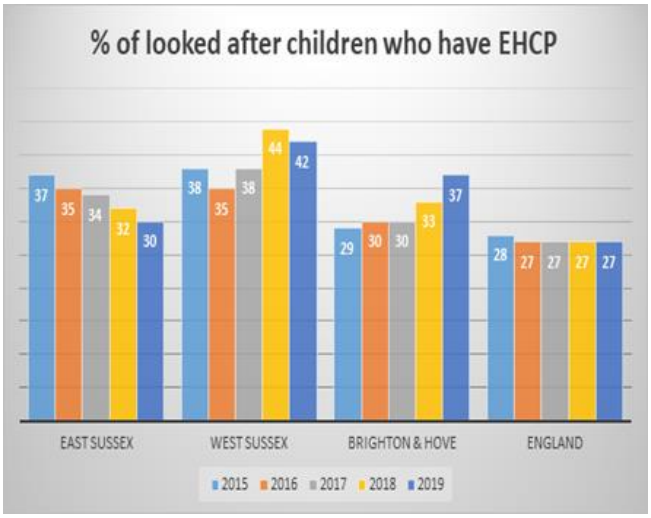
Unaccompanied Asylum-Seeking Children (UASC)

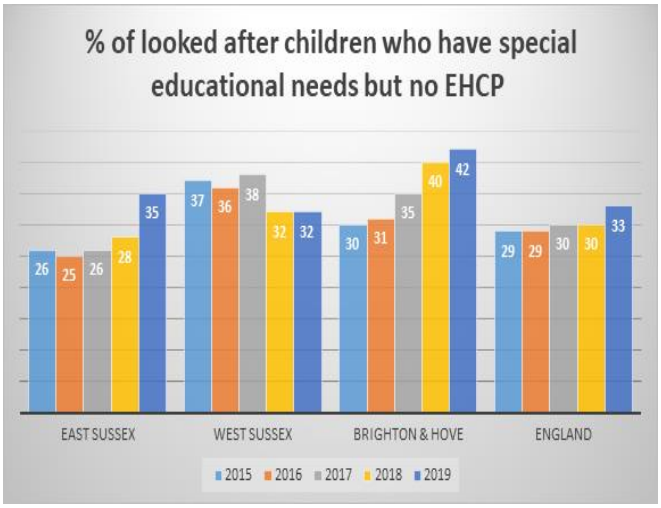
UASC are children who are seeking asylum in the UK and have been separated from their parents. While their claim is processed, a LA cares for them and has a legal duty to provide accommodation. LAs with points of entry to the country, for example Kent and Croydon, have much larger numbers of UASC than other LAs. However, there is a National Transfer Scheme to encourage all LAs to care for UASC and in Sussex children arrive either as part of this scheme or are spontaneous arrivals, found either by the Police, or at Newhaven Port and Gatwick Airport. They currently account for 8% of Sussex Looked After Children (higher than the overall 6% among Looked After Children nationally). Their needs and circumstances share many of the characteristics and have similarities to those of other UK Looked After Children but in many other respects, they are quite different. They are separated not only from their family, but from their community and country of origin often following death of their care giver and significant trauma on their journey. These children have substantial health and social care needs and a high prevalence of physical and mental illness. There are challenges to ensuring that their needs are met including access to therapeutic services, places to learn English, legal advice, and translation services. Assessments may take longer and there is little time to establish services before a child turns 18. Assessments may go out of timescales due to delays in LA securing an appropriate interpreter or because they go missing. West Sussex Team commenced an audit in Quarter 2 '*Health outcomes of unaccompanied asylum-seeking children looked after by West Sussex Children Services*' and plan to share the findings with the wider system.



Special Educational Needs

Prior to entering care many children have suffered multiple forms of maltreatment, such as neglect and emotional, physical or sexual abuse, including neglect while in the uterus, due to alcohol or drug misuse during pregnancy. Research has shown that children with adverse childhood experiences such as these may struggle more with learning and participating at school, with language development, communication, attendance, and excelling academically. They have a higher likelihood of dropping out early or choosing not to pursue a higher education. This is consistent with the higher rate of special education needs within the Looked After Children cohort compared the overall population. Many are supported in their learning by additional provision within their school setting. However, some are identified as needing more and require an Education and Health Care Plan (EHCP).





7.0 Training and Supervision of Healthcare Staff

Training
The Designated Nurses and Doctors have attended Level 5 training as detailed in intercollegiate document and accessed quarterly supervision facilitated by an external company. They have also led and provided the following multi-disciplinary and inter-agency training:

- Pan Sussex Network Event in May and November 2019 for all health practitioners working with Looked After Children.
- Pan Sussex L4 training provided by CCG 2019 for all health practitioners working with Looked After Children
- Level 3 face to face safeguarding and Looked After Children package for CCG and Primary Care Staff
- Health of Looked After Children Training Package to Social Care Staff
- Looked After Children Session for University of Brighton Specialist Community Public Health Nursing (SCPHN) Course
- A joint tailored safeguarding package encompassing adults, Children and Looked After Children to the four CCG Governing Bodies
- Level 1 Looked After Children Training Leaflet for all new CCG staff

During pandemic restrictions, an online Level 3 safeguarding and Looked After Children package for CCG and Primary Care Staff has been developed and made available. Training is monitored within provider organisations.

Supervision
Sussex wide Safeguarding Supervision policy was updated in 2019 to include Looked After Children. Supervision is in place for named/lead professionals in provider organisations delivered by designates. From April 2019, the addition of Looked After Children reporting metrics was added into the contracts for six main providers across Sussex.

8.0 Statutory Looked After Children Health Assessments and Sussex Wide Service Specification

Sussex CCGs set performance targets against the requirements laid down to them in statutory guidance. There is not a national data set to directly compare timescales for initial (IHA) or review (RHA) health assessments and so reliance is on local data that can be inconsistent. Following a successful bid to NHSE the CCGs have secured the expertise of a safeguarding analyst for 20/21 to work across the system to create a pan-Sussex health of Looked After Children dashboard.

Provider exception reports highlighted low performance at the beginning of the year and the differences in commissioning and funding arrangements across Sussex. This made it difficult to make direct comparisons but led to a better understanding of capacity and demand and how services are delivered.

In East and West Sussex, the statutory requirement that children are seen by a medical practitioner for IHA is met as all assessments are undertaken by paediatricians and doctors working in the child development centres (CDCs). Children are then seen for subsequent reviews by a team of Nurse Specialists.

An unannounced Care Quality Commission (CQC) review of safeguarding and looked after children health in Brighton and Hove took place in July 2019. The published report highlighted positive feedback from children and carers on their experience of specific Looked After Children health services. The report made four improvement recommendations including one for the CCG to ensure IHAs are undertaken by appropriately trained professionals in line with current guidance. The Chief Nurse oversees a task and finish group to implement actions arising from the recommendations.

Unaccompanied Asylum-Seeking Children in B&H and West Sussex are seen in a joint clinic with a specialist nurse and doctor. In East Sussex they are seen in a CDC.

IHA data for of children entering care who had an IHA and care plan written distributed within 16 days of referral.

Quarter	SCFT (B&H)	SCFT (West Sussex	WSHFT (West Sussex)	ESHT (East Sussex)
Q1	34%	10%	0%	3%
Q2	95%	41%	39%	33%
Q3	86%	24%	0%	60%
Q4	68%	46%	0%	75%
Year Average	71%	30%	10%	43%

RHA data for children under 5 years who had a health assessment within 6-month timescale.

Quarter	SCFT (B&H)	SCFT (West Sussex	ESHT (East Sussex)
Q1	43%	44%	19%
Q2	82%	57%	61%
Q3	100%	58%	72%
Q4	100%	81%	100%
Year Average	81%	59%	63%

RHA data for children over 5 years who had a health assessment within 12 month timescale

Quarter	SCFT (B&H)	SCFT (West Sussex	ESHT (East Sussex)
Q1	52%	43%	40%
Q2	79%	37%	42%
Q3	90%	32%	66%
Q4	86%	46%	62%
Year Average	77%	40%	53%

The following interventions and initiatives have had a positive impact; however, sustainability is an issue:

- Development and monitoring of service development improvement plans with providers across Sussex directing focus on areas that require improvement to meet key performance indicators (KPIs) in current contracts
- Regular performance update meetings with provider executive leads and commissioners
- Escalation by exception report and briefing papers to CCG Head of Safeguarding, Chief Nurse, Quality Committees and Governing Bodies and to provider Clinical Quality Review Meetings.
- Chief Nurse participation in West Sussex Ofsted Improvement Strategic Partnership Meeting -IHA highlighted by Ofsted as an area requiring improvement
- Support to providers to improve reporting across Sussex and align quarterly reports
- West Sussex funding for additional locum paediatrician and specialist GP hours as part of a waiting list initiative throughout August and September to clear a backlog of 70 LA referrals
- Funding for a full time Band 7 IHA nurse secondment to pilot Dr/Nurse IHA model
- CCG tracker pilot to monitor the status of IHA's
- Continued building of positive relationships and networks across Sussex
- Promoting a caring system that wants the very best for all children
- Timeliness of IHA and RHA was added by ESHT to their Women and Children's divisional risk register.

A joint pathway has been agreed for LAs to make a referral for an IHA including essential information and rolling consent within 4 working days. To meet 20 working day target health must complete the assessment and provide a health plan within 16 working days of receipt of LA referral. When RHAs become due LAs make a referral at least 8 weeks before the expiration date to allow health time to provide an updated care plan within 6 months up until their 5th birthday and 12 months once they reach 5. Providers are encouraged to integrate health assessments with any other assessments and plans such as the child's Core Assessment or an Education, Health and Care Plan where the child has special educational needs. However, capacity and competing pathways, particularly within CDCs means this can be challenging. Providers have highlighted that one of the main issues that causes delay is writing up the IHAs in a timely manner, often as the clinician is waiting to receive the child's health history or key information from GP and other providers.

Designated professionals and commissioners have identified that an updated pan Sussex service specification is required for arrangements to become and remain statutory compliant. This has identified that additional investment is required if timescales are to be met consistently without a negative impact on quality and experience, which are of equal importance. Specialist Nurses complete an audit template and Designate and Named Nurses regularly dip sample assessments and give feedback to drive continuous improvement. Specialist Nursing Teams regularly receive

plaudits from teams outside of Sussex. The quality of health assessments for Looked after Children were highlighted by Ofsted in the East Sussex inspection, where an 'outstanding' rating was achieved.' (Sussex-wide annual LAC report 2018-19).

Pan Sussex version aligns services, reduces variation and meet recommendations of CQC and Ofsted inspections. It reflects the additional needs of certain groups such as UASC, Care Leavers, children placed cross boundary and those with special educational needs and disabilities. It has been developed with consultation and feedback from LAs and health providers. CQC '*Not seen Not Heard'* document and messages from research and training were also important influencers. The updated service specification strengthens contract requirements and key performance indicators. Health Providers will be set a target of 100% to achieve the IHA 16-day pathway for which they are ultimately responsible and meet statutory requirements for RHA. They are expected to work closely with LAs to achieve this and escalate any areas of concern. A threshold for CCG involvement would be if compliance were to fall below 85%. This is in recognition that each child enters care in a unique set of circumstances and health services need to be sensitive to individual needs. By seeking and acting on the views of carers, social workers and children it is likely that there will be a small cohort of children where it is not possible or in their best interests for them to be seen for the scheduled appointment or they refuse to attend or decline. Where these targets are not met exception, reports are required with supporting narrative. If threshold is not met for two quarters development of Service Development Improvement Plans (SDIPS) are necessary highlighting a detailed recovery plan, agreed with the commissioners.

There is recognition that numbers of children entering care may rise or fall and commissioning discussions are triggered regarding capacity if there is a 10% change.

The service specification has been agreed in principle by executive leads of CCGs and agreed in principle by providers. There is sufficient funding to implement fully in East Sussex but in West Sussex, due to the large increase in the numbers, capacity does not match the recommendations set out in Royal College's intercollegiate framework. In Brighton and Hove investment is required to fund doctors to undertake IHA to become statutorily compliant, releasing Nurse Specialist capacity to take over RHA from the Health Visitors and School Nurses.

Whole system conversations, in relation to the process and next steps for a longer-term sustainable solution, continue at a senior strategic level.

9.0 Emotional Health and Wellbeing

The events that lead to children entering care are frequently traumatic with obvious implications for their emotional wellbeing and behaviour. Department of Health reports that almost half of children in care have a diagnosable mental health disorder and research published by Social Market Foundation in August 2018 identified that Looked After Children are around five times more likely than their peers to experience mental ill health. Forming a large part of the Designates workload this is a priority area for 2020.

LAs are required to use Strengths and Difficulties Questionnaire (SDQ), completed annually by the carer, to give social workers and health professionals' information about a child's wellbeing. Across Sussex the average score of the three LAs suggests that there are a significant number of children where there is cause for concern suggesting current services could be improved. A comprehensive local mental health data specific to Looked After Children is not readily available so commissioners

and designates are working with providers to remedy this. Improved identification and flagging are the starting point so that activity is captured to gain better insight into referrals, waiting times and outcomes. Proposed next steps are to work with commissioners to develop a contract similar to the pan Sussex service specification aimed at improving mental health services provision.

An independent Sussex-wide review of emotional health and wellbeing support for children and young people has been commissioned and the findings and recommendations are awaited. Designates facilitated a focus group so that reviewers heard directly from frontline health and social care practitioners what is working well for looked after children and the challenges they face accessing timely and appropriate recovery packages. Themes raised were confusing referral pathways, lack of clarity of commissioning responsibilities and long wait times.

In February 2020, Ofsted, CQC, HMI Constabulary and Fire & Rescue Services and HMI Probation carried out a joint inspection of the multi-agency response to Mental Health in East Sussex. The inspection included a deep dive focus into the response of two children in care living with mental ill health. A multi-agency action plan will be implemented in response to the report's findings and recommendations.

Anna Freud Pilot

Following a competitive application process, Brighton and Hove were selected to be one of nine pilot sites across the country working with the Anna Freud centre to improve Mental Health Assessments for Children Entering Care. This is a National initiative sponsored by the Department for Education and runs from June 2019 to Sept 2020. Brighton and Hove are focusing on the needs of UASC with a designate nurse taking the project lead when the mental health commissioner moved role.

Aims of pilot:

- Deliver a timely and trauma informed assessment to enable the network around the child or young person to think about their needs and how they might change and what might help at the point of coming into care and later through their journey.
- A voice for the child – how they feel, what would help
- Joint working with the child carers and professionals to improve the child's emotional well being

Key Benefits:

- Mental Health Assessment- identify need and appropriate services
- Skilling workers- in building trust and relationships
- Placement Support- Reflective practice, training & strategies
- Staff Wellbeing – Reflective practice
- Network Support – consultations with key agencies around care and planning

The outcomes of the pilot are not yet available and the delivery will be affected by the Covid 19 crisis.

10.0 Care Leavers

The Children (Leaving Care) Act 2000 states that a Care Leaver is someone who has been in LA care for a period of 13 weeks or more spanning their 16th birthday. It is important that there are effective plans in place to enable a smooth transition to adulthood and ensure young adults are still able to obtain the health advice and services they need. Across Sussex, a Health Summary is provided to ensure young people exiting care understand how to access their full health history. It also includes a short health history as well as advice on how to maintain health in the future including signposting to local health services and appropriate health websites. Provision of leaving care health summaries is reported quarterly.

Providers report that performance for completing health summaries is good and meets or is close to meeting 85% target. When health summaries are not completed, exceptions are provided, and the reason is usually because the young person has declined, no forwarding address or children going missing. Quality is audited by the Named Nurses who advise that they are of an adequate or good standard.

Quarter	SCFT (B&H	SCFT (West Sussex)	ESHT (East Sussex)
Q1	75%	92%	Data not available
Q2	90%	77%	100%
Q3	72%	92%	100%
Q4	83%	80%	100%

Data March 31 2020

Development of a new aligned health summary for care leavers and improved pathway has commenced and a multi-agency Pan Sussex working group established led by the Looked After Children Nurse Specialists who are responsible for completing these documents. Input from the three LAs and their Care Leavers will influence the process and final document.

11.0 Child's Voice and Experience

The full participation, involvement and contribution of children in care, leaving care and care experienced adults is crucial. Designate Nurses collaborate with Sussex LAs via their participation forums such as Children in Care council, Care Leaver Groups, Corporate Parenting Boards and The Bright Spots Programme. Bright Spots is a partnership between Coram Voice and the University of Oxford, to hear what looked after children say are the things that are important to them. In CQC document 'Not seen- not heard' children say that the thing that makes the biggest difference to them is when the health professional that they are speaking to '*actually listens to them and shows them that they really care'.*

Designates and Commissioners encourage health providers to seek children's views using tools such as adapted versions of friends and family testing (FFT). Nurse Specialists have worked with the SCFT Communications Team to develop an anonymous client feedback survey via their smartphones. This incorporates a suitably worded FFT question and a further additional 6 questions. This went live in December 2019 and raw data to the end of the reporting year was received for 59 children which was 100% positive. The method of using the smartphone has been enthusiastically received by children and their carers.

Designates will continue to work closely with providers to focus on outcomes and report how they ensure that children and young people are actively engaged in their care. This will include those children with complex and severe developmental, physical, emotional and mental health needs who also need to have their views heard and represented.

Pan Sussex networking and training events facilitated by CCG have focus on the voice of the child. Key speakers are engaged to challenge and motivate staff to ensure this is central to their service. Designates regularly participate at events that have care experienced participants or speakers.

12.0 Summary of achievements

- Improvements to IHA process and timescales for statutory health assessments
- Development of a Sussex Wide Service Specification for Looked After Children with staffing resource in line with the intercollegiate framework and RCPCH guidance to enable a service that can deliver on statutory responsibilities and improve health outcomes for Looked After Children.
- Compliance to the Looked After Children reporting metrics aligned to safeguarding included in Sussex Safeguarding standards added in the contracts of main providers from April 2019. Audit of compliance was undertaken in February 2020 and action plans are in progress to address any deficits.
- S11 audit re-design to include specific sections on Looked After Children for the first time, which goes to all providers across the Local Safeguarding Children Partnerships.
- Successful Safeguarding and Looked After Children bid to NHS England to fund a data analyst to create a health of Looked After Children dashboard across Sussex
- Continuing strong working relationships across all agencies

13.0 Conclusion

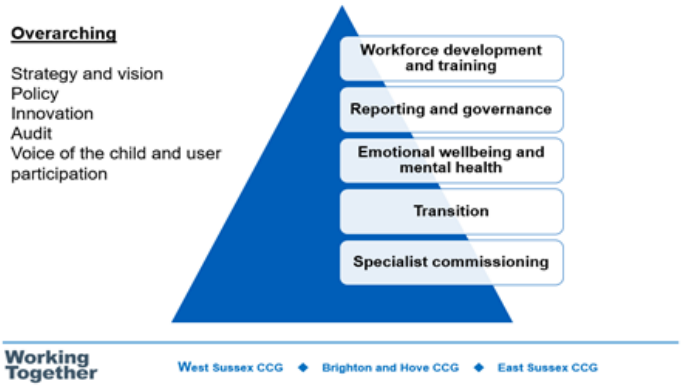
The main priority for the year was to develop and implement a Sussex wide service specification for Looked After Children that would enable to providers to meet the statutory requirements for health assessments. Implementation has been delayed due to the Covid 19 crisis and funding decisions. Health data for the year evidences some clear progression in the pathway and timeliness for health assessments but also highlights where there needs to be further sustainable improvements.

Over the last year, there has also been a significant focus on increasing the profile of Looked After Children within CCG, Joint Commissioning Units, newly forming Local Safeguarding Children Partnerships and health providers. Work to align services across Sussex and improve health outcomes has continued. Additional Designated professional capacity will give more opportunity to audit and better understand whether current service provision is having the desired impact and how services can continue to be developed.

The sudden onset of Covid-19 pandemic changed the way that the NHS works and delivers services and the crisis will inevitably change the way services are delivered in the future.

14.0 Priorities for 20/21

From April 2020, the CCG Looked After Children team are transforming the way they work to become an intrinsic part of the newly formed Integrated Care System (ICS) - Sussex Health and Care Partnership (HCP).
To better meet the statutory responsibilities and needs of Children in care the team have moved away from 'place based' responsibility for a LA area and are now all working across Sussex. Designated Nurses will focus on allocated portfolios with key work streams. These, and overarching principles, will underpin the Sussex CCGs Looked After Children Strategy.



Workforce Development and Training

- To ensure that the Looked After Children workforce are trained commensurate to their role
- As a minimum, all CCG staff will receive level 1 awareness training and information at induction.
- Develop Level 3 training, amalgamating current Looked After Children training for Social Workers, foster carers, GPs, Health Visitors into a multi-agency Looked After Children training that is accessed via LSCP as a Pan Sussex offer.
- To provide a three-monthly forum for sharing and promoting good practice in Sussex across the health providers. To identify what is working well and proactively collaborate to address areas that require support or intervention and discuss new guidance.
- To organise two Sussex wide network events per year open to all staff across the health providers.

Reporting and Governance

- Strengthen reporting from providers to inform a health of Looked After Children dashboard to inform commissioning decisions going forward. This will include a strong focus on emotional wellbeing and mental health
- Clearer governance and reporting to highlight what is working well and escalate areas of concern

Emotional Wellbeing and Mental Health

- Designates to work with commissioners to agree specific reporting requirements for looked after children and support commissioners to formalise these into contracts
- The formal evaluation of the Sussex wide review, the Brighton and Hove CQC Looked After Children review, the East Sussex JTAI and the national Anna Freud pilot to be used by CCG, designates and commissioners to inform development of services

Transition

- Increased oversight of offer to all Looked After Children across Sussex irrespective of placing authority
- Increased oversight of service offered to Looked After Children placed out of Sussex
- ICS collaboration to refresh and align Care Leavers Health Summary for implementation across Sussex
- Partnership working to refresh Local Care Leavers Health Offer across Sussex

Specialist Commissioning

- Funding for Service Specification to be finalised to support implementation
- Designates to support the implementation of the service specification
- Implementation to include aligned reporting and assurance from providers to bench mark and measure Looked After Children's health and evidence improved outcomes
- Designated Doctors propose to audit all babies who were 'born into care' in West Sussex during the calendar year 2019. The data gathered will help to inform the possible development of an IHA pathway for newborns, specifically identifying what the IHA might add to the contact that babies already have with health professionals during the 1st few weeks of life.

15.0 References

Promoting the health and wellbeing of Looked After Children DoH, DFES (2015)

Intercollegiate document: Looked After Children Knowledge skills and competence of healthcare staff (March 2015)

The Children Act Guidance and Regulations Volume 2-4: Care Planning, Placement and Case Review, Transition to Adulthood and Fostering Services (1989/2004) HM Government

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies DoH (2013)

Who Pays? Determining responsibility for payments to providers NHSE (2013)

National Tariff Payment System NHSE (2019/20)

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East Sussex Healthcare NHS Trust

Appendix 3 – East Sussex NHS Trust ESHT report on health of LAC in East Sussex

Looked After Children (LAC) Annual Report 2019-2020

Introduction

The purpose of this report is to inform the Trust Board, stakeholders and members of the public of the work that has taken place and is ongoing to achieve the recommendations of statutory guidance 'Promoting the health and wellbeing of looked after children' and NHSE 'Unwarranted variation' document November 2017. It also intends to offer outcome data, quality measures and information about staff wellbeing.

In April 2018 in line with statutory guidance 'Standard Approach Document' and Coram BAAF. Processes were changed in East Sussex and it became the responsibility of the Local Authority with the agreement of the designated and named professionals and ESCC to inform and request Initial and Review Health Assessments (IHA and RHA) for children who are looked after in East Sussex. Over the past 24 months ESCC have been leading on the process for requesting an IHA within 5 working days of a child entering care and adding all East Sussex LAC to a live database that will trigger a reminder to the social worker, prompting a request to the LAC nursing team to undertake the statutory RHA. Progress has been made with improved completion of the paperwork and appropriate consent. However there continues to be a proportion of requests that are submitted late, which impacts on the ability of ESHT to fulfil its obligation to achieve statutory timescales. The statutory timescales are for IHAs to be completed within 20 working days of the child entering care RHA's should be completed and distributed before expiry of the previous report (6 monthly under 5 years of age, annually between 5-18 years of age). As of 30th March 2020 133 (ESCC data) review health assessments were either late or overdue representing 22% of the East Sussex LAC population. Work continues between ESHT, ESCC and the CCG to improve this situation.

Statutory and legislative background

- Promoting the Health and Well-being of Looked after Children was published by the Department of Health and Department of Education in March 2015. This guidance is issued to local authorities, CCGs, and NHS England
- Intercollegiate document: Looked After Children knowledge skills and competence of healthcare staff was published in March 2015, outlines the competency framework, and skills, knowledge, attitudes, values and training for staff.

Other publications that inform commissioning services for Looked After Children include:

- The Children Act 1989 Guidance and Regulations Volume 2- 4: Care Planning, Placement and Case Review, Transition to Adulthood and Fostering Services Children Act 1989- legislation.gov.uk
- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
- Who Pays? Determining responsibility for payments to providers who-pays.pdf
- National Tariff Payment System Care Planning, Placement and Case Review (England) Regulations (2010) legislation. gov.uk

NHS England also aimed to improve practice by producing

- "A guide to meeting the Statutory Health Needs of Looked after Children, a standard approach to Commissioning and Service Delivery" in November 2017. However, this was subsequently withdrawn in August 2018 and re-issue remains under review.

LAC Profile

Nationally, the number of Looked After Children continues to rise. At 31st March 2019 the number of children looked after by local authorities in England increased to 78,150 from 75,370 in 2018 and 72,610 in 2017 showing a continuing trend of increases seen in recent years. This is equivalent to a rate of 65 per 10,000 in 2019, which is up from 64 per 10,000 in 2018 and 62 per 10,000 in 2017.

Rates of Looked after Children (per 10,000 of child population) vary significantly across the three local authority areas of Sussex. In Brighton and Hove, the rate is high and in West Sussex low relative to the National rate of 65 per 10,000 East Sussex numbers fall in between.

	2017	**2018**	**2019**
Sussex wide	1674	1725	1702
West Sussex	663	704	702
East Sussex	55556 per 10,000	602 57per 10,000	60056 per 10,000
Brighton &Hove	456	418	393

The LAC data only ever gives a snapshot of children moving in and out of the system at a fixed date each month/year and considerable activity sits beneath it. The data

below is referred to as 'churn'. This cohort of children will come in and out of the system within the year, or some may come in and stay whilst others leave. It has been calculated that the churn figure East Sussex for 2018/19 was 188 which, when added to the total number of LAC, equates to the service working with 788 children. This total figure is higher than last year (756 children), and the churn rate is also higher than for the previous years (153 for 2017/18, 175 for 2016/17).
LAC nurse resource in East Sussex has not increased despite the number of LAC rising year on year and so demand has outweighed capacity of 100 LAC per 1.0 WTE nurse

Services provided by ESHT include:

East Sussex Health Care NHS Trust (ESHT) provides statutory (initial and review) health assessments for children that are Looked After by the local authority. The three cohorts of children include, East Sussex children placed in East Sussex, East Sussex children placed outside of East Sussex (OOA) and other local authority children placed in East Sussex (OLA).

- Paediatricians within Community Paediatrics (Child Development) department undertake statutory Initial Health Assessments (IHA) within 20 days of a child entering care. In addition to a range of child and adult health assessments that are required when a child is placed for adoption.
- The LAC nursing team based at Centenary House Eastbourne undertake Review Health Assessments every six months for children under 5 years of age, and annually for children aged 5-18 years, along with caseload work (100 LAC per 1.0 WTE nurse) and a 'Leaving Care Health Summary' for all children between the age of 16- 18 years
- The Lansdowne Secure Children's Home:
  NHS England separately commissions primary and secondary healthcare for young people accommodated in the Secure Estate. ESHT is commissioned to provide nurse input for the 'physical' health of the young people who need to be placed for their own safety, or the safety of others for welfare reasons under Section 25 of the Children Act (1989). The Lansdowne in Hailsham East Sussex is one of only six homes in England that provide welfare only placements.
  The commissioned service undertakes a health assessment of young people entering the secure estate using the Comprehensive Health Assessment Tool (CHAT), provides a health care plan for ongoing physical health needs and a discharge summary. The provision from ESHT includes a LAC nurse specialist (Band 7 0.4 FTE) permanently assigned to the Lansdowne SCH and an administrator (0.53 FTE) who provides equally divided support for physical health, mental health and substance misuse. On the on-site nurses' non-

working days and during periods of leave/ absence the core ESHT LAC nursing team visit the home to complete the CHAT when a young person is admitted. Building work is underway due for completion summer 2020 and the home will be increasing capacity from 7 to 12 beds. A business case has been put forward by ESHT to NHS England commissioner for the increased physical health provision that will be required, with a view to reducing the reliance (impact) on the core LAC nursing team by having cover during hours of greater demand across the working week. This has been responded to favourably and a decision is anticipated shortly. The NHS England commissioner and ESHT are working closely together on an SLA that will have a strong focus on health promotion and be fit for the future. The contract for the Hailsham SCH is due for renewal April 2021

LAC Service Level Agreement (SLA)

Whilst ESHT have an SLA for LAC with the CCG this is not the case for other providers across the region. Designated Professionals across Sussex Transformation Partnership (STP) have been using the ESHT SLA as a framework and are working to support the commissioners across the region establish an SLA that will align the Looked After Children service specification to reduce unwarranted variation of Looked After Children services Pan Sussex. The initial draft (Oct 2019) was rejected by ESHT as it contained no detail of expected activity numbers. An updated version of the service specification is currently under review with the CCG.

Performance against Statutory Requirements

Meeting the Health and Well Being Needs of Looked After Children (2015) and the Care Planning, Placement and Case Review (England) Regulations (2010) states that a child coming into care requires an Initial Health Assessment (IHA) and care plan collated, and this is shared with the local authority to inform the first review meeting, held 20 working days after entry in to care. The initial health assessment must be completed by a registered medical practitioner. The review of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months after the child's fifth birthday. Review health assessments may be carried out by a registered nurse or registered midwife.

The STP oversees and monitors the provision of care to LAC across West Sussex, Brighton & Hove, and East Sussex through the designated professionals.

You will see from the data below that the measures introduced across the whole of the LAC team throughout 2019 have brought about significant improvements in achievement of statutory timescales. In May 2019 the performance of the ESHT LAC

team on achieving statutory timescales for IHA's and RHAs, Leaving Care Health Summaries and robustness of data being reported was challenged by Sussex Transformation Partnership (STP). ESHT LAC team provided a response to the points raised via Clinical Quality Review Meeting (CQRM) and the CCG provider meetings and out of this a joint action plan with shared accountability was devised between ESHT LAC and the CCG. This action plan is reviewed bimonthly at CCG provider meetings and steady and continued progress is being made in all areas.

During Q2 the STP introduced a new data monitoring tool. Some of the measures were found by the LAC team to be ambiguous and open to interpretation. The service manager and LAC administrators worked with the named Dr and designated nurse over Q2 and Q3 to gain clarification. In Q4 ESHT was made aware that the STP had identified disparity in the way data was being reported by the different providers pan Sussex, and changes to the tool have been made that will commence from Q1 2020 to ensure uniformity and consistency in activity data reporting.

Initial Health Assessments

Initial Health Assessments IHA 2019-20	IHA should be completed and report distributed within 20 days of child entering care	
	Within 20 days of entering care	Within 16 days of complete paperwork being received by ESHT
Q1	20%	6.6%
Q2	24%	33%
Q3	43%	64%
Q4	25%	100%

The factors that impacted on breaches (failure to meet statutory timescale) across all four quarters that were non attributable to ESHT and impact on achieving IHA distribution within 20 days of entering care, included delayed notification to ESHT LAC by ESCC of a child's entry into care, incomplete paperwork, none or incorrect consent, carer or social worker declining first appointment offered, young person not attending for appointment or absconding from care. A high proportion of those absconding from care were Unaccompanied Asylum Seeking Children (UASC).

In Q2-the factors that impacted on breaches attributable to ESHT and impacting on achieving IHA distribution within 16 days of complete paperwork being received by LAC administrators were identified as, medical staff annual and special leave (some of which was unanticipated and at short notice). Many public holidays falling on the days IHA clinics were scheduled, 1st appointment offered being declined or cancelled

and a higher number of adoption medicals being requested which impacted on LAC clinic IHA appointment availability. In response to this LAC Drs agreed to plan requests for leave that would ensure a minimum level of cover for the LAC service. Some LAC clinics have been moved to alternative days of the week, to avoid public holidays and consideration is given to the LAC clinic capacity when reviewing Drs job plans. The adoption team in ESCC were asked to give consideration to the number of adoption reports being requested. Alongside this a newly recruited NHS locum required induction and to become familiar with internal LAC processes and all of the reports required Quality Assurance (QA) by the named or designated Dr before being distributed. A corporate approach to the workload of the secretarial team was being introduced but not fully embedded; LAC reports are now flagged to all as high priority and a waiting list tracks the progress of the report.

In Q3, October one IHA that breached statutory timescale was attributable to ESHT LAC as the report was awaiting quality assurance. In November and December no timescale breaches were attributable to ESHT processes.

In Q4 none of the IHA timescale breaches were attributable to ESHT processes

From Q3 there has been increased scrutiny of the data by the Designated Nurse. East Sussex Health Care NHS Trust, the CCG, Designated Looked After Children Professionals and the commissioner are actively working with the local authority to identify the obstacles in the referral process and are implementing strategies to improve the pathway. The LAC service manager and named nurse for LAC attend the monthly Clinical Quality Review and bi monthly provider CCG meetings, to formally present the data and respond to questions from the CCG with an improvement plan. There is a quarterly operational meeting with ESCC, and the LAC service manager meets bimonthly with ESCC LAC admin.

Review Health Assessments

Review Health Assessments RHA 2019-20	RHA should be completed and distributed before expiry of the previous report (6 monthly under 5 years of age, annually between 5-18 years of age)	
	Under 5 years of age	**5-18 years of age**
Q1	19%	29%
Q2	61%	75%
Q3	71%	65%
Q4	100%	62%

Across all four quarters the factors that impacted on breaches (RHA not completed and distributed before expiry of the previous report) that were non attributable to ESHT included, late or overdue request to LAC nurse administrators from ESCC for RHA,

incomplete paperwork, none or incorrect consent, carer or young person declining or cancelling appointment offered, young person not attending/ no access or declining to have an RHA. The LAC nurse team have worked closely with the designated Dr, named nurse, ESHT information governance and ESCC to promote 'best practice' for gaining consent and there has been a marked reduction in the number of RHA requests being returned to social work colleagues by the LAC nurse team due to incorrect consent. This has been challenged by one or two other local authorities that use rolling consent and the team have looked to uphold this best practice without causing any detriment to the child or young person.

In Q2- the factors that impacted on breaches attributable to ESHT were identified as lack of nurse capacity due to annual leave, historical requirement for 5 day turnaround of report being distributed being impacted by staff part time working patterns. In August and September 100% of RHA's not delayed by ESCC factors were achieved by the LAC nurse team in timescale.

In Q3- two breaches were attributable to ESHT. One in November and one in December. One was due to a lack of nurse capacity and one due to the complexity of the case that required collecting of a significant amount of additional information for the LAC nurse to complete a robust report and health care plan.

In Q4-100% of RHA's not delayed by factors attributable to ESCC were achieved by the LAC nurse team in timescale.

Data Reporting

It proved challenging to establish explicit enquiry questions for the information management team to draw data from Systmone to match the requirements of STP monitoring tool for the year 2018/19 so as to provide accurate and meaningful data for the CCG. A lot of work has and continues to go into refining the enquiry questions to ensure robust data from Systmone. The data drawn down is reviewed each month by the Service manager, named Dr and Information management advisor. Progress with this is currently further advanced for the IHA's than for the RHA's. Standard operating procedures (SOPs) have been written for all RHA processes and good progress is being made on SOPs for IHA processes.

Leaving Care Health Summary (LCHS)'Passport'

It is important that there are effective plans in place to enable Looked After Children aged 16 or 17 to make a smooth transition to adulthood so that that they are able to continue to obtain the health advice and services they need. Care Leavers should be equipped to manage their own health needs wherever possible. They should have a summary of all health records (including genetic background and details of illness and treatments) with details of how they can access a full copy

of their LCHS if required. Across Sussex, children leaving care at the age of 18 are provided with a 'Health Passport'. This includes the summary and additional advice on how to maintain health in the future such as guidance on how to register at a dentist, GP etc. As well as signposting to local health services and appropriate health websites.

To ensure consistency details on the proportion of health passports/LCHS completed is included in the STP quarterly reports. There is variation in the LCHS templates across the region and development of a new template for the LCHS /passport is being led pan Sussex by the Named Nurse for ESHT and West Sussex with input from specialist nurses

Leaving Care Health Summary 2019-20	All eligible children between 16-18 years of age leaving care should be provided with a health summary	
Q1	62%	
Q2	100%	
Q3	100%	
Q4	100%	

In Q1 it was identified that a backlog of 'completed' Leaving Care Health Summaries had accumulated on caseloads across the nursing team. After discussion it was agreed that managing this situation and workload was a shared nurse team task. Work to clear the backlog continued throughout Q2 and has resulted in a process by which 100% of young people leaving care in Q2, Q3 and Q4 have been provided with a completed LCHS. For those young people who decline to receive the LCHS it is retained on record for access in the future. There are discussions planned between ESHT and ESCC about who else the summary should be distributed to and what level of detail is to be included, specifically around birth parents history.

Adoption

Under current adoption legislation, when a child is adopted they are given a new NHS number. All previous medical information relating to that child should be merged into a newly created health record ensuring continuity of healthcare, and there should be no reference on the record to the child being adopted. Concerns have been raised that in some instances these requirements are not being met. Discussions have taken place with Local Medical Committee and training will be updated to include guidance to enable the process to be managed correctly. East Sussex Healthcare Trust and Sussex Community NHS Foundation Trust are developing policies for internal management of their community and hospital records. These policies are still under review as there are significant challenges in meeting the requirements with records that span multiple electronic systems, paper records and a lack of capacity within departments to manage the workload required to address the issues with new

adoptions and historic cases as they are uncovered. Similar challenges are being experienced by providers across the country. Efforts are ongoing across departments within ESHT to progress this and we have been working under the guidance of the designated Dr and local medical advisors. Further guidance from the Government is anticipated in June 2020 following a pilot project in Leeds and local medical advisors have recommended no further action until the outcome of the pilot is released. This has been delayed due to the Covid-19 pandemic, but work is restarting in this project.

During the year 2019-2020 the adoption team performed:

A minimum of 63 adoption medicals
A minimum of 107 adult health reports
A minimum of 24 prospective adopters meetings

Unfortunately due to the medical advisor leaving at the end of Q1 and some of her work being subsequently covered by other doctors some of this activity is uncaptured.

Going forward (and indeed from mid August 2019) all adoption medicals and adult health reports were recorded as such within system one , so that data for the coming year should be more reliable. In addition to this additional codes have been added to the system medical advice should now be recorded as such.

During 2019-2020 the medical team attended 35 panels where a total of 76 cases were heard.

In April 2020 the East Sussex adoption service was subsumed into Adoption South East as part of a national regionalisation programme. The goal of this process is to pool resources with our surrounding areas to maximise the efficiency of the service and optimise outcomes for children.

Staffing

Looked After Children-Medical team

The Designated Dr vacancy (March 2019), was appointed to by an associate specialist already working in the LAC medical team. LAC Dr FTE is 1.65, with 1.0 FTE for Designated Dr and the other 0.6 FTE forming part of other Drs job plans. Additional LAC capacity has been achieved through an NHS locum contracted until July 2020, and a permanent 1.0 FTE associate specialist with an interest in LAC joined the community paediatrics department in January 2020.

To aid IHA distribution performance dedicated administration capacity has been increased through additional investment within ESHT LAC and a corporate approach to report preparation throughout the secretarial team. This has had a positive impact on the IHA reports being completed within timescales.

Looked After Children-Nurse team

Attendance at work within the nurse team is excellent and has been commended and remained consistently high throughout 2019 with staff demonstrating great flexibility to manage personal appointments around work commitments. The budgeted nurse team establishment is 5.53 FTE (excluding 0.4 band 7 for The Lansdowne SCH- directly funded by NHS England). There are Band 7 and Band 6 nurses within the team and the current nurse establishment is 5.61 FTE. Additional investment by the Trust has brought the establishment up to 6.0 WTE from April 2020 and nurse capacity now reflects the recommended caseload of 100 LAC per 1.0 WTE LAC nurse.
The administration budgeted establishment is 1.9 FTE (excluding 0.53 The Lansdowne SCH directly funded by NHS England). Total administration establishment is 2.03 FTE the additionality is funded by income from Other Local Authority Health Reviews. The structure consists of a business administrator band 4 who now has responsibility for line management of both the band 2 and band 3 administrators.

Clinical Service Manager

1.0 FTE Clinical Service Manager was recruited to in April 2018 with dual responsibility for LAC and Community Paediatrics.

Named Nurse

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0.48 FTE Named Nurse there was a change in employee in December 2019, and this is now a dedicated role for LAC

Staff Wellbeing

The LAC nurse team have relocated from the basement at Centenary house in Eastbourne to office space on the first floor and whilst there continue to be issues with the aged Victorian building the office space is lighter and airy and provides a more conducive working environment.

All nurse team staff have had 1-1's with their line manager every 8-12 weeks

Annual appraisals within the nurse team are 100% compliant

Mandatory training within the nurse team is 95%

Annual team Stress Assessment Oct 2019 saw a 5% increase from the 2018 assessment

Demands: Employees are able to cope with the demands of their job	88.88%
Control: Employees have a say about the way they do their work	83.33%
Support: Employees receive adequate information and support from their colleagues and superiors	100%
Relationships: Employees are not subject to unacceptable behaviour e.g. Bullying or harassment	100%
Role: Employees understand their role and responsibilities	100%
Change: Employees are engaged frequently by the organisation when undergoing an organisation change	100%
Total	94.87%

Quality and Dip samples

'The high quality of health assessments for Looked after Children were highlighted by Ofsted in the East Sussex inspection, where an 'outstanding' rating was achieved.' (Sussex-wide annual LAC report 2018-19)
Joint Targeted Area Inspection JTAI- the inspectors commented on the high quality of the IHA and RHA assessments that were reviewed.

A proportion of IHA's are QA'd by the named and designate Drs

Throughout the year the LAC nurses have received plaudits from other LAC nurse teams on the quality of their assessments and reports. In Q4 the Named Nurse has been made aware of 3 plaudits for the LAC nurse team in relation to the high quality of their RHA from external LAC teams.

A proportion of RHA's are dip sampled by the named nurse each quarter. In Q4 35 RHA's were dip sampled -Throughout the dip sample there was evidence that consent had been sought where age appropriate. There was also evidence that information had been gathered to inform the assessment. There was evidence that health events had been recorded since the last review, although not always evidence of a discussion. There was good evidence throughout all RHA's reviewed that the physical, developmental and emotional /behavioural health of the LAC had been considered and addressed. There was evidence that dental health and vision was discussed, though not all LAC had dentist or up to date vision assessment. However, there was evidence that the LAC nurse had emphasised the importance of these screenings to the foster carer(s) in addition to offering local dentists contact details. Throughout there was substantial evidence of health professional involvement where relevant. Immunisation status was always referenced and considerable evidence from the LAC nurse of the importance of up to date immunisations as well as evidence of GP Immunisation clinics. For some the LAC nurse has gone to great lengths to inform the

carer of the availability of GP clinics for accessing immunisations, specifically school leaving boosters and HPV vaccines for teenagers. There is evidence that keeping safe discussions had taken place predominantly with the 10-18 yr. olds and, where relevant, there is evidence for the under 10s. Where appropriate there is evidence of healthy relationship discussions. Apart from one RHA there is evidence that alcohol and/or substances have been discussed within the RHA, where applicable. Throughout the review the RHA's were personalised and the 'voice of the child' was clear, evident and apparent. Even when the LAC had additional needs and nonverbal the RHA still evidenced the needs and wishes of the LAC

Supervision and Training

Sussex wide Safeguarding Supervision policy was updated in 2019 to include Looked After Children. Supervision is in place for named/lead professionals in provider organisations delivered by designates. Within ESHT all LAC nurses receive supervision every 6-8 weeks from the Named Nurse. Each supervision is recorded in the child's record. All LAC nurses have received regular supervision throughout 2019-20. The Named doctor provides advice and supervision to the LAC nurses in respect of Looked after children via a bi monthly 'case discussion clinic'.

"Think Family" is a newly devised training for the whole of ESHT which incorporates safeguarding adults, safeguarding children and LAC issues. This training has generated external interest for potential adoption by other organisations. The LAC nurse specialists offer level 3 training to HV teams between 4-6 times annually. Named Nurse for LAC offers ad hoc training to other divisions and teams throughout the year e.g. Sexual health services and Urgent care/ Accident and Emergency teams

A Level 4 training day facilitated by the Designated Professionals took place in May 2019. This was aimed at doctors and nurses undertaking initial and review health assessments.

All LAC nurses have completed and had their LAC and safeguarding competencies signed off

LAC policy

A LAC policy for ESHT was written by the named nurse in post during 2019 and is available on the extranet

Complaints/ FFT/ Datix

A young person was unhappy that information she shared with the LAC nurse during an assessment was referenced in the care plan and information returned to her and the carer. The nurse has reflected on the conversation she had about consent with the

young person and how she will ensure in future that young people have a full understanding of consent to share.

Since the move from Meridian the LAC nurse team have received no FFT feedback despite continuing to encourage feedback from families. The team have engaged with the FFT team lead to understand how feedback can be obtained. They initially continued with paper, then a link was set up on the LAC Children In Care section of the community paediatrics website they have also enquired about use of SMS. They are now looking into use of a QR code, but may ultimately return to paper replies, whilst continuing to work with young people, children families and social workers to encourage feedback.

The predominant theme for Datix throughout 2019 relate to digital and Systmone IT failures that have on frequent occasions resulted in the loss of long reports and assessments with the associated loss of workforce time. Liaison with IT and Systmone is ongoing to try to resolve issues. All nurses have received new Smartcards, and a number have had laptops updated or renewed.

Learning from other areas

After attending a conference facilitated by Kent LAC services during which they shared how they had significantly improved their LAC performance the ESHT LAC service manager and named nurse made a site visit to the LAC nursing team in Kent. It became apparent that unlike East Sussex they continue to initiate the RHA requests from the local authority and use a highly sophisticated tracking process with one administration team at the front end of the process (from RHA request through to appointment/ contact, including requesting and collating of additional information from GP etc) and a second administration team managing the back end of the process. (RHA assessment through to report and care plan distribution). They have a very high administrator to nurse staffing ratio. The nurses hand write and scan initial notes to the child's record (part B of the Coram BAAF) and use dictation for reports that are then formatted by the administration staff.

Following this site visit the ESHT LAC team have set up a means of flagging IHA reports to secretaries as high priority and have dedicated LAC admin who track the progress of reports to distribution. The nurse team administrators send out information requests on behalf of the nurses. The nurses are trialling scanning in hand written notes to the child's record and are planning to start using 'Bighand' voice recognition dictation once it is available for use.

Conclusion

Meeting Statutory timescales for IHAs and RHAs remains a challenge but with the improvements that have been achieved this has been removed from the ESHT Women and Children's divisional risk register. Service improvement plans developed

by providers and agreed with the CCG have both highlighted and addressed many of these challenges, stakeholder meetings in each area across Sussex will be ongoing to support and challenge progress. The ESHT LAC team are committed to continue with and build on the improvements achieved throughout 2019. There will be specific focus on establishing SLA's, timeliness and completeness of IHA and RHA requests, medical staffing (with staffing changes on the horizon). Use of 'Bighand' dictation and the expansion of the Lansdowne SCH.

Covid-19 and LAC

In response to PH advice all face to face contacts have been replaced with telephone contacts. The LAC team are in the process of trialling 'Attend Anywhere' and IHA's with UASC that require an interpreter are being arranged by ESCC via Skype. Drs and nurses are working remotely from home using laptops and VPN. The nurse team with support from the business administrator have RAG rated the entire LAC caseload into low, medium or high risk and will use this to determine which assessments to prioritise if staffing capacity is reduced, and in agreement with the designated professionals and ESCC requirements for written consent have been relaxed during the pandemic. Letters offering contacts for support are being distributed to all foster carers and a portfolio of helpful information is being collected by the nurse team and shared with health visiting and community paediatric colleagues and the ESCC Foster carers training lead. As yet no Drs or nurses have been redeployed as LAC assessments remain a priority to continue.

Administration and secretarial staff have been temporarily relocated to non-patient accessing community sites and it has been a significant logistical challenge to get digital and phone networks set up, some of which are not yet complete. Whilst there has been no direct impact on IHA or RHA work in March it is anticipated that there will be some effect in April, however the team are working hard to mitigate against the temporary disruption. All staff are making use of Microsoft teams and phone contact to stay in touch and support each other and information regarding wellbeing is distributed by the service manager to members of the team.

Committee:	Corporate Parenting Panel
Date:	30 October 2020
Title of Report:	Looked After Children (LAC) Statistics
By:	Director of Children's Services
Purpose of Report:	To update the Panel on changes in the last quarter

Recommendations:

The Corporate Parenting Panel is recommended to comment on and note the report.

1. Background and supporting information

1.1 Services for Looked After Children (LAC) are predominantly funded from the Children's Services base budget with some additional smaller funding streams supporting specific activity for example Virtual School activity from the Pupil Premium Grant.

1.2 The data is drawn as a snapshot on the last day of the month and inevitably there will be some changes subsequently as data is cleansed, however the past quarter have seen an increase in numbers of children and on the last day of September there were 606 children in care, up from 586 in June after the figures were cleansed. It is still extremely busy with ongoing pressure on the Fostering Duty system to find placements as new children come in and existing children disrupt and need to be moved, often at short notice. The context of Covid-19 placed additional pressure on many households, including on our foster carers. Both internal and external placement options have been quite limited and, in particular, external fostering agency placements have been virtually non-existent which has mean that some of our children who would previously have been placed with agency foster carers have had to be placed within a residential setting. The number of internal East Sussex County Council (ESCC) foster carers now available for placements has again returned to normal levels, although there are never enough to meet the need.

1.3 A total of 365 children were in foster care at the end of September, with 82 of those children in agency placements, a reduction of 1 since the end of June. In addition, there are 64 young people in supported housing options, homes or hostels, a rise of 8. 23 children were placed for adoption. 7 children were placed with foster carers who are also approved adopters under the Fostering for Adoption pathway.

1.4 At the end of the quarter the number of children with kinship carers stood at 60.

1.5 The number of children placed at home with their parents whilst remaining subject to a legal order stands at 23. Planning for placements of this sort is always monitored rigorously in order to mitigate any risk factors and agreement to begin or end a placement with parents is given at a senior level, unless it is court mandated when realistically ESCC has no choice in the matter.

1.6 At the end of September 51 children were placed in agency residential care placements, up 11 over the quarter. Staff continue to make every effort to place children in our in-house beds before they seek agreement from a senior manager for an agency placement and robust negotiations on both quality and price are a feature of every external placement search.

1.7 At the end of September 3 ESCC children were secured at Lansdowne. 1 in the context of sexual exploitation, 1 having experienced both criminal and sexual exploitation and 1 having been transferred from Brodrick Road following a lengthy period of very violent and sexualised behaviour. There is also a

child placed in a secure home in Northumberland in the context of criminal exploitation, that being the only available bed after a lengthy search.

1.8 At the end of the quarter there were no remands to custody, the young man who has been in a young offender's institution for many months having been found guilty and sentenced.

1.9 Overall the numbers of Unaccompanied Asylum-Seeking (UASC) young people rose to 51 at the end of September, up 11 over the quarter.

1.10 The numbers of children subject to Child Arrangement/Residence Orders and Special Guardianship Orders have also remained stable at 337 and 453 respectively.

1.11 There was one complaint from a LAC in the last quarter which arrived in July. Child A aged 15 had been living at Brodrick Road and objected to the fact that her mother requested that she return home at the beginning of the pandemic. She found this stressful and wanted to be back at Brodrick Road or in another placement. Although legally ESCC could not have refused her mother's request, the complaint was partly upheld, and learning identified around how expectations of the young person could have been better managed. Child A did not return to Brodrick Road however, remaining with her mother until July with outreach support from the Brodrick team and oversight from the social work team and from senior managers. In July Child A moved to a foster placement where she remains.

2. Conclusion and recommendations

2.1 Pressure on the system continues, driven by complexity and costs for children.

2.2 There has been 1 complaint from a child in the last quarter which was fully investigated.

2.3 The Corporate Parenting Panel are recommended to comment on and note the report.

STUART GALLIMORE
Director of Children's Services

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Appendices
Appendix 1 – LAC Summary statistics between 01/10/19 – 30/09/20

Appendix 1

Children's Services LAC Summary between 01/10/2019 and 30/09/2020

Placement Type	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
A3 - Placed for adoption with consent (under section 19 of the 2002 Act) with current foster carer					1	1	1	1	1			
A4 - Placed for adoption with consent (under section 19 of the 2002 Act) not with current foster carer	4	4	2	2	2	2	2	2	2	2	2	2
A5 - Placed for adoption with placement order (under section 21 of the 2002 Act) with current foster carer	4	4	4	5	5	6	5	5	5	5	5	3
A6 - Placed for adoption with placement order (under section 21 of the 2002 Act) not with current foster carer	25	25	24	22	22	22	20	21	22	18	18	18
H5 - Residential accommodation	34	37	39	30	29	29	38	38	40	42	44	51
K1 - Secure unit	2	2	2	2	3	3	3	3	3	3	2	3
K2 - Homes and Hostels	54	57	58	60	59	56	58	56	56	60	62	64
P1 - Placed with own parents	21	20	21	24	24	20	18	18	17	17	23	23
P2 - Independent living	6	5	3	2	2	4	7	6	4	3	3	4
R2 - NHS/Health Trust	2	2	3	2	1	1	1	1	1	1	4	2
R5 - Young Offender Institution or prison		1	1	2	1	1	1	1	1	1	1	
S1 - All Residential schools								1	1	2	3	4
U1 - Foster placement with relative or friend- long term fostering	5	5	6	6	5	5	5	5	5	5	5	5
U3 - Foster placement with relative or friend- not long term or FFA	60	64	58	62	56	56	56	58	50	49	54	55
U4 - Placement with other foster carer- long term fostering	84	82	83	82	82	82	80	80	78	76	76	75
U5 - Placement with other foster carer who is also an approved adopter- FFA	3	5	5	8	6	5	5	5	6	7	7	7
U6 - Placement with other foster carer - not long term or FFA	290	290	284	284	293	292	292	291	294	291	288	290
Total	594	603	593	593	591	585	592	592	586	582	597	606

Immigration Status	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Asylum Seeker	3	4	4	3	2	2	2	1	1	1		
British Citizen	2	2	2	2	2	3	2	2	2	2	2	2
Discretionary Leave to Remain in the UK to 18 (DLR)	1	1	1	1	1	1	1	1	1	1	1	1
Exceptional Leave to Remain in the UK (ELR)	1	1	1	1	1	1	1	1				
Humanitarian Protection applied for under ECHR	1	1	1	1	1	1	1	1	1	1	1	1
Refugee Status	11	12	10	3	3	3	3	3	3	3	3	3
Unaccompanied Asylum Seeking Child	21	21	20	21	23	24	32	33	33	36	37	44

Legal Status	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Child Arrangements Order/ResidenceOrder S8(1)CA'89	333	333	335	335	335	336	336	336	337	337	337	337
Special Guardianship Order S14A CA 89	454	454	454	453	455	455	455	454	454	453	452	453