NHS
Dorset
Clinical Commissioning Group

NHS
Poole Hospital
NHS Foundation Trust

Looked After Children Annual Report

2018-2019

Dr Rachel Lachlan Designated Doctor for Looked after Children Dorset

2018-19 Annual report

Children New into care

In the year 1st April 2018 – 31st March 2019 346 children became looked after in Bournemouth, Dorset and Poole. This is very similar to the 347 children who became newly looked after in the previous 12 months. In Bournemouth and Poole there were increases in the number of children coming into care, whereas in Dorset the number continues to decline.

Children new into care 2016-19

	Bournemouth	Dorset	Poole	Pan Dorset
2016-2017	91	217	92	400
2017-2018	95	173	79	347
2018-2019	105	152	89	346
% change from 2017-18 to 2018-19	+ 10.5%	-12.1 %	+ 12.7%	-0.002%

The medical advisers who carry out the Initial Health Assessments (IHAs) for Looked After Children (LAC) are employed by Poole Hospital NHS Foundation Trust. Appointments are provided at Poole Hospital and also at the children's centre in Poundbury Dorchester, which reduces the travelling for children placed in west Dorset. The medical advisers work flexibly seeing children from all 3 Local authorities.

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 20 working days in time for the first statutory review by an Independent Reviewing Officer.

Timeliness of IHAs 2018-19

	Bournemouth	Dorset	Poole	Pan Dorset
Children new into care	105	152	89	346
Children requiring an IHA	93	137	77	307
IHA completed in 20 working days	54 (58.1%)	72 (52.6%)	36 (46.8%)	162 (52.8%)
IHA completed in 21-30 days	21 (22.6%)	27(19.7%)	19 (24.7%)	67 (21.8%)
IHA completed after 30 days	3 (3.8%)	0	6 (3.7%)	9 (3%)

2017-18	Bournemouth	Dorset	Poole	Pan Dorset
IHA completed in 20 working days	71 (91%)	91 (56.5%)	36 (46.8%)	211 (69.6%)

Reasons for delays:

Bournemouth:

In total 54 out of 93 (58%) IHAs required were completed within 20 days:

This means 39/93 (42%) were not completed in the timeframe required

21 (22.6%) were completed between 21 and 30 days

18 (19.4%) were completed after 31 days

All medicals required were completed, none are outstanding.

Reason for delay	Number
Delay in notification by the local authority	4
Delay in consent by local authority	9
Young person/child was not brought to appointment	2
Offered appointment declined by foster carer	3
Refusal to attend by young person	2
Child/young person placed out of area	10
No medical adviser appointment available	9

Poole:

In total 36 (47%) of 77 required IHAs were completed within 20 days;

41 /77 (53%) were not completed within the required time frame.

19 (24.7%) were completed between 21 and 30 days

10 (13%) were completed after 31 days

All medicals which were outstanding have now been completed

Reason for delay	Number
Delay in notification by local authority	8
Delay in consent by local authority	16
Young person/child was not brought to appointment	3
Offered appointment declined by foster carer	0
Refusal to attend by young person	1
Child/young person placed out of area	6
No medical adviser appointment available	7

Dorset:

In total 72 (52.6%) out of the 137 medicals required were completed in 20 days

This means 65/137 (47.4%) were not completed in the required time frame.

27 were completed between 21 and 30 days (19.7%)

20 were completed after 31 days (14.6%)

At 31.05.19, 3 medicals are still outstanding: 2 are out of area and have been chased, one young person did not attend the first appointment and this will be rebooked.

Reason for delay	**Number**
Delay in notification by local authority	6
Delay in consent by local authority	9
Young person/child was not brought to appointment	5
Offered appointment declined by foster carer	12
Refusal to attend by young person	2
Child/young person placed out of area	13
No medical adviser appointment available	3
Children inpatient in Hospital (NICU)	3

ANALYSIS:

REASONS FOR DELAY COMBINED FOR ALL 3 LOCAL AUTHORITIES

Reason for delay	Number
Delay in consent by local authority	34
Child/young person placed out of area	26
No medical adviser appointment available	19
Delay in notification by local authority	18
Offered appointment declined by foster carer	15
Young person/child was not brought to appointment	10
Refusal to attend by young person	5
Other	3

Notification and Consent delay:

In the last 12 months' delay in notification and sending consent remain the main reasons for delay in completion of IHAs. This has previously been the case in Dorset but has become more apparent in Bournemouth and Poole, possibly due to changes in staff and restructuring. Meetings have been held in Dorset with senior social work managers. There was initially some improvement but despite the ongoing meetings the completion rate has not improved overall. This has been escalated to the corporate parenting board and the chief executive of Dorset County Council and highlighted as an area of concern. Involvement of the corporate parenting board officer has also helped. The numbers of IHAs completed within 20 days in Bournemouth and Poole have fallen from the previous year.

In light of the concerns across all 3 local authorities, a clearer process was developed by the named nurse and designated doctor with clearer pathways for escalation. These are due to be implemented from 1st June 2019. This information was shared with senior managers from Bournemouth and Poole in February who have reviewed their processes for notification and obtaining consent. Since 1st April 2019 there have been 2 Local authorities- Bournemouth,

Christchurch and Poole (BCP) and Dorset council. The new processes have been sent to senior manager within both these authorities for dissemination to all staff.

This will continue to be reviewed during the next year and escalated to corporate parenting boards if no improvements are apparent. The formation of a new local authority combining Bournemouth, Poole and Christchurch may also have some effect on working practices.

Children placed out of area:

This has been highlighted by the CQC inspection and a new standard operating procedure has been developed to ensure escalation to the designated doctor when medicals are not happening in a timely way.

Appointments declined/ not attended:

These are highlighted to the local authority. As part of the new process appointments are not rebooked without the social worker taking requesting this and taking responsibility for the young person or child to attend. This happens more often in Dorset and the designated doctor meets with the fostering manager to discuss how foster carers can better understand the importance of attending the appointment. Currently all appointments are also copied to the fostering duty team so they can remind foster carers to attend.

Medical Adviser Availability

There have been several changes in medical staff resulting in reduced capacity whilst recruitment is undertaken. Following retirement in May 2018, a new doctor was appointed to start in September, however this was only short term until March 2019.

Delay in notification and consent put pressure on medical appointments. During the months of delay appointments can be unfilled, when these appointments are then booked they can put pressure on the following months. This results in appointments not being available for other young people to be seen within 20 working days. During the next 12 months the LAC medical team at Poole Hospital will be responsible for analysing the data of children requiring an IHA. This will better enable an ongoing analysis of the number of appointments available against the number of IHAs required and the effect of local authority delay on capacity.

A new LAC administrator was appointed in February 2019 and this has been an opportunity to review and make more efficient the collection and recording of data enabling timely accurate reporting to the CCG.

Quality

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 development
- Include existing arrangements for routine checks, screening, and immunisation.

Health Assessments should be of good quality in order for them to be seen as useful by children, young people, Foster Carers and social workers.

Medical Advisers should have regular supervision meetings with the Designated Doctor every 3 months. Team meetings are held regularly with peer review and discussion of any issues arising.

All IHAs are sent to the LAC administrator based in Poole Hospital. This enables them to be saved onto the electronic patient record at Poole Hospital. This means that if the child or young person presents to outpatients or the emergency department some background health information is available. It is also important for clinical governance that a record of all consultations is available. The reports are also easily accessible for the Designated Doctor to quality assure. A dip sample of 10% of IHAs completed in each of the three Local Authorities between April 2018 and March 2019 were quality assured using annexe H Quality Assurance Tool. This is done quarterly and information fed back to medical advisers. Separated children seeking asylum were quality assured separately using a tool more appropriate to their specific health needs.

Quality of IHAS 2018-2019

		Q1	**Q2**	**Q3**	**Q4**
1.	No. IHA Reviewed:	9	9	20	6
2.	IHA completed within statutory 20 working days of being taken into care	7 (78%)	5 (56%)	8 (40%)	4(67%)
3.	Consent obtained	9 (100%)	9 (100%)	20 (100%)	6 (100%)
4.	Where the young person is over 16 years has written consent been sought	0 (8 N/A)	0 (7 N/A)	4 (100%) (16 N/A)	1 (100%) 3 (N/A)
5.	A chronology of medical health history including risk factors	9(100%)	9(100%)	17(85%)	6 (100%)
6.	Evidence that child or young person's concern/comments have been sought and recorded	5 (100%) 4 N/A	7 (100%) 2 N/A	10 (63.5%) 4N/A	4 (80%) 1N/A
7.	Any outstanding health appointments recorded	5 (84%) *3-N/A*	5 (84%) *3-N/A*	14 (100%) 6 N/A	6 (100%)
8.	Record of immunisation summary	6 (100%) 3-N/A	8 (100%) 1-N/A	16 (100%) 4-N/A	6(100%)
9.	Family Health History	6 (67%)	5 (100%) 4- not available	16 (100%) 4- not available	2 (100%0 4 not available
10.	Summary of child health screening	6 (75%) 2-N/A	7 (87.5%) 1 not available	18 (100%) 2N/A	5 (100%) 1 not available- born abroad
11.	Emotional/behavioural assessment	8 (89%)	7 (78%)	17 (85%)	5 (83%)
12.	Life Style issues discussed and health promotion offered	5 (100%) 4- N/A	8 (100%) 1- N/A	19 (95%) 1- N/A	5 (83%)
13.	Developmental History/ assessment recorded	6 (67%)	4 (44%)	19 (95%)	5(83%)
14.	Any special educational needs (EHCP)	6 (67%)	7 (100%) 2- N/A	15(100%) 5- N/A	6 (100%)
15.	Height and Weight recorded	9 (100%)	8 (89%)	18 (90%)	6 (100%)

16.	BMI recorded (if over 2 yrs.)	4/6 (67%) 3- N/A	6 (100%) 3- N/A	11 (78.5%) 6 N/A	4 (100%) 2 N/A
17.	Record of neonatal hearing screening or any hearing concerns	7 (78%)	9 (100%)	18 (90%)	5 (83%)
18.	Record of vision screening	5 (100%) 4- n/a	7 (100%) 2- n/a	15 (100%) 5- n/a	3 (75%) 2 N/A
19.	Evidence that carer's concerns have been sought and recorded	1 (20%)	2 (22%)	10 (50%)	4 (67%)
20.	Record of Dental screening / registration enquiry (over 3 yrs.)	6/6 (100%)	5/7 (71%) 2-N/A	13 (100%) 7-N/A	2 (50%) 2 N/A
21.	Record of GP registration / Name	7 (78%)	8 (89%)	16 (80%)	6 (100%)
22.	Summary Report and Recommendation Typed	9 (100%)	9 (100%)	20 (100%)	6 (100%)
23.	Recommendations have clear time scale and identified responsible person	9 (100%)	9 (100%)	20(100%)	6 (100%)
24.	Evidence that referral to appropriate services have been made	5 (100%) 4- N/A	1 (100%) 8- N/A	16 (94%) 3- N/A	6 (100%)
25.	Evidence that the child/YP was offered the opportunity to be seen alone	2/5 (40%)	5/8 (62.5%) 1-N/A	16 (100%) 4-N/A	4 (100%0 2- N/A
26.	Signed	9 (100%)	9 (100%)	20 (100%)	6 (100%)
27.	Completion date	9(100%)	9(100%)	20(100%)	6 (100%)

Quality assurance has identified the following areas for improvement:

- Carer's comments being recorded. Following advice from previous quarterly quality assurance, this has improved.
- Recording of developmental history- this has improved following feedback from previous quality assurance.
- Record of dental screening has not been so good in the last quarter and this has been fed back to Mas
- Recording of BMI has previously been a concern but this has improved.

The completed IHA is sent to the social worker, the Independent Reviewing Officer (IRO) the GP and the Health visitor (for preschool children). It is the responsibility of the local authority that each LAC has an up to date health plan based on the IHA 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.

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 LAC 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 for all Looked After Children. This was also highlighted in a recent inspection. The importance of these has been explained to senior managers and to social workers. We will be reviewing this area for improved practice in the best interest of the child.

IHA venue

The majority of appointments available are at Poole Hospital, either in the Child Development centre or Children's Outpatients. Both areas are appropriate to see children and young people. One clinic a fortnight is held in Poundbury Children's centre. This enables some children living in west Dorset to be seen closer to their homes.

For some children with complex medical and learning needs attending a clinic for the IHA is not appropriate. The IHA can by arrangement be completed by the specialist who already sees these children for their medical care, which is often more appropriate for the child or young person. On occasion children were seen by Medical Advisers for their IHA in their special school.

SEPARATED CHILDREN SEEKING ASYLUM

An unaccompanied asylum-seeking child (UASC) or separated children seeking asylum (SCSA) is an individual, who is under 18, who has applied for asylum in his/her own right, is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.(DfE)

The National Transfer Scheme (NTS) for Unaccompanied Asylum Seeking Children (UASC) (now known as Separated Children Seeking Asylum SCSA) was established in 2016 to enable the safe transfer of children from one local authority to another. The transfer protocol is intended to ensure that unaccompanied children can access the services and support they need. It forms the basis of a voluntary agreement made between local authorities in England to ensure a more even distribution of Unaccompanied Children across local authorities. It is intended to ensure that any participating local authority does not face a disproportionate responsibility in accommodating and looking after UASC, simply by virtue of being the point of arrival of a disproportionate number of unaccompanied children. The scheme is based on the principle that no local authority should be asked to look after more UASC than 0.07% of its total child population.

In Bournemouth, Poole and Dorset 0.07% of the total child population equates to 110. The Designated Nurse for Looked After Children and one of the named GPs have devised a Healthcare Pathway for UASC who should all be offered an appointment for an Initial Health Assessment (IHA) within 20 working days by a Medical Adviser. In light of the complexities which may be involved and the need for an interpreter, a longer appointment is offered (2 hours).
All SCSA are seen in Poole Hospital where there are more available appointments. This enables the service to better manage the time needed for these medicals. This enables the testing for blood borne viruses, if the young person consents, to be carried out in the pathology department on the same day and with the interpreter present, making it a better experience for the young person and enabling the majority of the assessment to be completed on one occasion.

All SCSA are seen for TB screening at Bournemouth Hospital and all are offered mental health support if they want to engage with this at the time.

There is useful information available on the UASC health website set up by the health services in Kent who were originally seeing most of these children. They have designed a

quality assurance tool which is more appropriate to these children's needs. This Tool has been used to assess the quality of all the IHAs completed for these children.

During the year 2018-19, 20 medicals were completed for SCSA, these have all been quality assured and the results of this fed back to medical advisers.

QUALITY ASSURANCE FOR SCSA

		YES	NO	Declined
1.	Child or young person's consent for assessment (where appropriate) recorded	13(65%)	7 (35%)	
2.	DOB	20 (100%)	0	
3.	Age	20 (100%)	0	
4.	NHS Number	9 (45%)	11 (55%)	
5.	Social Worker named on report	20 (100%)	0	
6.	Is the child or young person registered with a GP in the area?	10 (50%)	10 (50%)	
7.	GP details have been recorded	9/10 (90%)	1/10(10%)	
8.	Evidence that child or young person's comments have been sought and recorded	20 (100%)	0	
9.	The young person has been asked about their experience both in home country and on journey to UK.	18 (90%)	1 (5%)	1 (5%)
10.	Emotional, behavioural needs have been assessed and any identified concerns documented	13 (65%)	5(25%)	2 (10%)
11.	Any self-care / independence or learning needs have been assessed and any identified concerns documented	19 (80%)	6 (30%)	
12.	Any possible safeguarding concerns have been explored e.g. trafficking, CSE, PREVENT	17 (85%)	3 (15%)	
13.	Lifestyle issues discussed and health promotion information given	17 (85%)	3 (15%)	
14.	Height recorded and plotted	19 (95%)		1(5%)
15.	Weight recorded and plotted	19 (95%)		1(5%)
17.	Physical health including dental has been assessed	19 (95%)		1(5%)
18.	Handwritten document legible	20 (100%)	All reports	typed
19.	Document is typed	20 (100%)	0	
	Document includes the following			
20.	A summary of pre-existing health issues	17 (85%)	3 (15%)	
21.	Any newly identified health issues	17 (100%)		3 N/A
22.	Information about journey to the UK including identified risk factors	17 (85%)	2 (10%)	1 (5%)
23.	An up to date immunisation summary	0	1	19-unknown
24.	Summary of dental health needs	19 (95%)	1 (5%)	
25.	Summary of vision and hearing needs	19 (95%)	1 (5%)	
26.	Summary of child health screening	unavailable		
27.	Opinion re risk of BBV given	19 (95%)	1 (5%)	
28.	Date for next health assessment has been recorded	16 (80%)	4(20%)	
29.	Recommendation re immunisation status	20 (100%)	0	
30.	Recommendation made re BBV and TB screening	19(96%)	1 (5%)	
31.	Recommendation made re dental health needs	19 (95%)	1 (5%)	
32.	Recommendation made re any vision needs	16 (80%)	4 (20%)	
33.	Recommendation made re mental health- identifying any risks	16 (80%)	3 (15%)	1 (5%)

34.	Any other health risk has been acted upon and documented in the health plan	16 (80%)	1 (5%)	3 N/A (15%)
35.	In your opinion does this IHA give a true sense of this young person's needs and form a sensible plan to address these needs?	16 (80%)	4 (20%)	

Results of the Quality assurance have been fed back to medical advisers. When reviewed consent was available for all young people, and medical advisers have been reminded to make this clear on their reports. There are still many young people who don't have an NHS number or GP at the time of the medical and this can impact on their ongoing medical appointments, for example booking optician, dentist and blood test appointments require a NHS number and the GP practice usually assists with the immunisations. The reasons for this need to be explored.

Discussion has been had regarding assessment of emotional health needs. There have been concerns that using non face to face interpreters, video links and telephone interpreters makes it hard to assess emotional health well. Following feedback from social workers to the Designated Doctor, it has been arranged with PALS that all interpreters will now be face to face.

The pathway for UASC health assessments needs review now that there is more experience of these assessments, particularly the follow up for emotional health concerns which may not be apparent at the time of the IHA but present later. This has been discussed with the clinical psychologist.

Feedback

Carer feedback

Previously anonymous feedback was sought from Foster carers following every IHA appointment. Only 14 forms were available. Feedback is largely very positive.

Overall view of service	Excellent:10 Very Good: 4 Good:0
FC felt that the doctor listened to and respected their views	Yes, definitely: 11, yes to some extent: 3

Written feedback:

Listen to our views
Go through everything to do with health in a kind considerate way.
Interpretation from Somali was useful.
Involved the child and made it an easy appointment. Interested in the children. Friendly.
Listened to my son's views.
More parking
Listen, explain make you feel comfortable very friendly - made me feel at ease

Child/young person feedback

Forms have been designed which are suitable for use by school age children and young people. Encouraging young people to participate in their care and feedback about the service

may help them take more responsibility for their own health and engage better with LAC health professionals in the future. In total 12 forms were returned.

	YES	NO
Did you know you were seeing the Doctor today?	12	0

	10	9	8	7	6	5	4	3	2	1
Did the Doctor Explain things to you clearly?	12	0	0	0	0	0	0	0	0	0
Did you feel listened to, respected and involved in making decisions about your health?	11	1	0	1	1	0	0	0	0	0

Written Feedback:

Amazing, best doctor ever

Felt good after visit

Everything was amazing

The interpretation system failed which reduced the certainty of accurate information

Even though there were not many forms returned young people have responded positively to their experiences. Overall young people's feedback was positive and they felt listened to, respected and involved, this is an important outcome for the service and for future engagement with the service. Ways to improve uptake need to be considered in the next year.

The difficulties with the interpretation systems have been covered in the section 'separated children seeking asylum'

Out of Area IHAs

For children placed out of Dorset, the Social worker and foster carer are requested to bring the child back for their IHA, if safe and within 1-hour travel time. This ensures continuity for the child and thorough health assessment. If this is not appropriate, 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 2014-2015 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 2015-2016 an administrator to manage the OOA (IHAS) was appointed. Poole Hospital Is paid for the OOA IHAs completed for other Local Authorities. IHAs completed elsewhere are quality assured by the designated doctor when they are returned. Whilst there is still improvement to be made with regard to timeliness of these IHAs, we are now able to evidence that children's IHAs are being requested and completed.

A standard operating procedure for organising Out of Area medicals has been produced as a result of the CQC inspection in late 2018. This ensures a robust escalation system to ensure

children placed out of area are receiving their medicals in a timely way and are not disadvantaged by being placed elsewhere.

IHAS requested by other CCGs and completed in Dorset

IHAs requested	IHAs done	Completed in 20 working days
31	14 (17 have been cancelled/no longer required)	3

IHAS requested by Bournemouth, Dorset and Poole and completed elsewhere

IHAs requested	IHAs done	Completed in 20 working days
31	**17 (13 no longer required)**	**0**

Last year (2017-18) 29 medicals were done for Out of Area children placed in Dorset from other areas and 13 were completed for Dorset children placed Out of Area. This year the numbers are smaller and the IHAs completed by Dorset are similar to those completed elsewhere so this doesn't currently have a significant impact on medical adviser workload.

The only outstanding request from 1st April 2018 – 31st March 2019 is for an adoption medical for a Dorset child placed out of Area.

Fostering

Each prospective foster carer has a comprehensive health assessment completed by their GP, these are reviewed by a medical adviser who provides a type written report, including advice on the implication of any health problem on their ability to parent a child. If required additional information can be requested from the GP or hospital specialist. Some Foster carers have more complex health needs and these reports require longer to write, however overall the average time to complete the medicals is balanced by the more straight forward cases enabling capacity to be maintained.

Number adult health forms advised on:

	Q1	Q2	Q3	Q4	Total 2018-19	Total 2017-18
No of advice reports written by MAs	**89**	**89**	**87**	**117**	**265**	**229**

Adoption

Regional Adoption Agency- Aspire Adoption

The Regional adoption agency incorporating Bournemouth, Poole and Dorset Local authorities was launched on 1st July 2017. Since this time all approval and matching of adopters and children has been through this agency. Adoption panels are held twice a month and attended by Medical advisers. Once children in Bournemouth and Poole have a placement order, they are transferred to a social worker from Aspire. Dorset transfers some of its younger children, but some Dorset children maintain a Dorset Social worker until they are matched with adopters. This can result in confusion as to who is the responsible social worker and has resulted in lack of clarity amongst social workers about who is responsible for organising the adoption medical, resulting in requests for medicals to be done at very short notice, which is not always possible or in the best interests of the child. This has been escalated to the manager of Aspire who is addressing it within the organisation.

The Designated Doctor sits on the operational Management Board of Aspire Adoption as the health representative and will review the issues at this meeting.

Adults

Each prospective adopter has a comprehensive health assessment completed by their GP, these are reviewed by a medical adviser who 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.

Number of adult health forms advised on:

	Q1	Q2	Q3	Q4	Total 2018-19	Total 2017-18
Number of advice reports written by MAs	30	30	34	32	126	133

Prospective Adopters attend a series of preparation workshops. These are held every 2 months. One of the medical advisers speaks at the 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.

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 advisers comment on the adult health assessment and are able to answer questions on any questions relating to the adopters physical and mental health. Feedback on the medical advisers' contributions to panel have been positive.

Children

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. For children placed in early permanence placements very soon

after their IHA, it is possible to provide an adoption medical report based on the IHA and any additional information provided.

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

In the year 2018-19, 82 adoption medicals have been completed in Bournemouth, Dorset and Poole. This has increased from 66 in the year 2017-18. Since 2018 all adoption medicals have resulted in the production of a type written report for prospective adopters, summarising the child's family history, birth history, physical and emotional health, development and experiences to date as well as any possible implications of these.

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.

Children Adopted (Adoption Orders granted)

	2018-19	**2017-18**	**2016-17**
No. Children Adopted	74 (+17%)	63 (+5%)	60
Male	43 (58%)	52%	
Female	31 (42%)	48%	
Age at adoption order			
Under 12 months	7 (9%)	4 (6%)	0
1-4 years	49 (66%)	37 (59%)	40 (67%)
5-9 yrs	16 (22%)	21 (33%)	20 (33%)
>9yr	2 (3%)	1 (2%)	0

Nationally (England) the number of looked after children ceasing to be looked after due to adoption increased between 2011 and 2015 to a peak of 5360. In 2016 and 2017 the number of adoptions fell for the first time since 2011, by 12% and in 2017 by 8% to 4350. In 2017-18 the number of looked after children adopted nationally fell again to 3820, a decrease of 13%.

During this time the number of adoptions in Dorset has continued to increase. Whilst this is a positive outcome for these Looked After Children. It does mean an increase in the number of adoption medicals, meetings with prospective adopters and length of time attending adoption panel. Currently there is only one medical adviser available to attend panel due to timing. This is being reviewed by Aspire to ascertain whether there is any flexibility with regard to which day panel is held.

Medical Adviser Supervision

Each Medical Adviser should have clinical supervision with the designated doctor every 3 months, a written summary is provided to the Medical Adviser following the meeting for their records. Medical Advisers are able to contact the Designated Doctor by telephone or e-mail for advice on any difficulties encountered. Regular meetings of all medical advisers every 2 months and regular supervision and review of reports.

Continual Professional Development (CPD) and Teaching

The medical advisers are expected to attend 10 hours each year of CPD, specific to the health needs of LAC and children adopted. Each of the medical advisers is up to date with medical appraisal and revalidation including safeguarding, PREVENT and child Sexual Exploitation training

Medical advisers meet twice a year with South West Adoption Consortium (SWAC) Medical advisers to discuss best practice, present audits and discuss issues arising.

Medical students from Southampton University receive a teaching session on Looked After Children from the Designated Doctor as part of the initial teaching during their attachment. They are also able to attend IHA appointments to observe.

The Designated Doctor delivers a teaching session to the Community Paediatric department at Poole Hospital at least once a year on a topic related to Looked After Children. Doctors in training attached to the community paediatric department are also encouraged to attend IHAs, adoption medicals and to observe adoption panel as part of their training.

Inspections

In December 2018 the Care Quality commission carried out an inspection of the health care provided to Looked After Children in Bournemouth as part of a CLAS inspection. Unfortunately, the inspectors didn't meet with the Designated Doctor so weren't able to clarify current processes.

The main outcomes related to Looked After Children Medical Advisers were:

1. Ensure more robust action is taken to ensure initial health assessments for those children and young people placed out of area are undertaken in a timelier manner and that where this is not done then the reasons are explored in more detail and findings acted onto reduce repetition.
2. Review and implement improved processes of quality assurance to ensure that both initial and review health assessments undertaken across all ages are of consistently good quality.
3. Ensure that all practitioners undertaking both initial and review health assessments are aware of the importance of examining, understanding and recording both the child's voice and lived experience so that those assessments more accurately reflect the wishes and needs of the children to who they pertain. This process must be assured by robust quality assurance processes.
4. Ensure that all avenues are explored to obtain and record as much parental history information as possible to inform both the initial and review health assessment process and that this information is recorded in service user records.
5. Explore with multi-agency partner's ways to implement and improve information gathering process to ensure both initial and review health assessments undertaken are complete with as much detailed information as is required.
6. Ensure faith and culture preferences are captured and recorded in both initial and review health assessments to reflect the child or young person's important preferences.

These are being addressed by the LAC health team

A more robust process is in place for organising Out of Area medicals and escalation to the Designated Doctor when this has not happened. A new Quality Assurance template is being developed for use in 2019-20, covering issues including recording the child's voice, and exploring lived experiences for preschool children as well as faith and cultural preferences. This information has also been discussed with medical advisers so that they can incorporate this into their assessments.

The new IHA process and clearer timeline includes collection of more parental health information and background as well as reasons for being in care.

SUMMARY

AREAS OF GOOD PRACTICE:

1. **MEDICAL ADVISER SUPERVISION:**
   Supervision of Medical Advisers happens consistently every 3 months with a written report summarising the meeting. Between these meetings medical advisers can contact the Designated Doctor for advice.
2. **QUALITY ASSURANCE OF IHAS:**
   IHAS are quality assured quarterly and this information is fed back to medical advisers, this has resulted in improvement throughout the year and therefore better health care for LAC
3. **DEVELOPMENT OF NEW IHA PATHWAY:**
   The Designated Doctor and Named nurse have worked together to produce a clearer one-page pathway for the local authorities to improve their understanding and timeliness of notification and consent. This also highlights the information expected from the local authority for the IHA.
4. **OUT OF AREA STANDARD OPERATING PROCESS:**
   A clearer process has been developed for the admin staff to ensure these children's IHAs take place in as timely a manner as possible and they are not disadvantaged by being placed away from Dorset.
5. **LOCATION OF CLINICS:**
   Regular IHA clinics are continuing to be held in Dorchester enabling some west Dorset children to be seen closer to home.
6. **ADOPTION MEDICAL REPORTS:**
   Adoption medical reports are produced in a standardised format including clear implications for all children where the plan is adoption.
7. **RECORD KEEPING:**
   All reports are saved on the child's electronic record enabling access by other medical practitioners when appropriate to provide background information.
8. **IMPROVED RECORDING OF CSE (CHILDHOOD SEXUAL EXPLOITATION RISK):**
   Looked after children are at increased risk of CSE. The short seraf questions are now incorporated in the IHA, enabling clinicians to complete CSE screening as part of the assessment. Medical advisers have been trained in the use of this tool.

CHALLENGES:

1. **DELAY IN NOTIFICATION AND CONSENT BY LOCAL AUTHORITY**
2. **REDUCED COMPLETION OF IHAS WITHIN 20 DAYS COMPARED WITH PREVIOUS YEAR**
3. **STAFFING ISSUES-** changes in medical adviser staff have impacted on capacity and required increased training and supervision, changes in admin staff have required increased supervision.
4. **INCREASED DEMAND FOR ADOPTION WORK**
5. **OUTCOME OF CQC INSPECTION**
6. **LOW RATES OF FEEDBACK FROM CARERS AND YOUNG PEOPLE FOLLOWING IHAS**

KEY AREAS FOR DEVELOPMENT 2019-20

1. **IMPROVED NOTIFICATION AND CONSENT BY LOCAL AUTHORITIES:**
   A new process and clearer pathway will be introduced from 1st June 2019. The designated doctor and named nurse have offered to meet with social work teams to discuss this. The impact of this will be reviewed in the quarterly reports
2. **IMPROVED INFORMATION PROVISION PRIOR TO THE IHA:**
   As part of the clearer process, local authorities have been asked to provide more information at the time of requesting the IHA including reason for coming into care, parental health history from and mother and baby form. This will be reviewed in the quarterly reports
3. **NEW QUALITY ASSURANCE PROCESS:**
   A new format has been developed for quality assuring IHAs including the areas outlined in the CQC report.
4. **IMROVED JOINT WORKING WITH LOOKED AFTER CHILDREN'S NURSING TEAM:**
   Following the CQC inspection, a template of what should be included in an IHA is being developed to better able the nurses who read the IHAs initially to challenge medical advisers if they feel something is missing or could be done better. This will further help improve quality.
5. **DEVELOPMENT OF CLEARER ADMINISTRATIVE PROCESSES:**
   Clearer processes will be developed to support the administrative staff at Poole Hospital. The information database for all children new into care will be held by Poole Hospital enabling clearer understanding and more efficient escalation on a day to day basis.
6. **DEVELOPMENT OF NEW PROCESS FOR ARRANGING ADOPTION MEDICALS:**
   A new process for arranging adoption medicals will be introduced allowing more efficient use of administrative staff and a clearer pathway for social workers.
7. **REVIEW OF FEEDBACK TOOL FOR IHAS:**
   Feedback rates are currently low, so the tools used will be reviewed with medical advisers to see how we can improve this, enabling us to gain greater feedback from young people and carers as to how the service can best meet their needs.