NHS
Dorset
Clinical Commissioning Group

Looked After Children & Care Leavers Annual Health CCG Report 2015-2016

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Supporting people in Dorset to lead healthier lives

Part One

1. Introduction

1.1 This Looked after Children (LAC) and Care Leavers Annual Health Report covers key activity for Dorset CCG, and performance activity provided by its health providers for the period from 1 April 2015 to 31 March 2016.

1.2 The purpose of the report is to inform the reader and give assurances that Dorset CCG are meeting their statutory responsibilities in commissioning services which are safe, effective, caring, responsive and well-lead in identifying and meeting the health needs of the Looked after Children and Care Leavers population of Dorset.

1.3 This report is also shared with the Corporate Parent Boards of the three local authorities across Dorset, involved in providing local authority services for the children they look after whose aspirations are to ensure the children receive the care and support they need in order to thrive. The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989 (2.) 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.

1.4 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. (Promoting the health and well-being of looked after Children DH, DH 2015. 1.)

1.5 Designated Nurse for Looked after Children (LAC) for the CCG remains an overarching statutory role and in response to service requirements this role has been increased to a 1 WTE from 0.6 WTE appointed in September 2014. The role continues to provide expert health advice and clinical leadership to the CCG local health providers and the local authorities by having a strategic overview of services to ensure robust clinical governance of NHS health services for LAC is in place. The Designated Doctor for LAC has recently retired**,** The Quality Directive are currently working with their provider of medical service for LAC to recruit a replacement interview date set for 8 June. PHFT have given assurance through sharing their cover arrangements to ensure service provision to LAC is not affected during this transition period.

2. National and Local Drivers for LAC

2.1 The NHS has a major role in ensuring the timely and effective delivery of health services to looked-after children. Key legislation includes; The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (3) the NHS Constitution for England (4.) and Safeguarding Vulnerable People in the Reformed NHS Accountability & Assurance Framework (5) 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.

2.2 The national and regional focus for LAC and care leavers has been identified as a main area for improvement for NHS England, NHS Wessex during 2016/17. Both the LSCB for Bournemouth and Poole and DSCB Dorset have also identified LAC and Care Leavers as a priority area to improve outcomes and reduce vulnerability.

2.3 The Queen's speech 26 May 2016 made a promise of a new Children and Social Work Bill: with an extension to the right to a Personal Adviser, someone who will make sure care leavers receive the support they need as they transition into adulthood, to all who want one up to the age of 25 currently its 21 years. This will have an impact on specialist health provision in place to support the health needs of Care Leavers.

2.4 The Children's Commissioner for England has published the "Lightning Review" (May 2016. 7.) In response to Health Committee House of Commons inquiry into Mental Health support for young people. This inquiry identified Current Mental health provision is not meeting the complex mental health needs of this vulnerable group. LAC and Care Leavers are reported as being five times more likely to attempt suicide than their peers, more likely to enter the criminal justice system, 23% of adult prisoners have been in care. The Pan Dorset C&YP Emotional Well-being and Mental Health Strategy recognises the complexity and increase need for specialist dedicated support for LAC as a vulnerable group who have experienced trauma, abuse and or neglect.

2.5 The Justice Lowell Goddard ten year inquiry commenced in July 2015, the focus is to identify how organisations fulfil their responsibilities to protect children. This will include how LAC and Care Leavers have been protected during their journey through the care system including a focus on how their psychological well-being and mental health has been supported and met. Interim reports as the inquiry proceed with the final report being published in 2025.

2.6 The Rotherham, Birmingham Child Exploitation Inquires and the 'Seville NHS Inquiry@ published in March 2015 has helped informed national consultations resulting in a new definition of Child Sexual Exploitation (CSE) and guidance for professionals working with vulnerable young people. This new approach is

raising professional curiosity to look beyond challenging behaviours presented by LAC when they go missing and ask the question to what's behind the behaviour, causing them to go missing increasing their vulnerability of CSE.

2.7 From February to August 2016 CQC inspection of Child Sexual Exploitation and children missing from home, care or education. This forms part of the 'deep dive' joint targeted inspections seen in Dorset in February 2016. The judgement from the inspection stated clear safeguarding policies, good communication with partner agencies and substantial training for staff show that the local authority has taken a thorough approach to the risks of female genital mutilation and radicalisation. Early indication of data collected locally Pan Dorset for 2015/16 show's a significant number of children going missing are looked after.

2.8 From April 2016 CQC inspections of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities (SEND) (12) under section 20 of the Children's Act (1). The CCG Quality and RD&D leads have met and agreed a process to follow when the Chief Executive receives notification of an inspection. Given that two thirds of LAC is identified as having SEND status (14) there will be a focus on the effectiveness of service commissioned for meeting the health needs of this cohort within LAC.

3. Governance and Quality Assurance

3.1 Health providers commissioned by Dorset CCG to deliver services for LAC were reviewed and agreed contract variations were implemented in April 2015. These included revised activity and performance indicators and for the first time quality schedules. Sessions were completed with the leadership teams, to give guidance to how the schedules would provide the mechanism for monitoring performance to report back through the CCG review contract meetings.

3.2 There has been a clear LAC work plan within the Quality Directorate of the CCG, this has been maintained and reviewed monthly by the Designated Nurse with areas for action, time frames and outcomes reported to the Directors Performance Meeting monthly and Quality Group and the Governing Body Quarterly.

3.3 In Novembers 2015 the CCG received a Care Quality Commission (CQC) review of its commissioned services for Children Looked After and Safeguarding within the Dorset County Council Area only. The one week review commenced on Monday, 16 November and concluded with a feedback session on Friday, 20 November. Inspectors tracked and audited nine cases (four were LAC) and reviewed approximately 130 others. The inspectors followed the child's journey across services for Maternity, Health Visiting, CAMHS, ED, Sexual Health, MIU, Adult Mental health and Substance Misuse and four practices in Primary Care.

3.4 The review process was rigorous and findings presented a mixed picture of the provider's response to LAC. Areas of positive practice were identified in

General Practice, where Inspectors reported seeing some exemplary practice for LAC. There were areas of good practice and areas for improvement noted for the CCG, Dorset HealthCare and Dorset County Hospital. Inspector's identified a disconnect between the leadership and frontline staff and capacity within Dorset Health Care (DHC) provider for the nursing services delivered for LAC as an area of concern.

3.5 The inspectors also expressed concern regarding the on-going delays in completing Initial Health Assessments within the statutory time frame(20 working day from when the a child is accommodated) by the medical service for LAC Poole Hospital Foundation Trust (PHFT). The inspectors recognised that delay's in providing timely notification and consent by Dorset County Council was presenting health form proceeding with their responsibility to complete the health assessment.

3.6 The inspectors recognised the positive practice of the CCG with the provision of a dedicated Designated Nurse for LAC; they judged the role to be facilitating the development of an effective three way partnership between heath commissioners, social care and the health provider with the establishment of a robust performance management framework. However, it recommended that all agencies needed to take ownership and work together to effect real change.

3.7 The Final Report was received in January and an action plan developed and overseen by the Director of Quality. This has informed the CCG, health providers and DCC LAC and Care Leavers work plans for the 2016/17.

3.8 For 2015/16 Pan Dorset LAC health annual reports covering all three Local Authorities, have been produced by the nursing and medical advisors and presented to the Designated Nurse and Doctor to give an overview of population, performance of service and to inform evidence of good practice, key achievements, challenges and developments for 2016/17. These will inform the second part of this report reporting on the activity, performance and health outcomes for LAC and Care Leavers as they journey through the care system.

4. Joint Working with Local Authorities within Dorset

4.1 In Dorset there are three Local Authorities; Bournemouth Borough Council, Borough of Poole and Dorset County Council, the Designated Nurse has forged successful professional relationships with all strategic leads for Looked After Children, and sits on the Corporate Parenting Boards for each authority. This has resulted in partnership working on service planning, strategy, commissioning of Looked after Children and Care Leavers provision across the county.

4.2 The Designated Nurse also a member and attends LAC and Care Leavers strategic groups within the three local authorities, and the LSCB and DSCB taking the lead for Serious Case Reviews where the child has LAC status. This has helped to imbed health focus as part of the child's overall care plan and inform CCG commissioners of areas of good practice or need for

development. Health performance data is shared with all three local authorities.

Child Sexual Exploitation

4.3 National reviews and reports such as; the Independent Inquiry into Child Sexual Exploitation in Rotherham - Baroness Jay (August 2014 and the Oxford SRC Reports (March 2015) have all recognised that LAC are particularly vulnerable to falling victim to exploitation and feature as a cohort in significant numbers in these reports.

4.4 This has also been reflected locally with 25% of LAC being at risk of CSE; unlike in other areas Dorset has not uncovered large criminal gangs or groups operating to sexually exploit young people. The Dorset profile identifies individuals or pairs of perpetrators having targeted local children's homes in Bournemouth and Dorset.

4.5 Over the last six months the Pan Dorset CSE/Missing and Trafficked Subgroup has received CSE and Missing data reports from the three Local Authorities (LAs). These show that at the end of Quarter 4 a total of 340 children were considered to be at risk of CSE, and of those 84 (25%) were LAC. Where Children were reported as having gone missing from home the total number was reported as 314 and of these 137 (44%) were LAC.

	No. Of CSE	**No. of LAC**	**No. of Missing**	**No. of LAC**
Poole	51	10	75	21
Dorset	187	40	51	27
Bournemouth	102	34	188	89
Total=	**340**	**84**	**314**	**137**

4.6 Within the current LA reporting criteria it is not possible to identify how many of the 84 LAC have been assessed using the multiagency CSE Risk Assessment Tool as being at significant risk of CSE, or how many of these young people are currently receiving specific interventions to address this. The Designated Nurse for LAC now attends the Pan Dorset CSE/Missing and Trafficked Strategic Group it is anticipated with the right questions being posed to the multiagency group that data collected can be used to carry analysis to inform trends and impact for LAC during 2016/17.

4.7 The monitoring and tracking of LAC placed out of the county by their accommodating local authority, or LAC placed in Dorset by other local authorities has continued through the CCG Notification Process implemented in June 2015. This enables the Designated Nurse of behalf of the CCG to carry out and meet its statutory requirements to ensure that any changes in healthcare providers does not disrupt the objective of providing high quality, timely care for the child.

4.8 In February 2016 Dorset County Council received notification from OFSTED of a four week unannounced Joint Inspection of its Children's Services which commenced on the 22 February 2016 and concluded on the 17 March 2016.

The report was published on the 23 May 2016 stating that Services for LAC required Improvement.

4.9 The report acknowledged that there has been historic poor performance and low progress in improving the provision of initial and review health assessments for LAC. This means that children's health needs have not always been properly identified or progressed. An increase in resources since November 2015, combined with significant improvements to systems, has led to rapid yet very recent progress. For example, January 2016 figures for initial health assessments increased from 20% to 70% in quarter three of 2015 and, for review health assessments, from 50% in December 2015 to 78% in January 2016. This means that children looked after are receiving more timely health assessments to address their health needs.

4.10 Since the inspection performance has dropped again partnership working to monitor continues to remain a focus for the CCG to see the percentage increase and sustain improvement above 70% month on month with aspirations to move performance to between 90-100% quarter on quarter.

5. Key LAC CCG Developments 2015/16

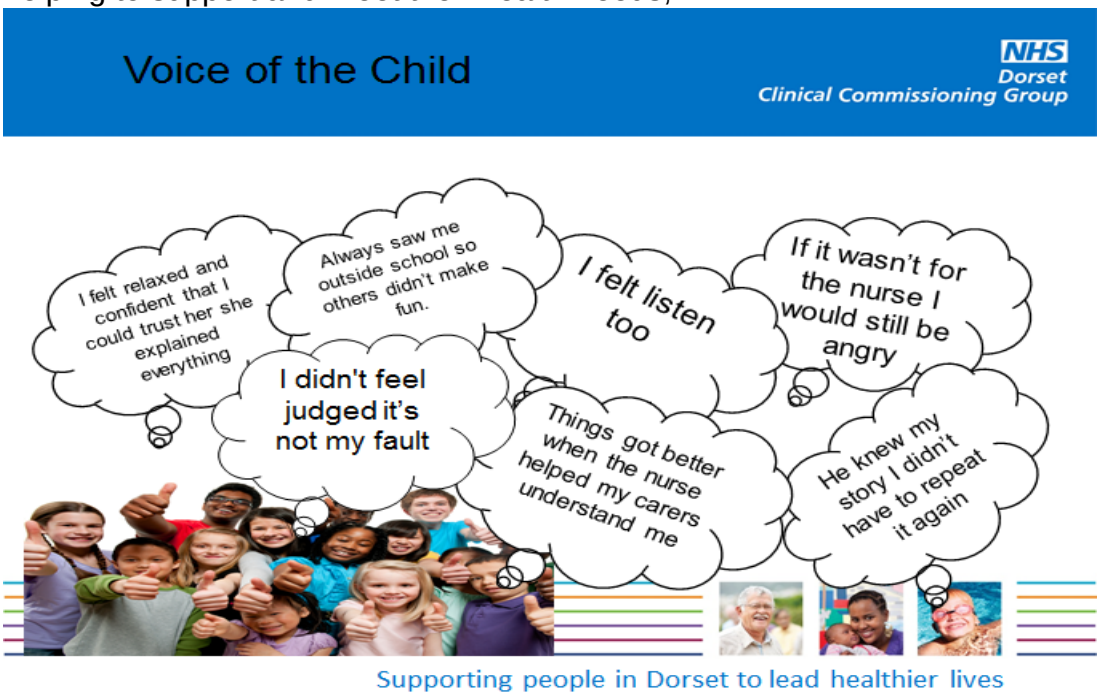
- **Mapping of current service and demand required to meet the health needs of LAC population across Dorset by Dorset Health Care.** A full review of services commissioned has been completed. The medical services provided by PHFT are within the recommended WTE caseload capacity to meet the demand for Initial Health Assessments, fostering and adoption requirements. The CCG have agreed further investment into the Specialist Nursing Service provided by DHC as current provision is significantly under the recommended guidance (11);

- **Medical Services have been decommissioned from Dorset County Hospital to form a Pan Dorset Service.** Following the review of medical service it was agreed for the whole service to be provided by PHFT, this is now fully imbedded offering a sustainable high quality medical service. Sessions are delivered at different locations across the count to provide equity of access for all LAC and their carers;

- **Reputational risk to Dorset CCG due to delays preventing commissioned Provider to medically assess all newly identified Looked after Children within the statutory 28 day timeframe.** Significant partnership work has been completed between the CCG, PHFT, DHC and DCC to progress this area of concern. Improvement was noted during the recent Joint Inspection for DCC, however performance has slipped again, and therefore this development area will remain a focus for 2016/17;

- **Voice of Looked after Children and Care Leavers**. The Designated Nurse completed six consultation events from January to March 2016 with young people in care and Care Leavers to seek their views of specialist health services available and/or delivered. Overall the feedback was very positive and a strong message came through that young people in care

and those now left value the specialist health provision commissioned in helping to support and meet their health needs;



- **CCG Notification System for LAC being placed outside their 'originating' CCG.** Development has continued over the last year in mapping and tracking LAC placed outside Dorset to monitor they are receiving health support without delay. Numbers of LAC placed in Dorset who have a right to receive specialist health provision continue to be tracked, current numbers stand at 309. It is anticipated this number is higher as residential independent homes and special schools are yet to be mapped this will be a focus for 2016/17 jointly with the three local authorities;

- **Serious Case Reviews.** The Designated Nurse now represents the CCG for LAC at the LSCB and DSCB Boards and sub groups and takes the lead for Serious Case Reviews (SCR) involving LAC. There is currently one SCR S23 under review due to be completed in November 2016;

- **Mental Capacity Act (MCA) for 16-18 years.** Joint work is being completed with the CCG Adult Safeguarding Lead and the Pan Dorset MCA Team DCC, to deliver bespoke training through four half day events. This is to cover all health professionals Pan Dorset working with the above age group including LAC on the specific implications of the MCA for young people transitioning to adult services;

- **Lead GP Peer Support Sessions.** The designated Nurse has joined the Safeguarding leads in delivering LAC awareness and question sessions for Lead GP's. This first session was delivered in April 2016 which was well attended and evaluation was positive. LAC will now feature as a regular topic area in future support sessions.

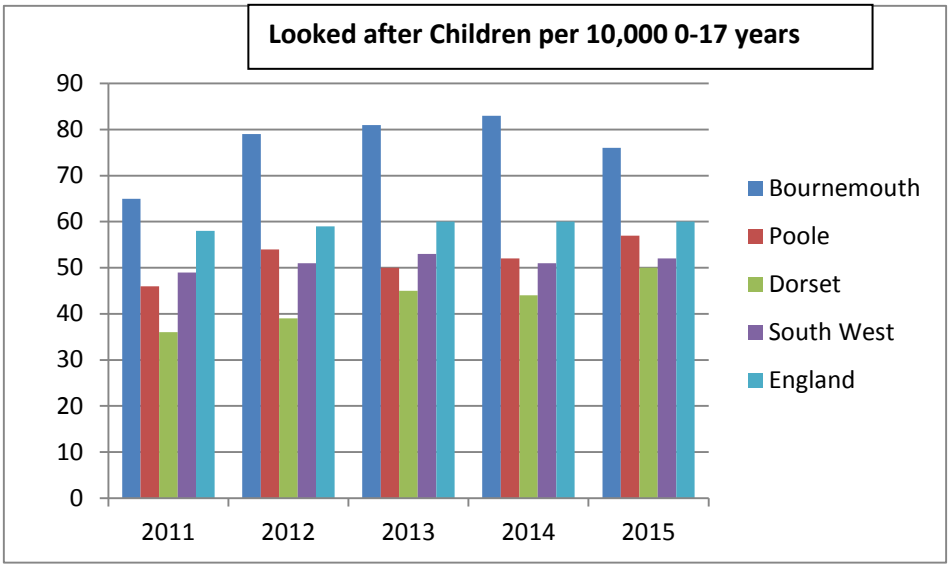
6. National and Local Profile of Looked After Children

6.1 The demographics for looked after children nationally are taken from the Statistical First Release (SFR) (6.) which provides information about looked after children in England for the year ending 31 March 2015. These figures are based on data from the SSDA903 return collected from each local authority. The 2016 data is not due to be released until September 2016.

6.2 Nationally there were 69,540 looked after children at 31 March 2015, an increase of 1% compared to 31 March 2014 and an increase of 6% compared to 31 March 2011. This compares to a 9% increase between 31 March 2014 and 31 March 2015 and a 47 % increase from 31 March 2011 and 31 March 2016 across Bournemouth, Dorset and Poole. Nationally the number of looked after children has increased steadily over the past seven years and is expected to continue, the same trend is visible across Dorset.

6.3 Nationally the rate of LAC per 10,000 is 60. For the same period year ending 31 March 2015, Bournemouth (76 per 10,000) despite a decrease in numbers from 2014 they remain above the national average by 26%.They have remained above the national average consistently since 2010. Poole (57 per 10,000) and Dorset (50 per 10,000) are below the national average and have been consistently since 2010.

Graph1. The Graph below compares the local, regional and national picture from 2010 to 31 March 2015



6.4 Between 1 April 2015 and the 31 March 2016 locally Dorset (West and East) has seen the largest increase in its numbers from 393 to 485 (23%). Poole have seen a slight increase from 177 to 179 (1%) and Bournemouth have seen a slight decrease from 276 to 261 (-5%) The national Statistics for 2016 will not be released until September 2016; however the overall national average Pan Dorset is unlikely to change.

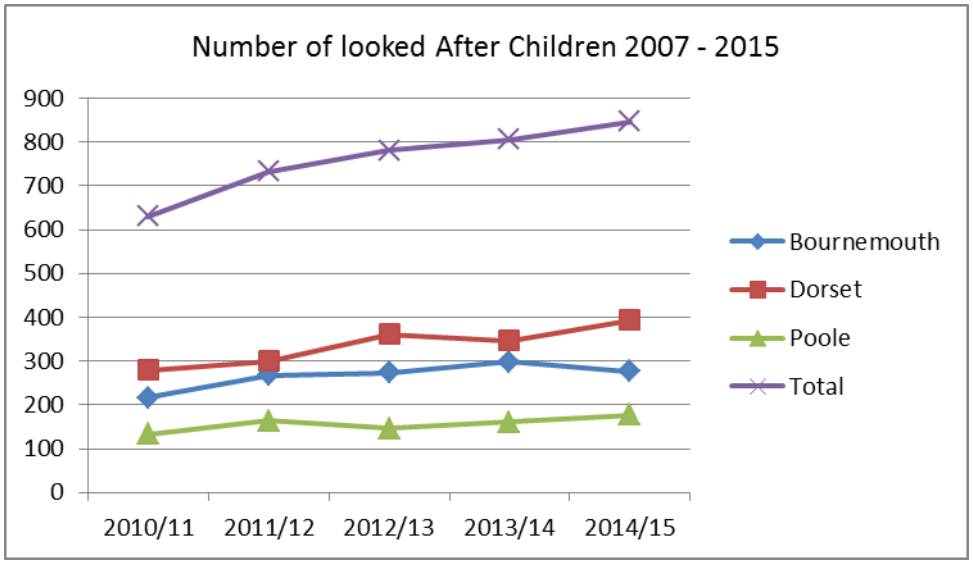
6.5 The table below sets out the local trend of increasing numbers of children being accommodated across Dorset.

Numbers of Looked After Children for Dorset

Year	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Bournemouth	204	217	268	274	298	276	261
Dorset West/East	275	280	300	361	347	393	485
Poole	119	133	164	146	161	177	179
TOTAL	598	630	732	781	806	846	926

6.6 In the last five years there has been an overall 47% rise Pan Dorset. With a 76% increase since the service was originally commissioned.

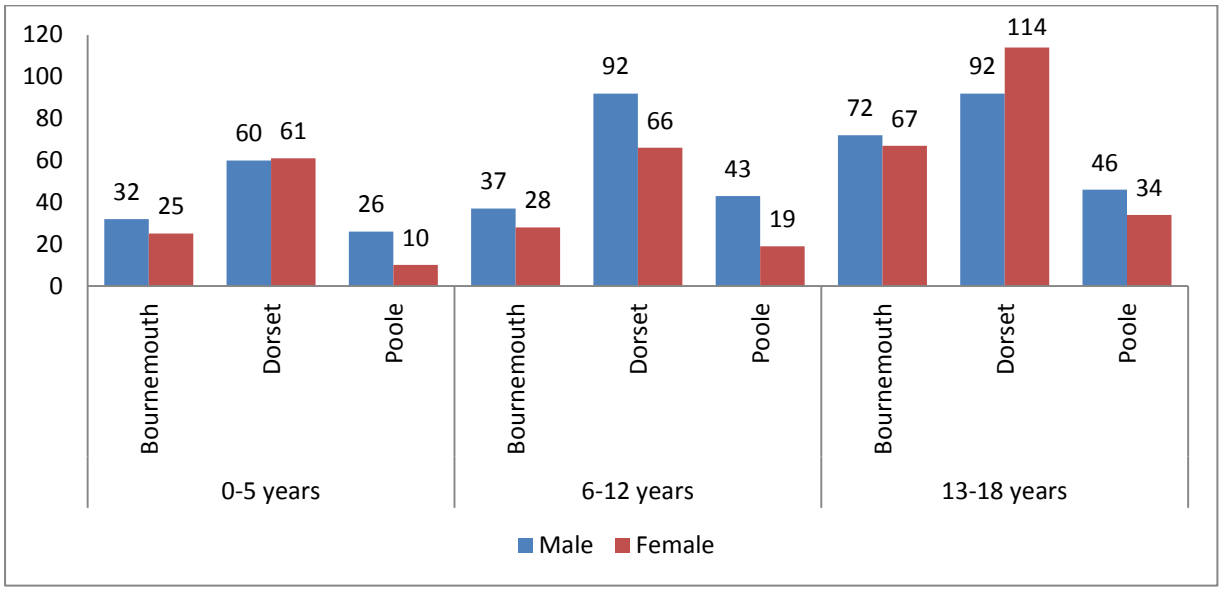
Graph 2 - Continuation of rising trends of Looked after Children accommodated Pan Dorset.



6.7 Bournemouth, Poole and Dorset local authorities are also net importers of children placed within their areas by other local authorities across England and Wales. As of 31 March 2015 an additional 309 children have been notified to the CCG as being placed within the county, the change in the statutory guidance in March 2015 also recommends the need for specialist health service to be provided to Care Leavers up to age of 21 years (357) and young people who have SEND status up to the age of 25 years (47) bringing the overall cohort of LAC in need of Specialist Looked After Health provision to 1,639. Additional analysis to understand this cohort more fully will be undertaken by the Designated Nurse during 2016/17.

6.8 The following statistics are for LAC accommodated by the three Local Authorities in Dorset per Specialist LAC Health Team.

Graph 3. Age and gender breakdown of looked After Children Pan Dorset



6.9 Nationally there are higher numbers of boys in care than girls, this is reflected locally. There has been an overall increase in both the number of girls and boys becoming looked after.There has been a 2% increase in the number of boys and an 18 % increase for girls.

6.10 In comparison to the year 2014/15, there has been a 22% increase in the 0-5 year age range becoming looked after. However this increase is only notable in Dorset reprsenting a101% increase in the under fives and a 20% increase for the under ones, with a decrease in both Bournemouth and Poole. The growth of 0-5 year olds coming in to care will have an impact on both health visiting services and the specialist LAC Nurses for Dorset.

6.11 For the 6-12 year age range there has been an overall increase of 11%, from 2014/15 with increases seen in numbers for Bournemouth and Dorset but a decrease in numbers by 3% in Poole. Dorset again shows the highest increase of 22% compared to 5% growth for Bournemouth.

6.12 For the 13-18 year age range there has been an overall increase of 2% from 2014/15. Poole has seen the highest increase of 16 % in this age range compared to a 2% decrease in Bournemouth and a 0.1% increase in Dorset. They make up 47% of the overal case load. The 13-18 year age group can present significant challenging behaviours, like the earlier age group they have often experienced years of physical and or emotional neglect, positive adult role models have been limited. They may have been the main carer for siblings and/ or parents, missing out on their own childhood. Due to their chaotic lifestyle, they may have experienced disengagement with education, history of sofa surfing prior to entering care, association with early alcohol and substance misuse, unhealthy relationships, inability to recognise risk and capacity to understand consequence makes them extremely vulnerable, especially to long term mental health problems and child sexual exploitation.

Ethnicity

6.13 The majority of children looked after at 31 March 2016 Pan Dorset and are from a White British background, the same proportion as the general population of all children across the county, which is in line with the national average for LAC. During 2015/16 eight unaccompanied asylum seekers, all were seen for an initial health assessment, seven required an interpreter. Processes are in place to seek advice for all children and young people with different ethnicity entering care to ensure their health needs are met with respect and understanding of any differing cultural or religious beliefs.

7. Commissioning Arrangements of health provision for Looked after Children in Dorset

7.1 Services for LAC Health are commissioned through Poole Hospital Foundation Trust (PHFT) and Dorset HealthCare (DHC).

7.2 Poole Hospital Foundation Trust (PHFT) delivers the medical services for Looked after Children. This consists of a Designated Doctor who works closely with the Designated Nurse in supporting the health agenda for LAC, and three Medical Advisors who together complete all Initial Health Assessments (IHAs) Pan Dorset. They also complete Adoption medicals for children and review and give advice on adult medicals for Adopters and Foster Carers; advising Panels monthly for Bournemouth, Poole and Dorset.

7.3 Dorset HealthCare (DHC) deliver direct nursing services to all children in care residing in Poole, Bournemouth and Dorset, by supporting the IHA process in terms of line managing the administration of the process, liaising with the appropriate local authorities, completing the statutory Review Health Assessments, 6mthly for children 0-5 years and annually for children 5-18 years, concluding in a Summary and Health recommendation plan to inform overall care planning. They deliver preventative and direct implementations to address identified health needs of this population, provide training to local authorities, health professionals, and foster carers and parents on the health needs of LAC. There joint commissioning arrangements in partnership working with the three local authorities across Dorset resulting in co-location of the nursing health teams within Children Social Care.

7.4 The CCG also commission 1.4WTE of dedicated child and adolescents mental health service (CAMHS) for Looked after Children, their carer’s and professionals.

Part Two

The Child's Journey through Care

8. Initial Health Assessments, Provider Key Performance Indicators and Quality Assurance

Children New into care

8.1 In the year April 2015 – March 2016 480 children became looked after in Bournemouth, Dorset and Poole. This is a 13 % increase from 426 children who became newly looked after in the previous 12 months. This increase in numbers conceals a 22% reduction in the number of children new into care in Bournemouth and a 45% increase in the number of children new into care in Dorset.

Children new into care 2014/15 and 2015/16

	Bournemouth	Dorset	Poole	Pan Dorset
2014-2015	150	189	87	426
2015-2016	117	273	90	480
% change	-22%	+45%	+ 3%	+13%

8.2 **Initial Health Assessments** Statutory Guidance requires that each child new into care should have an Initial Health Assessment (IHA), which must include a health plan that is available in time for the first statutory review by an Independent Reviewing Officer. The statutory time frame is 20 working days from when the child is accommodated. The performance indicator set has not been achieved, however clear rational to why this has not been possible is explained within the 8.4 to 8.9.

Timeliness of IHAs completed 2015-2106

	Bournemouth	Dorset	Poole	Pan Dorset
Children new into care	117	273	90	480
Initial Health Assessment Completed	98 (84%)	223 (82%)	65 (72%)	386 (80%)
IHA completed in 20 working days	91 (90%)	65 (28%)	50 (70%)	2007 (51%)

8.3 Half of children starting to be looked after in the three local authorities had their IHA completed in a timely manner. This is an improvement from 34% of children new into care in 2014/15. The improvement in Bournemouth timeliness can be attributed to a reduction in the number of children new into care and the appointment of a new administrator to the team. The Poole IHA

timeliness remains similar to last year, the reasons for the sub optimal performance are not clear, but may include changes to medical adviser and a wide variation in the number of children new into care each month (none too 16), which makes management of medical adviser time challenging.

8.4 In the year 2014/15 only 39 of Dorset IHAs were completed within the time frame. The number of Dorset children having an IHA in timely manner in the year 2015-2016 has increased to 66; however, because of the increase in the total number of children new into care the percentage has only increased from 20% to 28%.

8.5 Common reasons for delay in the previous year were late notification by Social Workers (SW), SWs not sending parental consent for health assessment and Foster Carers (FC) being unwilling to bring children to appointments in Poole and Bournemouth.

8.6 In the last 12 months the Designated Doctor and Designated Nurse for LAC have held monthly meetings with senior managers from Dorset Children's Social Care, highlighting and escalating concerns about delays in notification and sending consent, and the Designated Doctor has visited most of the Dorset Child Care Teams to make clear the SW's statutory responsibility. A full time administrator to the Dorset LAC Health team has been appointed who has sole responsibility for arranging IHAs; much of the improvement in performance is attributable to her diligence. From January an IHA Clinic has been held at Dorchester Children's Centre, this has been largely well received but attendance continues to be variable. This is an area for further analysis to understand more fully during 2016/17.

8.7 Non-attendance at IHA appointments continues to be a problem for Dorset LAC. A common reason for this is that the child/young person has changed placement or returned home. Dorset Children's Service is failing to notify partner agencies of change of placement or status. This are of concern to comply with Statutory Guidance has been raised with senior managers from Children's Social care.

8.8 Pan Dorset 480 children started to be looked after and 386 children had IHAs. 39 children left care before 20 working days and so did not have an IHA. In Bournemouth five LAC refused to have an IHA and were referred to the LAC Nurse for an early Review Health Assessment (RHA). It is not clear from the data available if the Poole and Dorset children who did not have an IHA were referred for early RHAs, as per local policy and is an area for improvement during 2016/17.

Quality Assurance

8.9 Statutory Guidance requires that the IHA must be completed by a registered medical practitioner, and should include assessment of: the child's physical, emotional and mental health, the child's health history and his development, and include existing arrangements for routine checks, screening, and immunisation.

8.10 It is imperative that Health Assessments are of good quality and are seen as useful by children and young people and by Foster Carers, as well as professionals.

8.11 Every IHA completed in Bournemouth, Poole and Dorset and any completed out of area are sent to the Designated Doctor for a brief check before being saved for quality assurance. 10% of IHAs completed in each of the three Local Authorities between April 2015 and March 2016 were quality assured against Department for Health standards as identified in the table below.

Quality of IHAS 2015/16

	Bournemouth	Dorset	Poole	Pan Dorset
IHAs reviewed	14	25	9	48
Type written assessment and plan	14 (100%)	25 (100%)	9 (100%)	48 (100%)
Height and Weight	13 (92%)	23 (92%)	8 (100%) NB one child in plaster so not weighed	46 (96%)
BMI (if over 2 yrs.)	0	14 (82%)	2 (29%)	16 (62%)
Vision and hearing screening	14 (100%)	22 (88%)	9 (100%)	45 (94%)
Record of Dental screening enquiry (over 3 yrs.)	14 (100%)	22 (88%)	9 (100%)	45 (94%)
Record of Heath History Enquiry and family Health History	14 (100%)	22 (88%)	9 (100%)	45 (94%)
Record of Immunisation enquiry	14 (100%)	22 (88%)	9 (100%)	45 (94%)
Developmental Assessment	14 (100%)	22 (88%)	9 (100%)	45 (94%)
Emotional behavioural Assessment	14 (100%)	22 (88%)	9 (100%)	45 (94%)
Scored SDQ available at IHA appointment	0	0	1	1(2%)
Record of enquiry into life style issues (if age appropriate)	2 (100%)	4 (100%)	3(60%)	9 (82%)

8.12 The quality of the IHAs assessed was generally good. Three Dorset IHAs were of poor quality, essential information was not recorded and no summary or plan was available. These three IHAs had been completed by a Locum Consultant working in the department. As soon as the poor quality had been identified alternative arrangements were made.

8.13 The quality review identified that medical advisers did not always calculate and record the BMI. This finding has been shared with advisers in supervision and the paperwork has been amended to include a prompt to calculate BMI. For only 11 IHAs reviewed was it age appropriate to request information about lifestyle issues, however, there was no record of lifestyle issues for two of these.

8.14 Although the IHA is based on a standard proforma, there are opportunities for free text to record young people's own thoughts and feelings about the process and the situation they find themselves in. Regular Care Quality Commission inspections were introduced in 2009. These state that health assessments should be holistic and health promoting as well as diagnosing health and developmental problems. A theme that has emerged from inspections is the importance of the voice of the child and their contribution to the process. Evidence of the child's voice is an indicator set within the CCG/PHFT Quality Schedule. A recent Service Review of the IHA process carried out has identified that the "voice of the child" was often not recorded. The findings of this service Review have been shared locally and regionally, and medical advisers have been reminded of the importance of documenting how the child or young person presents none verbally and what actually said.

8.15 The scored Strengths and Difficulties (SDQ) was only available in one of the assessments reviewed. Consideration is needed as to whether the IHA appointment is an appropriate time for the first SDQ to be reviewed, as it is clear that reviewing the scored SDQ at the IHA is not achievable. Further development is needed to be able to assess LAC emotional well-being on entry to care; this will be taken forward with CAMHS colleagues during 2016/17.

8.16 Vision and hearing screening was always available for Bournemouth and Poole IHAs, included in the health visitor (HV) information provided or in school health records. This information was often not available for Dorset IHAs because HV information is rarely provided and school health records never available. For children living in Poole, Bournemouth and East Dorset the medical adviser is able to access Poole Hospital Electronic Patient Record (EPR) to inform the IHA. The medical advisers do not have access to Dorset Count EPR so for children in the west of the county less information is available. This is an area for development by the new Designated Doctor when in post.

8.17 The IHAs identified a wide range of health problems, including missed screening (dental, vision and hearing), incomplete immunisation, developmental delay, physical health problems (obesity, risk of blood borne virus infection) and emotional health problems (sleep, feeding, anxious behaviour). Where heath history and family health history was not available

recommendation was made for the social worker to request this from birth parents and hospital of birth. Referrals were made to a variety of health professionals to ensure that previously unmet health needs were addressed. These referrals were identified within the Health Plan with clear time frames for outcomes. This informs and enables the specialist nursing teams to take forward any outstanding health needs and follow up on outcomes of referrals.

8.18 Where emotional health problems are identified, usual practice is to request that the specialist nurse scores the SDQs and makes contact with the carer or young person to carry out a review. The specialist nurse is able to refer to the clinical psychologist within the LAC team, for further assessment if required.

8.19 The completed IHA is sent to the SW, the Independent Reviewing Officer (IRO) GP, care and Young Person and is stored in the child's LAC health record. It is the responsibility of the local authority that each LAC has an up to date health plan as part of the IHA process and to take action if recommendations identified in the health plan are not being followed. The IRO should, at each LAC Review, note any actions and updates to ensure that the health plan continues to meet the child's needs.

8.20 It is difficult to know if the completed IHAs are being used to inform care planning. Personal experience of medical advisers is that actions for the medical adviser or specialist nurse are completed; however, recommendations for the SW to undertake (such as requesting family health and birth history) are often not completed. In discussion with social workers, it seems that social workers do not recognise the importance of family health history and antenatal and birth history to all Looked after Children. The importance of this area has been explained to senior managers and to social workers who attended the team meetings attended by the Designated Doctor. This was also a recommendation to DCC following the CQC Inspection for LAC. Joint work with all three local authorities and IRO's to evidence health plans are being implemented and used to inform the C&YP overall care planning.

8.21 A process was agreed to be put in place for 2015/16, that at each RHA the recommendations from the previous IHA or RHA would be reviewed; if completed the date of completion and outcome would be documented. If not completed the person responsible for that recommendation should be contacted and if still appropriate the recommendation should be transferred to the recommendations of the current RHA. Unfortunately due to capacity resource the specialist nurses have not put this into practice and there is no measure of outcome from the IHA.

8.22 When a child is under the care of a Paediatrician at Poole Hospital or Dorset County Hospital a copy of the completed IHA is sent to that Paediatrician to be held in the hospital record. Feedback from Paediatricians at both hospitals has been very positive.

IHA Venue

8.23 In the year 2014/15, feedback from SWs and Foster Carers made clear that for some families from West Dorset, it was not acceptable to travel to

Bournemouth and Poole for IHA appointments. Considerable work has been done to identify a venue in Dorchester suitable for medical consultations. From January 2016, three IHA clinics per month are held at Dorchester Children's Centre.

8.24 For some children with complex medical and learning needs attending a clinic for the IHA is not appropriate. Three children were seen by Medical Advisers for their IHA in their special school. This flexibility was appreciated by parents and is viewed as an example of good practice in meeting individual children's health needs.

Asylum Seekers

8.25 In the year 2015/16 eight asylum seekers were seen for IHAs (Four from Dorset and two from each of Bournemouth and Poole), seven were seen with an interpreter. The LAC health team administrators have been reminded that a translator is always available, and that it is the responsibility of the Social Worker to arrange and fund this. In previous years the number of asylum seekers seen has not been recorded.

9. Carer feedback

9.1 Anonymous feedback is sought from Foster carers following every IHA appointment, 123 unspoiled forms were completed. Feedback is largely very positive, there were comments about the distance to travel to appointments, but hopefully these were for assessments completed before January.

Overall view of service	Good	97
	Very Good	26
FC felt that the doctor listened to and respected their views	Yes Definitely	114
	Yes to some extent	7

9.2 Written feedback: *Listened and advised well, very caring and made things easy to understand, very thorough, good with teenagers, easy to talk to, listened, communicated with young person, detailed assessment, good toys.*

10. Young People Feedback

10.1 Child friendly feedback forms were given to all school age children, some needed help from their carer to complete. One hundred and one (101) unspoilt forms were completed. Apart from comments about the venue and lack of cake) the feedback was very positive. A common theme is that the young people appreciate the opportunity to be listened to and to take some responsibility for their own health.

Score 10 being the highest 0 being the lowest	10 (out of 10)	9 out of 10	8 out of 10	Less than 5 out of 10
Did the Doctor explain things clearly?	73	21	7	0

Did you feel listened to and respected:	68	31	0	2

10.2 Written feedback: *Went well and I feel things are getting sorted, she listened to me I don't usually get listened to, everything was clearly explained, we spoke about my health, my worries and my family, it was fun, the doctor was smiley, I like the lego.*

10.3 The IHA is a statutory assessment, however if it can be a positive experience for young people it may encourage them to engage better with the LAC nurse and health professionals in the future. Older young people are of an age where they need to start taking responsibility for their own health, their health history and their family. The IHA is an important first step in recording the information available and seeking out further information.

11. Out of Area IHAs

11.1 For Children placed away from Dorset IHAs are requested to be undertaken in the area where the child is placed, and Dorset medical advisers are asked to complete IHAs for children from other areas placed in Dorset. In the year 2014/15 many children placed Out of Area (OOA) did not have an IHA, and those that were completed were not completed in a timely manner. In the year 2015/16 an administrator to manage the OOA (IHAS) has been appointed, a process identified and contracts agreed. The process has run smoothly, however, it has become clear that some CCGs do not have processes or medical advisers to complete IHAs requested by Dorset.

IHA'S requested by other CCGs and completed in Dorset

IHAs requested	IHAs done	Completed in 20 working days
12 (4 children moved before IHA completed)	8	0

11.2 At the time of all requests the 20 working day target had already past. Two IHAs were completed for Kent CCG and we received an e-mail of appreciation for the prompt service and the high quality of the assessment. PHFT have been paid for completing these IHAs for other CCGs.

IHAS requested Bournemouth, Dorset and Poole.

IHAs requested	IHAs done	Completed in 20 working days
36	**23**	**0**

11.3 Twenty-six (26) of the 36 Out of Area IHAs requested were for Dorset LAC. Because of the increase in children new in to care in Dorset, it has not been possible to identify local placements, so children are placed out of area.

11.4 Thirteen (13) IHAs still have not been completed, two children were moved to live abroad, five children subsequently returned to live in Dorset so that the IHA was completed locally, and two young people were remanded to prison and the prison medical staff completed the assessment. One young person refused to attend, so arrangements were made for the LAC nurse to complete an early RHA. One young person is placed in a mental health facility; repeated requests have been made for medical staff in the unit to complete the IHA, but with no result. Some CCGs report that they are unable to complete IHAs for Dorset and details of these CCGs have been passed on to the Designated Nurse for LAC at Dorset CCG.

12. Fostering

12.1 Each prospective foster carer has a comprehensive health assessment completed by their GP; the medical adviser reviews the assessment and provides a type written report, including advice on the implication of any health problem on their ability to parent an adopted child. During April 2015 and March 2016 286 fostering assessment were reviewed. If required additional information can be requested from the GP or hospital specialist. In the year 2015/16 286 medical advice was provided for Adult Health Assessment. Commonly presenting health issues include obesity, mental health diagnoses and previous malignancy.

13. Review Health Assessments, Provider Key Performance Indicators and Quality Assurance

13.1 *Promoting the Health and Wellbeing of Looked after* Children (DfE March 2015) statutory guidance states that 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.

13.2 The review of the child's health plan occurs 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 Independent Reviewing Officer (IRO) have a role to play in monitoring the implementation of the health plan, as part of the child's wider care plan.

13.3 The statutory guidance highlights that health assessments should never be an isolated event and that they need to be a continuous cycle of assessment, planning, intervention and review. Prior to completing a review health assessment the LACHT ensures where practicable to receive information to inform the assessment – the relevant social worker is contacted for information on up to date changes or outstanding health issues. SystmOne records are available to access immunisation history, health history and GP history where GP surgeries use SystmOne. A system of seeking information from GP surgeries with different patient record systems and Child and Adolescent Mental Health Services is currently under development as highlighted by the CQC inspection team.

13.4 Timely completion of Review Health Assessments (RHAs), immunisation and dental screening rates are used as indicators for the health of Looked after Children nationally and locally. Dorset Healthcare is accountable to, and reports to, Dorset Clinical Commissioning Group (CCG) and each of the local authorities' who have accommodated them.

13.5 The agreed key performance target for the completion of Review Health assessments is 90%. The tables below for 2015/16 shows there has been variance in achievement of this target across the County. This key performance target has not been achieved Pan-Dorset (83%). This is reported as being attributed to changes in staffing over the year including maternity leave, staff sickness and staff vacancies, late returns of RHAs completed out of area. In comparison to 2014/15 the total completion rate Pan Dorset has decreased marginally from 83.5%.

Key Performance Indicators for 2015 -2016

LAC KPI's2015/16	Target	Bournemouth Total	Poole Total	Dorset Total	Pan Dorset Total
RHA	90%	81%	87%	65%	83%
Immunisations	85%	81%	92%	64%	78%
Dental Checks	80%	81%	91%	64%	76%

13.6 Exception reporting alongside the RHA KPI data is provided by the LACHT to provide a rationale if a health assessment is not completed in the month that it is due, for example if the health assessment has been refused by a young person or a review has been returned late by a health visitor. The gathering of this data has not been consistent in 2015/16 with a number of exceptions not recorded, however this data will become more robust and the process simplified with the introduction of SystmOne in 2016/17.

Immunisations

13.7 The agreed key performance target for the completion for immunisations is 85%. As can be seen from the table above for 2015/16 there has been variance in achievement of this target across the County, the key performance target for Pan Dorset LAC has not been achieved (78%). In comparison to 2014/15 the total % completion rate for children up to date with immunisations Pan Dorset has decreased from 85.8 %. Rational given by DHC for this 7.8% reduction may be linked to prior history before becoming looked after and difficulties with gaining consent. Late RHA return from Health Visitors and out of area LAC Health teams also impacts on accurate reporting for immunisation status. In addition to this there has also been the introduction of additional vaccines, influenza in 2014 for four-year old children, and

Meningococcal B and Meningococcal ACWY (for year 10 and year 13 students) in 2015.

13.8 There is an established pathway for ensuring that consent is obtained from the person with Parental Responsibility (PR). However, there are occasions when consent is declined making it impossible to complete the immunisation programme for some children in care. This is particularly relevant for children in care under Section 20 (Voluntary Care). When the young person reaches 16 years and is Fraser Competent if they wish to proceed with their missing immunisations then this is arranged with their GP.

13.9 In Bournemouth and Poole the LAC health team liaises with school nursing teams to ensure LAC receive their school aged vaccinations each year. The LAC nurses ensure the consent forms for the influenza, school leavers' booster, meningitis booster and HPV immunisations are forwarded to the school nurses in readiness for the vaccination sessions delivered by school nurses. This has improved the uptake of school based immunisations for LAC and is a process that is being replicated in Dorset.

Dental

13.10 Oral health remains an area of neglect for children coming into care. The 16-17 year old age range is a particularly challenging group to encourage attendance of dental check-ups. The agreed key performance target for LAC having a dental review is 80% has not been achieved Pan–Dorset (76%). In comparison to 2014/15 the total % completion rate for children up to date with dental review Pan- Dorset has decreased from 87.0 % to 76%.

13.11 The provision of dental care is generally good across the Pan–Dorset area, with referral pathways into the community dental service. The data relating to the specific issue of registration with a dentist and attendance is not available for this report due to the previous manual recording of the data. The Trust will progress this through SystmOne reporting in 2016/17.

14. Out Of Area (OOA) RHAs

14.1 Children and young people who are cared for out of Bournemouth, Poole and Dorset continue to be some of the most complex and challenging young people in care. Many are placed within specialist residential units or residential educational settings with a smaller number placed with independent fostering agencies.

14.2 The placement of LAC outside of the county continues to present challenges in meeting health needs. The specialist nurses liaise closely with other health providers to ensure that children's health needs are identified and met. To ensure the continuity of care and the provision of high quality, are equitable with the assessments provided in county, the specialist nurse's travel to children placed within 60 miles of the originating authority.

14.3 Where this is not possible, a Service Level Agreement (SLA) for Out of Area (OOA) health assessments is in place and working well to arrange completion by out of area health providers, often specialist LAC nurses from other teams is in place.

14.4 The review health assessments completed by out of area providers are quality reviewed by the LAC Specialist Nurse using the Quality Benchmarking tool (Dorset CCG 2015, BAAF appendix H) as agreed with the CCG. There is minimal data relating to the quality assurance of Review Health Assessments provided by out of area providers for 2015/16. This is recognised by the Trust and will be in place going forward for 2016/17.

14.5 In the year 2015/16 there was a total of 174 children placed out of area. This is broken down for each area in table 4 below.

Total number of children and young people placed out of the local Authority area at March 2016

	Bournemouth	Dorset	Poole	Total
Number placed OOA 2015/2016	17	124	33	174
Number placed OOA 2014/2015	47	81	23	151

14.6 In comparison to 2014/15 Bournemouth has seen a decrease of 63% of children and young people placed out of area, whilst Dorset has seen an increase of 53% and Poole an increase of 43 %.

15. Children from Other Local Authorities placed in Bournemouth, Dorset or Poole

15.1 The health team have continued to complete Review Health Assessments for children placed in the area by other local authorities.

Requests completed from other areas for Review Health Assessments

	Bournemouth	Dorset	Poole	Total
Number completed 2015/2016	30	13	17	60
Number completed 2014/2015	27	No data available	9	36

15.2 The data from Bournemouth and Poole both indicate an increase in the number of Review Health Assessments completed for children placed in county by

other areas in 2015/16; this indicates an 11% increase in Bournemouth and an 89% increase in Poole. Where there is no data available for comparison for Dorset this will be provided going forward.

16. LAC health team activity

16.1 This data was not reported in the annual reports submitted for 2014/15. Currently Dorset HealthCare is in discussion with Dorset Clinical Commissioning Group to set agreed activity targets. The activity recorded for 2015/16 is summarised below for Pan-Dorset and includes initial contact with a child, young person and/or carer, follow up work with a child, young person and/or carer including group work and non-face to face contact such as a telephone call.

Total Pan-Dorset activity 2015/16

Type of contact	**2015/2016**
New contact face to face	305
Follow up contact face to face	2,430
Non face to face contact	4,047

17. The Number of LAC with an Educational Health Care Plan due to SEND

17.1 Around 70% of looked after children have some form of Special Educational Needs and Disabilities (SEND). This requires a substantial level of co-ordination of the care, health and education needs of children. The Care Plan sets out how to meet the care needs of the child, addressing all important dimensions of a child's developmental needs. These include health, education, emotional and behavioural development, identity, family and social relationships, social presentation and self-care skills. The Care Plan will specifically include a Personal Education Plan (PEP) and a Health Plan.

Number of LAC with a Special Educational Need or Disability

	Bournemouth	**Dorset**	**Poole**
Number 2016	50	70	13
Number 2015	43	No data available	15

17.2 In total at 31 March 2015 there were 133 children and young people in care with SEND across the county. This is broken down into 50 children and young people in Bournemouth, 70 in Dorset and 13 in Poole. For Bournemouth this represents an increase of 16 % and for Poole a decrease of 13%.

17.3 Data relating to the identification of LAC with SEND due to respite needs or for safeguarding needs is only available for Poole and Dorset. Of the 13 Poole

children, three are LAC due to respite reasons, eight for safeguarding reasons and six are section (20) (Children's Act 1989/2004) due to complex needs. Of the 70 Dorset children 15 are LAC for short breaks and 55 are LAC for other reasons.

17.4 Going forward into 2016/2017 this data will be available for the county.

17.5 The specialist nurses liaise closely with the nursing teams attached to specialist provision for this group of children. There is a co-ordinated approach to support the child's health needs whilst recognising the expertise of the in house health team.

17.6 The data relating to the use of different communication methods with this group of children and young people is not available for 2015/16 due to the previous manual recording; however this will be progressed in 2016/17 with the implementation of SystmOne.

17.7 The nurses are part of the Dorset Disability Nursing network. This group meets quarterly to discuss good practice and share skills and knowledge and has proven to be an effective arena for raising the profile of disabled children and young people in care.

17.8 The Designated Nurse aims to scope the criteria used by each local authority and health provider to ensure consistency Pan Dorset in reporting numbers for 2016/17.

18. Meeting the health needs of children and young people looked after

18.1 The information gathered at review health assessments identifies if on-going or further health needs exist, with the specialist health nurse holding a duty of care to that child/young person, this includes making necessary referrals for investigation and treatment if needed. The information gathered also provides a plan to address these health needs which is integrated with any other assessment and plans such as the child/young person's education or care plan.

18.2 The health care plan may identify that referrals need to be made the Specialist LAC Nurses are able to carry out support visits and identify the need to refer on to the most appropriate service, so that the child or young person has access to the right intervention, at the right time, by the right person.

18.3 In communication with other services the issuing of the health plan to relevant agencies and carers clearly denotes responsibility for the completion of health actions and recommendations. Over the past year the LAC Health Team has communicated with the Independent Reviewing Officers and Social Care Teams to ensure that the health plan is reviewed and monitored more effectively. This has raised the profile of the health plan but continues to be a challenge particularly with the regular turnover of social care staff. The implementation of actions identified on the health plan along with need to

quality assures review health assessments remains areas for development during 2016/17.

19. Quality Assurance

19.1 One hundred per cent (100%) of children and young people who are looked after are registered with a GP in Bournemouth, Dorset and Poole. If a child or young person is not registered with a GP actions would be taken to address this.

19.2 The Equality and Diversity policy is adhered to, to ensure that discrimination is avoided and services are equitable. Translation services and interpreters are used as necessary; however there is limited data on the use of translators which can be reported on. Bournemouth are reporting the use of one translator for an IHA and Poole are reporting four young people requiring a translator for an IHA. Dorset is not reporting any data for this for 2015/16. This area will be taken forward via SystmOne recording for 2016/17 reporting.

19.3 The LAC Nurses treat each C&YP person as an individual. Prior to each Review Health Assessment they make contact with the Childcare Social Worker and the Foster Carer to build a picture of the child and identify any areas on which to focus or to avoid thus ensuring the assessment is tailored to the child or young person. For school aged children, all visits are arranged out of school time or in the school holidays to prevent valuable education time being lost and the interaction between the child and carer can also be assessed. The young person is given the choice of who he or she wants to be seen with. In many cases children and young people are happy to have their carer present for the second part of the assessment. Should a young person not want to be seen in placement an alternative venue can be arranged.

19.4 Dorset HealthCare aims to complete all Review Health Assessments within the statutory timescale. Timely completion ensures that Health Care Plans are circulated that they form part of the child/young person's wider care plan and that referrals to other health services are actioned.

19.5 Practice example:

Health Visitor Review Health Assessments were not being returned on time therefore delaying the completion of potentially important health plan actions. This was reported via the Ulysses system and the LAC Health team across Dorset reviewed the processes in place to ensure that RHA's were sent out to Health Visitors with sufficient time for completion and return to the LACHT.

19.6 Contact with the C&YP named social worker is made prior to the health assessment to discuss the capacity of the child or young person. At the time of the review health assessment, this is discussed and explained appropriately with the child/young person allowing them to give their informed consent to the nurse that they understand the purpose of the health assessment and where the information they are giving will be shared.

19.7 A separate consent form has been adopted for young people over 16 years of age and for those who have been assessed as having capacity to consent. The young person signs to indicate that they understand the need for the health assessment and with whom the summary and recommendations will be shared. They have the option to delete or add people to this list. The signed consent is then held within the young person's health record. Bournemouth and Dorset are currently unable to report on this data for 16-18 year olds due to past manual recording, however Poole is reporting one young person who refused consent for the RHA.

19.8 From a recent review of 18 completed quality assurance tools (Dorset CCG 2015) for Dorset RHAs, seven were over 16 years of age and had given signed consent. 11 children were under the age of 16 and it was deemed not appropriate to seek their consent. With the implementation of SystmOne, it is the intention to continue using the forms which will be scanned on to the child's record using an appropriate naming convention as well as via SystmOne reporting. This process of seeking consent will also be monitored within the benchmarking tool (Dorset CCG 2015) at peer review of records, quarterly audit and through reporting systems in SystmOne.

20. Diet and Obesity within the Looked after population of Dorset

20.1 This continues to be a challenging area due to the complexity of the emotional and behavioural context of eating. Discussions about food, mealtimes and links with emotional wellbeing are an integral part of all RHAs, and also discussed opportunistically and on a one to one basis if a concern is identified.

20.2 Carers are encouraged to provide healthy meals and act as positive role models. However, children may not have been used to a healthy varied diet or family meal routines, so information and support is provided to enable carers to adopt strategies to help the child or young person to enjoy healthy food and meal routines.

20.3 Weight, height and Body Mass Index (BMI) and BMI centile are completed for every child and young person (unless they decline) at their IHA and each RHA. In the year 2015/16, for Bournemouth 32 children over the age of five were identified as having a BMI over the 91st centile and for Poole 12. The data is not available for Dorset; however this will be available through SystmOne recording and reporting during 2016/17.

20.4 Training for carers on awareness of eating difficulties in LAC is provided individually and through the carer's forum. This training has been supported by a clinical psychologist, nurse specialist and dietician. Prevention work with children and young people is completed individually during their RHA, and followed up if required.

21. Reducing Sexually Transmitted Diseases and Teenage Pregnancy within the Looked after population of Dorset

21.1 Dorset HealthCare's sexual health team is well established across the county with both drop in/advisory centres and sexual health workers that all young people in care can access or be referred to. The LACHT have made 15 referrals to sexual health services.

21.2 The protection of children and young people in care who are identified as being at risk of child sexual exploitation (CSE) is central to the role of the nurses within the LACHT. Individual support can be provided by the nurses, and where appropriate, referrals can be made to sexual health services, safeguarding and other statutory agencies. Data regarding the number of children highlighted as at risk of CSE and who have had a CSE risk assessment by LAC Nurses in 2015/16 is not reported due to the manual recording of this information. Recording and reporting of this will be progressed in 2016/17 by the use of SystmOne. The Specialist Nurses and Team Nurse do however continue to work with multi-agency colleagues and police in an attempt to protect LAC identified at risk of CSE.

21.3 Practice example:

The LACHT nurse recognised that a situation with a young person was escalating and responded accordingly. The nurse completed a CSE matrix for a young person who had caused concern at an assessment. Despite the fact that other members of the team did not share the concern a multi-agency meeting was convened and the level of risk identified and jointly acted upon.

21.4 It is not possible to definitively report the number of conceptions amongst young people in care because many access confidential support through sexual health services. They may actively choose not to discuss this with the health team, Social Worker or their carers. If young people do disclose early pregnancy the nurses will work jointly with their social worker (if consent given) to ensure the young person is supported to be able to make an informed choice whether to continue with the pregnancy.

22. Substance Misuse including Alcohol and Smoking within the Looked after population of Dorset.

22.1 No data has been submitted to the Designated Nurse for this area and therefore the quality indicator has not been achieved. Rational reported f or not meeting this indicator is due to the manual recording of this information. Recording and reporting of this will be progressed in 2016/17 by the use of SystmOne.

23. Referrals to other support provision with Dorset

23.1 It is known that although looked after children share the same health risks and problems as their peers the extent is aggravated due to experiences of

poverty, abuse and neglect (RCN RCGP, RCPCH 2015). Two thirds of this population group have been found to have at least one physical complaint, such as eye or sight problems, bedwetting, co-ordination difficulties and speech and language problems. In the year 2015/16 a total number of 139 referrals were made to additional health services.

23.2 Any referrals need to be relevant and timely. The lives of children and young people in care are often very busy with arrangements for contacts with family members and meetings, involving multiple numbers of professionals. If a 'home based' intervention can be offered, this has often proven more acceptable by children and young people and is profitable in outcomes in meeting the health needs of children and young people in care.

23.3 In comparing numbers of referrals made to other services, there has been a reduction from 172 in 2014/15 Pan Dorset to 139 Pan Dorset in 2015/16 which represents a drop of 19%.The referral pattern for 2015/2016 indicates a decrease in all referrals except for referrals to Health visiting, School nursing, Steps to Wellbeing and Sexual health services which have increased.

Health referrals from Specialist Nurses to other Community Health Services

Speech and Language Therapy	**11**
CAMHS	**10**
Enuresis	**2**
Substance Misuse Services	**1**
School Nursing	**3**
Community Dentist	**4**
Sexual health services	**15**
LAC Clinical Psychologist	**26**
GP	**28**
Community Paediatrician	**8**
Physio	**1**
Orthoptist	**5**
Learning dis services	**3**
Adult services Social Care	**1**
Steps 2 Wellbeing (IAPT)	**1**
Health Visitors (non RHA)	**20**
Total	**139**

24. Mental Health/Emotional Well-being within the Looked after population of Dorset

24.1 The Future in Mind (DOH and NHSE 2015) document highlights that 50% of lifetime mental illness, excluding dementia starts by age 14 and 75% of lifetime mental illness excluding dementia starts by the age of 18 years. It is known that nationally one in ten children and young people need support or treatment for mental health problems, which may impact in lower educational attainment, are strongly associated with risky behaviours and disengagement with support services.

24.2 Looked after children show significantly higher rates of mental health disorder than others, 45% rising to 72% for those in residential care, compared to 10% of the general population aged 5-15. Conduct disorders are the most prevalent, with others having emotional disorders (anxiety and depression), or hyperactivity, 11% are reported to be on the autistic spectrum, with many others having developmental problems.

24.3 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.

24.4 Practice Example:

The LAC nurse has offered on going emotional support to a young person who had appeared to be 'fine' through their time living in foster care. This young person had not exhibited any obvious difficulties in placement, education or socially. However, they had disclosed some difficult emotions to the LAC nurse during their visits. As the young person has got older it has become evident that they do have significant emotional difficulties and self-harming behaviours which had not been disclosed to any other agency. Through close support in clinical supervision with the psychology team the LAC nurse has continued to support this young person. They have also consented for the LAC nurse to share some information with their Social care support which has helped considerably with the overall understanding of this young person and their needs. The LAC nurse feels strongly that this young person's emotional difficulties and self-harming behaviours would have remained 'hidden' if there had not been the intervention and support from the LACHT.

24.5 The LAC Health Team places an emphasis on developing resilience, self-esteem developing positive friendships and social skills for this group of children and young people. The team recognises the importance of emotional health and well-being and the impact of poor emotional health on developmental and long term outcomes.

24.6 In the year 2015/16 there were 37 (26.6 %) referrals made to emotional health and wellbeing services including psychology and Steps to Well-Being. This compares to 39 referrals made in 2014/15 (22.6 %). Fostering and adoption psychology referrals remain the same number for 2015/16. However the percentage difference in 2014/15 and 2015/16 in psychology referrals indicates a 3.5% increase in 2015/16. This may reflect the need to access emotional health and wellbeing services that are not Child and Adolescent Mental Health Services. (CAMHS).

24.7 The Bournemouth LAC team have provided specific input regarding emotional health and wellbeing to 12 children and young people in 2015/16. This data is not available from Poole or Dorset, however every contact with a child or young person would take into account their emotional health and wellbeing needs and how to build resilience and self-esteem through intervention by the Nurses. Therefore 100% of C&YP seen for a Review Health Assessment have input. It is key that going forward in 2016/17 that the LAC nurses receive specific learning and development on emotional health and wellbeing, including attachment and evidence based interventions for this population group. This need was recognised as an area of focus within the CCG Transformation Plan 2015.

24.8 The LAC Nurses encourage attending Brownies, Cubs, dance and other groups to enhance children and young people's social skills, self-identity and to deliver health promotion activities.

24.9 Where specialist CAMHS work is not appropriate, the health team continues to facilitate support for children through their carers by coordinating support from the dedicated psychologist placed within the fostering and adoption teams and/or through the pastoral support at school. The LACHT has also offered direct advice and support to carers.

24.10 Practice Examples:

Continuing to be co-located has given the LACHT the opportunity to be supportive and to have an influence within the social care setting. The LACHT works collaboratively with social care colleagues to address children's emotional difficulties which result in challenging behaviours. For example, a young person in a long term placement 'ran off' following a disagreement with their carer. On return to the placement the carer, possibly as a result of both frustration and worry, adopted quite a behavioural and punitive response. The LAC nurse discussed the incident with the worker and thought about alternative responses which may have been more useful.

The LAC nurse has on occasions brought social care colleagues into discussions with the psychologist team during clinical supervision. An example of this has been to consider the approach to telling a child about a highly significant family health issue. These discussions were helpful in both support for the worker involved but also in thinking about how best to support the child and their carers through what may be potentially an emotionally distressing and challenging time.

24.11 Strength and Difficulty (Goodman 1999) questionnaires (SDQs) a brief behavioural screening questionnaire for 4-17 year olds, are distributed 1-2 months prior to the Review Health Assessment to schools, carers and the child/young person to enable triangulation to be completed and discussed at the time of the RHA. Bournemouth, and Poole are able to report on how many teacher, carer or young person SDQs have been completed and scored for the year 2015/16. Bournemouth reports a total of 156 received however there is no breakdown or analysis linked to these results. Poole reports a total of 118 received at 31 January 2016 the breakdown are as follows: carers 48, teachers 46 and young person 24. Again there is no analysis of the results available. Dorset figures are not available. This will be addressed as the Trust delivers the service in 2016/17.

24.12 The CCG have recognised and acknowledged the challenges DHC have faced due to insufficient capacity to meet performance from 2014/15 and into 2015/16 for the LAC and care leaver population across Dorset. In response the CCG have made further investment to increase the workforce profile of the LAC nursing health teams.

24.13 There is evidence that minimum contract standards are being met in Bournemouth and Poole and this is certainly reinforced through the voice of C&YP, carers and Children Social Care Colleagues. DHC acknowledge there is less evidence provided for the Dorset health teams. There is a clear action plan in place in response to previous CCG concerns raised and the findings and recommendation made following the CQC inspection for LAC in November 2015.

24.14 DHC has agreed that the Designated Nurse for LAC will receive quarterly performance reports in line with the Key Performance Indicators and Quality Schedule for 2016/17. This will support monitoring to inform Quality Assurance of service delivery to LAC and Care Leavers, going forward. The Designated Nurse will carry out provider visits in supporting improve practice during 2016/17.

25. The Child, Young Person and Carers Voice

25.1 There has been an increased emphasis on the voice of the child within the Review Health Assessment. Health Care Plan Recommendations are written for the child and focus on their strengths, achievements and what they are

doing well - for example looking after their teeth and eating healthily resulting in no further fillings. Potentially embarrassing subjects such as sexual health are dealt with sensitively and young people may be signposted to other professionals.

25.2 Young people and their carers are consulted through pre-assessment health questionnaires. Post assessment evaluation questionnaires are also sent to the young people and their carers and the responses are collated and acted upon.

25.3 There are pictorial questionnaires that are available for young people with learning disabilities where appropriate. These are audited on receipt and evaluated, following up comments as required.

25.4 Questionnaires are provided for carers and children and young people to complete on a yearly basis after the review health assessment, these are reviewed regularly by the LACHT and acted upon. Some of the feedback is highlighted in speech bubbles below.

"The nurse was friendly and professional

"She was a very nice lady and took time to talk to me."

"Listening to the LAC and taking into account their views and worries. You have also clearly stated what you can and can't do."

Nurse is very patient and good at gaining the child's trust."

"I enjoy seeing my nurse as she is very nice and also understanding. She also listens to what I have to say."

"Explaining things to children."

"Good initial contact to arrange mutually convenient time. LAC Nurse was very good with our young foster child – very patient! He doesn't like the constant stream of SW, visitors. He hid initially from her but gradually came out of hiding and began to trust her – Great! Lovely lady."

25.5 A development for the future has been the discussion of using 'survey monkey' to develop an online survey to improve usability, increase completion rate and use digital methods of information gathering.

25.6 The Specialist and Team Nurses attend their respective youth clubs, Poole Young People's Group, Total Respect Group in Bournemouth and DorsetKidz to provide one to one support, listen to the stories of children and young people or join the young people for tea.

26. Destination of Children leaving care within the Looked after population of Dorset.18.1 Leaving Care

Children who return home

26.1 A copy of the completed IHA and any subsequent RHAs are sent to the child's GP on completion. This means that when a child returns home the GP holds a record of all assessments and recommendations, ensuring continuity of care.

Transition from adolescent to Adulthood

26.2 Transition from adolescent to adulthood is a challenging time for any young person. For Young People who have been care this if even more challenging. Self-identity plays an import role in building resilience and confidence to make the transition to independence. Unlike their peers LAC and Care Leavers have often had poor attachment and stability experiences, to support the gradual preparation towards independence. These poor experiences combined with the lack of security to being able to return home if things don't work out in are real factors to be considered for LAC.

26.3 Transition planning need to commence as early as possible in a young person's life, to build and process gradual change, confidence and independence. For young people in care with complex health needs (SEND) the CQC From the Pond into the Sea publication 2014, identifies only 50% of this group had received support from a lead professional during the transition process. To date health providers have not reported on processes in place and outcomes for this LAC. This needs to be a focus for 2016/17.

Care Leavers

26.4 Care leavers face complex psychological challenges. While most young people make a gradual transition to independence, supported by their family, care leavers often experience multiple, overlapping changes in their living circumstances all at once. In 2014, nationally only 5% of care leavers were still living with their previous foster carers under staying put arrangements (DoH, DfE 2013), the rest were in semi-independent accommodation, supported lodgings or living independently. There has been a significant drive with the national stay put agenda locally during 2015/16 with more Care Leavers reporting being able to continue living with their previous cares.

26.5 Previously the LAC Health Team were not commissioned to provide services for Care Leavers, however this is a key priority for DHC and the CCG for the forthcoming year 2016/17 within the increased funding**.** The LAC Health Team do produce a health chronology or health passport, "Me and my health" for care leavers. This passport includes information on birth history, family history, previous health history, health contacts and an up to date immunisation record. For the young people who left care on reaching 18 years in 2015/16, 64 were provided with a health passport, across Bournemouth, Poole and Dorset. The percentage completion rate of health passports per number of care leavers is not reportable for 2015/16 however this will be available in 2016/17 by the use of SystmOne reporting.

26.6 The LACHT nurses continue to be responsive to the needs of young people approaching leaving care status.

26.7 Practice example:

The LAC nurse has been instrumental in raising the profile of the need to rethink a proposed 'plan of care' for a young person. A young person's SW was leaving and it was identified that it would be beneficial for that young person to access the services of the Pathways team earlier than planned. The LAC nurse was instrumental in initiating discussions about a young person's early move to the Pathways team to ensure a continuity of support through an emotionally challenging period. This gives an example of the importance and uniqueness of the LAC nurse role within the multi-agency team.

26.8 For children who are to be adopted, adoption notifications are received from the Bournemouth Adoption Team. The Specialist Nurse ensures the new and original health visitors are informed as soon as the notification is received. The original health visitor is asked to make contact with the new HV and give a verbal handover. This ensures that the information is shared as soon as possible and that the new Health Visitor is mindful of the need to maintain confidentiality at this sensitive time. This process will be replicated across the team in conjunction with social care and health visiting services.

26.9 Children who are in adoptive placements continue to receive health input during this time. Bournemouth provided 13 Review Health Assessments for children in adoptive placements and in Poole 10 children have received some

form of health input. However this information cannot be reported accurately for Dorset due to the manual recording of this information. The reporting of this information will be progressed by Dorset HealthCare through 2016/17.

26.10 For children and young people who cease to be looked after, notifications are made to primary care regarding their health needs and plans when leaving care. This is a system that the LACHT are embedding across the county.

27. Adoption of Looked After Children in Dorset

27.1 Each of the three local authorities has a named adoption medical adviser from the medical service commissioned through PHFT. The medical advisers play a part at each step of the adoption process for both adults and children.

Adults

27.2 Each prospective adopter has a comprehensive health assessment completed by their GP, the medical adviser reviews the assessment and provides a type written report, including advice on the implication of any health problem on their ability to parent an adopted child. If required additional information can be requested from the GP or hospital specialist.

27.3 In the year 2015/16, 96 Adult Health Assessment reports were provided. Local Authorities are assessing more prospective adopters and this represents an increase in the number of Adult Health Assessment reports from 71 in 2014/15. Prospective Adopters attend a series of preparation workshops. One of the medical advisers speaks on the first day of each of these preparation workshops, presenting information about the health needs of children placed for adoption, child development and the impact of antenatal substance misuse. Feedback from the presentations given by the medical advisers is very positive.

27.4 On completion of the social work assessment each application to be approved as an adopter is considered by the adoption panel. It is a statutory requirement that each adoption panel has a named adoption medical adviser. The medical adviser comments on the adult health assessment and is able to answer questions on any questions relating to the adopters physical and mental health. The Independent Chairman of each panel has provided positive verbal feedback on the contribution of the medical Advisers to the working of the Adoption Panel.

Children

27.5 In England almost all adoption is of children in care. These children will already have had an IHA and sometimes an RHA. Each child for whom adoption is the plan is required to have an Adoption Medical Report. This is usually produced following an additional health assessment; the adoption medical. All adoption medicals are carried out by the medical advisers, who have available to them the previous IHA and RHAs, and also any additional health history and additional family health history. The Adoption Medical

Report forms part of the Child Permanence Report that is presented to the Agency Decision Maker and to Court.

27.6 Prior to matching with a new family all adopters are offered a consultation with the medical adviser to inform them of the child's health and family health history and any implications. The match is presented to the Adoption Panel, where the medical adviser will advise panel members on any medical issues for the adults or the child.

27.7 For some adopted children new health problems present after they are placed and subsequently adopted. In the year 2015/16 one of the medical advisers was asked to arrange genetic testing for the birth parents of a child adopted. It was found that the birth father had the same diagnosis as the child adopted, and that birth father has been referred to his GP for referral to the Genetics Service.

27.8 In the year 2015/16 81 adoption medicals have been completed in Bournemouth, Dorset and Poole.

Children Adopted 2015/16 and 2014/15

	Bournemouth	**Dorset**	**Poole**	**Pan Dorset**
Children Adopted 2015-2016	27	11	9	47
2014-2015	34	18	12	64
Age at adoption order				
Under 12 months	0	0	0	0
1-4 years	19 (70%)	8 (73%)	7 (78%)	34 (73%)
5-9 years	8 (30%)	3 (17%)	2 (12%)	11 (36%)

27.9 The number of looked after children placed for adoption in England, which rose from 2011 to 2014, has decreased by 15% in 2015 to 3,320 children adopted. This is consistent with the decrease in the number of looked after children with a placement order in place at 31 March which has dropped by 24% from 2014. The National Adoption Leadership Board has linked decreases in placement orders to the impact of two relevant court judgments, known as Re B and Re B-S (14).

27.10 If the information held in Adoption Medical is to be useful to the future parents, it needs to be comprehensive and legible. In the year 2015/16 all Adoption Medical Reports have been completed by medical advisers and type written, because the IHA is available to the medical adviser at the time of the adoption medical it should include a more complete record of the child's health history and family health history.

Health needs of children adopted 2015-2016

Health Risk	**Number of children affected**
Maternal mental health diagnosis (diagnoses include Emotionally unstable personality	**29 (74%)**

disorder, depression, anxiety, schizophrenia)	
Paternal mental health diagnosis (diagnoses include Bipolar Disorder, ASD, ADHD)	**13 (62%)**
Maternal physical health diagnosis (diagnoses include asthma, hay fever, squint, diabetes, hypertension)	**17 (44%)**
Paternal physical health diagnosis (diagnoses include asthma and hay fever, and one father had a rare genetic condition of skin and hair)	**6 (29%)**
One or both parents with a learning disability (IQ below 70)	**10 (21%)**
Antenatal drug exposure (drugs most frequently used include cannabis, heroin and cocaine)	**17 (36%)**

27.11 Eighteen (18) of the 47 children adopted had a physical health diagnosis, including Down syndrome, short stature, visual impairment, eczema and asthma; 20 of the 47 were recorded as presenting with emotional or behavioural difficulties, including anxious behaviours, sexualised behaviours and poor sleep behaviour.

Regional Adoption Agenda

27.12 New legislation requires local adoption agencies to combine to form Regional Adoption Agencies. Locally, Bournemouth, Dorset and Poole Adoption Agencies will be combining with Families for Children. The Designated Doctor for Looked after Children has attended early meetings, but it will be important that the current best practice of Adoption Medical Advisers continues.

28. Training offered by health providers to Looked After children their cares and professionals working with them

28.1 The Designated Doctor for LAC delivers four, one-hour teaching sessions on the subject of the Health of Looked after Children and Children adopted to medical students, paediatric trainees, and senior paediatric staff at Poole Hospital. Opportunities are available for medical students, trainees and senior staff to observe an adoption panel or a Looked after Children's Clinic. This is an area to review by the new Designated Doctor once in post for 2016/17.

28.2 The specialist nurses have delivered a package of training to Health Visitors (HV) to support them in their role of completing Review Health Assessments for children under five. This training has included a strong emphasis on safeguarding issues for children in care. 68 health visitors across the county have received this training package: 26 Bournemouth HVs; 27 Dorset HVs and 14 Poole HVs. The sessions have been well-attended and have given the attendees a deeper knowledge of how to complete a Review Health assessment for under five's including completion of a thorough summary and robust health plan. The LAC Nurses are also offering training to school nurses, student HVs, student paediatric nurses, foster carers and social care

colleagues to ensure that the profile of the team is raised and that a child's health issues are recognised as being crucial in their overall well-being and development. This training will be continued during 2016/17.

28.3 The Specialist and Team Nurses are often invited to attend Fostering Forums e.g. to provide information on the role of the LAC Nursing Team; how to cope with a new placement and when to change the child's GP. In Bournemouth, the Specialist Nurse attends the Skills to Foster training on a regular basis. In this training session an overview of the service is provided which includes the LAC Health Team, IHA's, RHA's and further support and advice the nurses can give. This process will be replicated across Dorset and Poole in 2016/17.

28.4 Clarification supported by evaluation evidence is being sought by the Designated Nurse to ensure equitable delivery as to why children in care have additional complex health needs to those seen in their peer group who are not accommodated, and how cares and professionals can support LAC to meet these health needs.

29. Safeguarding the Looked after Children population of Dorset

29.1 Assurance has been given by PHFT and DHC that all healthcare staff who comes into contact with LAC children meets 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. Assurance can be given that the Designated Nurse and Doctor complies with level 5, all medical advisors and specialist nurses are compliant with level 4, Supporting Team Nurse, Health Visitor and School Nurses are compliant at level 3 and all Administrative staff compliant with level one.

29.2 All Medical Advisers for LAC and Adoption, Specialist Nurses and Team Nurses are trained to level 3 with the Designated Nurse and Doctor trained to level 5 Safeguarding Training. All Paediatricians have access to regular safeguarding supervision within the paediatric department at Poole Hospital NHS Foundation Trust, and the nurses through the DHC Safeguarding Service. The nurses also receive six-weekly clinical supervision from the CAMHS Clinical Psychologists for LAC.

29.3 Designated Leads, specialist nurses and medical Advisers have attended local, regional and national training on the Health of Looked after Children, including Child Sexual Exploitation, Neuroscience of abuse and neglect, Sexual Violence, Deliberate Self harm, Learning from Serious Case Reviews, MCA and Drug and Alcohol Awareness training.

29.4 Medical advisers and specialist nurses are able to identify any safeguarding concerns and action/escalate in line with the Pan Dorset Safeguarding Policy.

29.5 The specialist nursing teams are co-located within their area local authority; this enables them to escalate timely concerns within the multidisciplinary team. However, if for any reason they need to escalate outside this

arrangement, they access a named nurse through the DHC Safeguarding Service; to date this has not been necessary.

29.6 Specialist Nurses, medical advisors and other health professionals can seek advice from the Designated Nurse and or Doctor for LAC to discuss concerns to inform the decision making process. These are often areas in relation to C&YP being placed out of the county. There have been two occasions where the Named Nurse for Safeguarding at Poole Hospital has escalated concerns to the CCG Designated Nurse for LAC in response for guidance of frequent attendance of C&YP placed in Dorset by other local authorities attending Accident Emergency without carers being present.

30. Local Leadership and Governance of Looked after Children and Care Leavers Services

30.1 The Designated Nurse and Doctor for LAC maintain oversight of the health agenda for LAC and provide advice to the CCG, Local Authority and healthcare providers on service planning, strategy, commissioning and audit of quality standards including ensuring appropriate performance indicators are in place in relation to health services for LAC.

30.2 They achieve this by working in partnership with local service planners and commissioners to advocate on behalf of and ensure LAC benefit as appropriate from the implementation of wider health policies, to gain the best outcomes for the child/young person within available resources,

30.3 The Designated Nurse monitors performance of local health services for LAC and young people delivered by DHC and PHFT, reporting through the CCG contract mechanisms any areas of good practice and/or concerns, where performance is not being met in line with agreed contractual indicators.

30.4 The Designated Doctor acts as the medical lead for the medical service commissioned through PHFT. Newly appointed medical advisers have an induction period where they are provided with copies of statutory guidance, college guidance and the most recent annual report and observe two adoption panels and two or more IHA and Adoption Medical Clinics.

30.5 Each Medical Adviser has clinical supervision with the designated doctor; this has included the designated doctor observing the medical adviser in clinic or at adoption panel, sharing findings from quality review of IHAs and adoption medicals and attendance at regional meetings of medical advisers.

30.6 Medical Advisers are able to contact the Designated Doctor by telephone or e-mail for advice on any difficulties encountered. Difficulties are more usually with processes that clinical decisions and as the medical advisers become more experienced they require less support. The designated doctor checks each IHA and adoption medical when completed, identifying any areas which need to be amended.

30.7 The Designated Doctor takes the lead for collating and analysing activity and performance data provided by the medical advisors. This data is reported

monthly to the CCG and informs the CCG Contract Review mechanisms quarterly and annually through the PHFT LAC Annual Report in line with PHFT reporting and quality schedules.

30.8 DHC appointed an interim team leader in November 2015 to lead and oversee the developments needed to improve service delivery. The sharing of policies and procedures and consistent working practices are reported as becoming embedded across the county, with aim to ensure that the service is transparent and credible.

30.9 Governance arrangements for the team to ensure systems and processes are in place has been implemented:

- the LACHT is represented at the monthly Directors Reports Meetings chaired by the Locality Manager with Strategic Lead for Health Visiting and School Nursing, Pan Dorset. These meetings provide a clear framework for practice and monitoring of service delivery;

- the LACHT interim team leader attends the Joint Safeguarding Group meeting on a quarterly basis;

- the LACHT meets monthly to review practice. Links to direct reports meetings ensure robust communication to the team to highlight innovations across the organisation and expectations of the service. All team members now have direct access to Trust updates which encourages involvement in innovation and training;

- with the introduction of a dedicated SystmOne profile for Dorset LAC in addition to other changes, the team are ensuring that consistency, collaboration and best practice will continue to develop the approach to the health care of all the children and young people in care across Dorset;

- risks to safety and quality are reported through DHC internal systems;

- the LACHT team has a passion and commitment to the well-being of all LAC. This includes a drive to improve services and be responsive to the children and their carer's needs. Individual monthly clinical supervision and meetings with the interim team leader gives staff the opportunity to discuss any clinical issues, concerns or problems. In addition to this the interim team leader has supervision with the designated nurse working for the CCG;

- the team has a Business Continuity plan to ensure that the service is delivered during adverse incidents and events; this has been shared with the CCG.

30.10 The LACHT complete and are compliant with DHC Mandatory Training within the given timescales. This training includes; information governance, fire safety, infection control, basic life support and lifting and handling

31. Summary of Key Areas of Achievement by providers 2015/16

Providers:-

Poole Hospital Foundation Trust

31.1 Key Areas of Achievement for 2015/16:

- improved timeliness of completion of IHAs, from 34% in 2014/15 to 51% in 2015/16;
- almost all IHAs completed were of a very high standard;
- children in Bournemouth, Dorset and Poole have access to the same high standard of IHAs and Adoption Medicals;
- regular IHA clinics are held in Dorchester;
- processes are in place for Bournemouth, Dorset and Poole children placed out of area to have their IHA completed local to their placement, and for children placed from other local authorities in Bournemouth, Dorset and Poole to have their IHA completed by a medical adviser locally.

Dorset Health Care

31.2 Key Areas of Achievement for 2015/16:

Key Area for identified for development 2015/16	**Update**
Improve the timeliness of RHA completion to meet national target. Training will be provided for Health Visiting teams to improve understanding of the health needs of LAC and the importance of timely completion of RHAs. Reminders will be sent to HVs 2 weeks before the RHA is due, with a copy to the HV manager. Consideration will be given to LAC Nurses completing RHAs for children placed within 60 miles of Bournemouth.	**Training achieved, however completion of national KPI was not achieved.**
Improve the timeliness of IHA completion. The medical adviser will send a copy of the revised "Promoting the health and wellbeing of looked after children" to all social work teams and IROs. This revised guidance makes clear the responsibility of the Social Worker to notify the LACHT and send parental consent within 7 working days. SLA needs to be in place to ensure timely completion and return of Out of area IHAs	**Achieved.**
IHAs for children with disability will be arranged with the medical adviser and RHAs for children with disability will be arranged with the LAC nurses, unless the Social Worker requests otherwise	**Specialist nurses review children with disability.**

Introduce new pre RHA questionnaire for young people. This questionnaire was developed in collaboration with the Total Respect Group in Bournemouth.	**Achieved.**
Commence monthly meetings between specialist nurse and medical adviser to review outcomes from health assessment recommendations.	**Efficient liaison between medical advisors via email and telephone is reported.**
Carer, Teacher and Young Person SDQs to be sent in advance of IHA and all RHAs. Questionnaires and scores will then be available at time of assessment	**Achieved in Bournemouth and Poole. Commenced in Dorset in January 2016.**
Implement the use of the benchmarking tool (DCCG)for all RHA's, including RHAs completed in and out of area.	**Achieved.**
Establish regular meetings with IRO's and social work teams to ensure health needs are being monitored and met.	**Achieved. Bournemouth**
Develop and introduce a Health and Wellbeing Tool for use from 15 upwards which can be used at each RHA. We aim to ensure that by the time they leave care they will be able to access services, information, carry out simple first aid and keep themselves safe. This would be a more robust way of assessing their capability and feed into the Leaving Care Pathways Plan	**Not achieved – carried over to 2016/17.**
There is a need to develop the service to incorporate Care Leavers as this remain outside of the scope of the commissioned service. This is in line with Ofsted recommendation.	**Not achieved.**
Arrange meeting with CAMHS lead for LAC to discuss how information from CAMHS can be available for the IHA and how the health recommendations can inform CAMHS assessments.	**For further development to cover both IHA and RHA.**
Introduce into practice the recently developed Health Wheel and problem solving grid for young people.	**Not achieved but is used in Bournemouth when required.**
Introduce use of a written consent and consent to sharing information form for young people.	**Achieved.**
Introduce the use of a Neonatal Abstinance Syndrome (NAS) leaflet, produced by the specialist nurse, in collaboration with Bournemouth and Poole Hospital maternity leads	**Achieved.**
Pan Dorset LACHT to have access to and use SystmOne for enhanced information sharing and recording of RHAs.	**Achieved.**
DHC to undertake a skill mix review of the pan Dorset service to ensure the service is appropriately resourced across the county of Dorset.	**Achieved. Investment now agreed by CCG. Will form the key priority areas for 2016-2017**

32. Key Areas for Development for Providers 2016/17

Providers:-

Poole Hospital Foundation Trust

32.1 Key Areas for Development 2016/17:

- notification of children new into care and sending parental consent is still not embedded practice for Dorset Social Workers. The Designated Doctor and Nurse will need to continue to monitor this and raise concerns with senior staff from Dorset Children Social Care;

- increases in number of Dorset children new into care and the number of requests for adoption medicals for Dorset children have resulted in the medical adviser capacity being insufficient to keep up with demand, further analyses to map trend is required to ensure capacity sufficient;

- mapping of meetings to attend by the Designated Doctor and Designated Nurse for LAC;

- LAC nurses need to ensure that at each RHA the health plan from the previous IHA or RHA is reviewed, and the date of completion of all recommendations and outcome is recorded. This will enable some measurement of outcome from the IHAs and RHAs;

- medical advisers to provide a type written report for Social Workers, following the adoption medical, and for this report to be available for any subsequent meeting between the medical adviser and the prospective adopters. Designated Doctor to review in line with Regional Adoption Agenda and national guidance.

Dorset Health Care

Key Areas for Development 2016/17

32.2 DHC will provide a detailed implementation plan for 2016/17 however the key areas for development are as follows.

Service development

32.3 The development of the revised service model will be taken forward during 2016/17 underpinned by the financial investment from the CCG and will include:

- a service for care leavers;

- a focus on emotional health and well-being;

- an increase in the amount of whole time equivalent nursing staff that meets the core competencies, skills and knowledge in line with the Intercollegiate framework (RCN RCGP, RCPCH 2015);

- opportunities to develop the health promotion and prevention role of the nursing team;

- increased administrative support.

Emotional Health and Wellbeing

32.4 The emotional health and wellbeing of all LAC children and young people will be at the forefront of any developments proposed for 2016/17 within the LACHT. There is a national and local transformation programme underway (DoH 2015) which aims to increase accessibility to services and enable a child, young person or carer to receive the best evidence based intervention by the right service at the right time. With this in mind the LACHT will strengthen its links with emotional health and well-being services, specialist Child and Adolescent Mental Health Services and the LAC psychology team.

Participation

32.5 The LACHT will aim to maximise the opportunities of involving children, young people and carers in developing the service. There is already a plan to hold focus groups in Dorset, with children, young people and carers to develop a revised health information sheet about the service.

Performance and Quality

32.6 The implementation and enhancement of SystmOne will continue in to 2016/17 and a dashboard providing key performance information and activity data is currently under development.

32.5 There will be a drive to achieve the national targets set for KPI standards for completion of RHAs, immunisation and dental alongside the evidenced use of the quality assurance tool and reporting of agreed outcomes.

Part Three

33. Conclusion

33.1 Looked after Children and Care Leavers has never been more prominent. 2015 saw the revised statutory guidance for meeting the health of Looked after Children and Care Leavers. Key national government reviews and consultations recognition the increased vulnerability of this group for poor mental health outcomes, exposure to and victims of child sexual exploitation and long term poor health into adulthood.

33.2 The national and regional focus for LAC and Care Leavers has been identified as a main area for improvement for NHS England, NHS Wessex during 2016/17. Both the LSCB for Bournemouth and Poole and DSCB Dorset have also identified LAC and Care Leavers as a priority area to improve outcomes and reduce vulnerability.

33.3 2015/16 has been a challenging year for Looked after Children Services Pan Dorset, significant progress has been made in reviewing services commissioned with advice and recommendation going to the CCG Governing Body to ensure where ever possible they are and continue to meet their responsibilities in commissioning services for this vulnerable group.

33.4 The CQC Review of health services for Children Looked After and Safeguarding has reinforced the areas previously identified within the CCG work plan for development. The recommendation from the CQC review has helped focused areas of priority for health providers to take forward during 2016/17.

33.5 The Increased CCG investment in the LAC Nursing Service will support much needed development in workforce capacity to meet the increasing numbers of LAC, and new guidance for Care Leavers, Dorset LAC placed out of county and LAC placed in Dorset by other local authorities. Revised contract variations will be implemented to ensure outcome focus delivery of service delivery is implemented.

33.6 The provision of a dedicated Designated Nurse for LAC within the CCG will continue to facilitating the development of an effective three way partnership between heath commissioners, social care and the health provider with the establishment of a robust performance management framework.

34. Key areas for Development for the CCG Designated Nurse 2016/17

34.1 Complete recruitment of the new Designated Doctor for LAC, agree work plan for 2016/17.

34.2 Designated Nurse to review and update the CCG LAC work plan, reporting monthly to the Directors meeting and Quarterly to Quality group and governing Body.

34.3 Continue to build partnership joint working with the three local authorities in tracking trends and impact for Looked after children and Care Leavers.

34.4 Work with providers to ensure CQC recommendations are implemented and improved service delivery in meeting the needs of LAC & Care Leavers is sustained.

34.5 Continue to monitor health provider activity and performance in line with contractual arrangements.

34.6 Carry out provider visits to seek assurance that quality assurance of IHA's and RHA's is being completed.

34.7 Work with the three local authorities in mapping independent care homes and residential schools across Dorset to identify if unknown LAC placed by other local authorities are resident within the County but have not been notified to the LA's or CCG.

34.8 Take forward a focus with health providers to meet the physical, emotional-wellbeing and mental health needs for LAC transitioning to independence. Where transition to adult health provision is required joint working with the multidisciplinary team around the child will be paramount.

34.9 Repeat consultation events with C&YP and Care Leavers to gain their views and suggestions for health provision commissioned by Dorset CCG.

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