CORPORATE PARENTING COMMITTEE (FORMAL)	AGENDA ITEM No. 10
20 JULY 2022	PUBLIC REPORT

Report of:	Nicola Curley Director for Children's Services	
Cabinet Member(s) responsible:	Councillor Lynne Ayres, Cabinet Member for Children's Services, Education, Skills and the University	
Contact Officer(s):	Ricky Cooper, Assistant Director Children's Social Care Catherine York, Designated Nurse Children in Care	Tel:

HEALTH ASSESSMENT AUDIT REPORT

RECOMMENDATIONS	
FROM: Assistant Director Children's Social Care	Deadline date: N/A

It is recommended that the Corporate Parenting Committee:

1. Notes the content of the report
2. Raise any queries with the lead officers

1. ORIGIN OF REPORT

1.1 A report from Health is presented to each formal Corporate Parenting Committee

2. PURPOSE AND REASON FOR REPORT

2.1 This report is the annual health assessment audit report for 2021/22. The report provides an overview of the Initial Health Assessment and Review Health Assessment audit process and findings undertaken by the Designated Professionals for Children in Care as part of the quality assurance systems in place by Cambridgeshire and Peterborough Integrated Care System (previously CCG).

2.2 This report is for the Corporate Parenting panel to consider under its terms of reference no:
2.4.3.6 (c) Promote the development of participation and ensure that the view of children and young people are regularly heard through the Corporate Parenting Committee to improve educational, health and social outcomes to raise aspiration and attainments.

2.3 2.3 This links to priority 4 of the Children in Care Pledge and Care Leavers Charter. Health issues of Children and young people in care

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**

4. BACKGROUND AND KEY ISSUES

4.1 **Audit of Initial and Review Health Assessments by Designated Professionals**
Report Date: 17th April 2022

4.1.1 The health assessments reviewed within the audit were completed by the Team between 1st April 2021 and 31st March 2022. The timescale concerned, fell within the continued COVID-19 pandemic when service delivery was adjusted and managed as per NHSE guidance, to reflect the national and local lockdowns and restrictions detailed by the Government and Public Health Services for Cambridgeshire and Peterborough.

As such, during this period:
Review Health Assessments (RHAs) were undertaken by the Attend Anywhere (AA) virtual platform until July 2021, at which time they were delivered by a combination with face-to-face appointments and AA appointments depending on the needs of the child/young person, the foster family or care setting and the national and local position at the time of the assessment. Where appointments were undertaken using a virtual platform, face-to-face follow up arrangements were utilised as required with GP, Health Visitor, Specialist Children in Care Nurse, or specialist services.

Initial Health Assessments (IHAs) were undertaken by a face-to-face consultation for those aged 0-5 years throughout the audit period, with those aged 6 years and over returning to face-to-face appointments from June 2021. Where appointments were undertaken using a virtual platform, face-to-face follow up arrangements were utilised as required with GP, Health Visitor, Paediatrician, or other relevant health team.

The cases for both the IHA and RHA audits were picked at random from the overall list of children and young people who had received their health assessment during the above period. The selection was made to include cases from across each of the following age groups: 0-4 years, 5-10 years, and 11-17 years, and included some Unaccompanied Asylum-Seeking Children (UASC). The audit sample included children/young people placed out of area, however all the RHAs were undertaken by the CPFT Children in Care Team.

Pre Covid-19, the Designated Professionals would undertake their annual audit of health assessments by attending the Children in Care Team base and be given access to the records, however due to the pandemic records have been redacted and shared electronically. This method of accessing the records has resulted in the audit being restricted to the HAP, and in 3 cases the Leaving Care Health Assessment/Passport; further information regarding some parameters of the audit is often identified from the Health Assessment Questionnaire and/or the SystmOne record.

4.1.2 **Initial Health Assessment Audits**

5 Cases audited by Dr Mona Aslam, Designated Doctor Children in Care

Issue	Doctor's Assessment			Notes
County where child placed	N=1 0-5 years	N=2 5-11 years	N=2 11-17 years	Peterborough
Conducted by	Dr 100%	DR 100%	DR 100%	
Paperwork	F2F 100%	F2F 100%	F2F 50% Review of records 50%	11-17 category 1 UASC very little time for assessment as brought late to IHA. 1 child admitted to the ward night before, so the medical notes were used.
Neonatal blood spot testing	100%	NA	NA	NA- There is not a specific question for Neonatal blood spot testing in the over 5s.

Family History	100%	100%	50%	
Birth History	100%	50%	0%	There is no separate category for Birth History in forms for over 5-year-olds
Outstanding actions from previous HA	NA	NA	NA	Not applicable as this is their first health assessment.
Other Health professionals identified	100%	100%	100%	
Previous Health concerns identified	100%	100%	100%	
Dentist appointment date	0%/NA	50%	0%	0-5 years = not registered with dentist 5-11 years = 1 child still trying to book with a dentist 11-17 years = 1 young person needed urgent care and 1 needs to book an appointment.
IHA – Children < 3y Examination of both eyes	100%	NA	NA	
Vision appointment date	NA	NA/Yes	NA/Yes	5-10 years = I child booked 11-17 years = 1 child booked
Hearing – concerns	100%	100%	100%	Every child/young person were asked, but no concerns were identified.
	100%	NA	NA	0-5 years = identified that the neonatal hearing screening was passed.
Neonatal hearing screen recorded	100%	NA	NA	
Immunisations (Routine and additional immunisations)	NA	100%	100%	11-17 – UASC no immunisations documented but the need to commence the catch-up programme was documented in the HAP and the young person was advised to see a dentist.
Height, weight and BMI recorded	100%	100%	100%	
Head circumference (IHA all and RHA only in <2 years)	100%	NA	NA	
Gives picture of development	100%	50%	NA	Very detailed assessment of development.
Educational progress (school age only)	NA	100%	100%/na	11-17 years = 1 case was a UASC who had not yet commenced school.
SDQ score available (completed prior to assessment)	NA	0%	0%	

If not available, SDQ given to carers /young person	NA	100%	50%	11-17 years = 1 case it was not identified that this needed to be sent to the carer.
Emotional well-being discussed	NA	100%	0%	11-17 years = 1 young person not seen face to face and 1 UASC was late to their appointment so there was not enough time to discuss in detail.
CRAFFT screening used	NA	NA	50%	
Child/young person's view	NA	100%	0%	11-17 years = 1 UASC was late to their appointment so there was not enough time to discuss, and 1 young person was not seen face to face.
Lifestyle discussed > 10y	NA	NA	0%	No documentation of sign posting to relevant services. 11-17 years = 1 UASC was late to their appointment so there was not enough time to discuss.
Health issues documented in Action Plan	100%	100%	100%	
Health Action Plan SMART	100%	100%	100%	
Referral made	100%	100%	100%	Difficult to know if referral made as no access to the SystmOne record, but the requirement was captured in the Action Plan and relevant professionals were copied into this.
Are health professional's details clearly documented and paperwork dated?	100%	100%	100%	
Name//NHS Number	NA	NA	NA	All personal information redacted
Evidence has been gathered from S1/ Medical Records	NA	NA	NA	No access to SystmOne to enable checking

Findings

4.1.3

0f the 5 health assessments were conducted face to face by a senior doctor. 1 child was not seen face to face as was admitted to hospital due to self-harm at the time of their appointment.

There was good compliance with health checks overall

100% of children were asked about their immunisation history, and where these were outstanding for a UASC, this was identified as an action in the Health Action Plan.

100% of children/young people had their height, weight, and where appropriate head circumference, documented.

Access to dental health remains a concern, with only 1 of the 2 5-11 years old having been seen by a dentist, and neither of the two 11 -17 years old being seen.

100% Educational progress was noted. 1 UASC was still waiting to be registered in education.

Only 1 of the two (50%) of cases had the developmental progress recorded in the 5-10 category. 0% of SDQs were completed prior to the IHA. All carers were provided with a questionnaire at the end the IHA.

It was unfortunate that in the 11–17-year-old category, 1 young person had been admitted to hospital the day before his/her appointment and was not seen face to face, and that the other young person who was a UASC was brought late to his appointment. As a result, 0% of the child/young person's views and emotional well-being were considered and documented. Lifestyle issues were also not discussed.

Recommendations

4.1.4 There needs to be a better understanding of the importance of SDQ (Strength and Difficulties Questionnaire) by carers: educating carers regarding the purpose of the SDQ and the importance of them completing it, how the SDQ result informs the holistic assessment and contributes to referral for appropriate services or interventions. To further develop the SDQ Pathway as a partnership with social care and education colleagues.

Time must be given for a better understanding of the young person's feelings and concerns. It may be that this already happens, but is not captured in the documentation, in which case the recommendation is to record this information.

For UASC there should be sign posting to the Refugee Council, Cultural and Religious and other charity organisations if appropriate so that the young person can get a sense of belonging. This sign posting may already have taken place by social care colleagues or the care provider, but this should be checked, and relevant information given if required; this should then be captured in the health record.

Lifestyle risks must be explored and signposting to appropriate services and information; this should then be captured in the health record.

Dental health remains a challenge as the Covid-19 pandemic greatly impacted on dental provision, and although provision is increasing, the back log still has implications for access to routine care. Urgent care is always accessible via NHS 111 and no concerns around accessing this was identified in this audit. NHSE Regional Dental Services are working with the Designated Professionals and Lead/Named Nurses to ensure that children and young people in care can access routine dental treatment, with data around need being collected and collated, and General Dental Practices being approached to provide this service to children and young people who they would not normally see. Social Workers and health professionals should continue to escalate issues of non-access to routine dental care to the Designated Professionals so that they can support management of this issue by escalating to NHSE Dental Services for support.

Review Health Assessment Audit

4.2 15 cases were reviewed and audited by Catherine York, Designated Nurse Children in Care

4.2.1

Issue	Nurse's assessments	Notes
County where child placed	All cases reviewed were undertaken by the CPFT Team. The mode of assessment delivery was: Face to face = 6 (40%) Attend Anywhere (AA) = 6 (40%) Telephone = 3 (20%)	Reasons for Telephone as opposed to AA: Foster carer connectivity issues.
Age range of cases reviewed	0-4 years = 5 (33%) 5-10 years = 5 (23%)	

	11-17 years = 5 (44%)	
Conducted by	Specialist Nurse = 15 (100%) Paediatrician = 0 (0%)	
Paperwork	Y = 15 (100%) N = 0 (0%)	
Neonatal blood spot testing	Y = 6 (40%) – This included 100% of those aged 0-5 years. No – 0 (0%) N/A – not on HAP due to age = 7 (47%) N/A UASC = 2 (13%)	The HAP only has a Neonatal Blood Spot Testing field for those aged 0-5 years.
Family History	Y = 11 (73%) N = 2 (13%) UASC N = 0 (0%) Limited = 2 (13%) PH forms - Nil	No record that PH Forms were available for the younger children. It is likely that these were available via SystmOne, but this is not reflected in the HAPs audited.
Birth History	Y = 11 (73%) N = 2 UASC (13%) N = 0 (0%) Limited = (7%) MB forms - Nil	No record that MB Forms were available for the younger children. It is likely that these were available via SystmOne, but this is not reflected in the HAPs audited.
Outstanding actions from previous HA	Y =1 (7%) N = 0 (0%) N/A = 14 (67%)	Yes = 1 outstanding action regarding visiting the dentist. It was recorded that the young person had not been able to get an appointment. This was carried through as an outstanding action on the HAP.
Other Health professionals identified	Y = 15 (100%) N = 0 (0%) N/A = 0 (0%)	
Previous Health concerns identified	Y = 15 (100%) N = 0 (0%) N/A = 0 (0%)	Each HAP contains evidence of discussions regarding ongoing health concerns, including sleep, nutritional, emotional, vision, heart issues, hearing, toileting, puberty related issues, sexual health and drugs and alcohol use.
Dentist appointment date	Y = 10 (67%) N = 2 (13%) N/A = 1 (7%) UASC had not been able to register with dentist due to Covid-19 = 2 (13%)	N/A answer = X 1 baby. Yes answer = X 1 identified that the child was attending the dentist regularly with the foster family to familiarise her with attending the dentist as she had never been. A date for her own appointment is arranged for the near future.
Vision appointment date	Y =13 (87%) N = 0 (0%) N/A = 2 (13%) Vision discussed with both	Once HAP detailed referral to Ophthalmology at PCH.

Hearing – concerns	Y = 1 (7%) N =0 (0%) N/A = 0 (%) Hearing discussed with carer and young person = 15 cases (100%)	Only one child was identified has having a hearing problem and was under the care of the ENT specialist. Although hearing problems/issues were not identified in 14 of the 15 (93%) cases, hearing was discussed in each of the cases reviewed (100%).
Hearing date of check (indicated if previous concerns)	Y = 4 (27%) N = 0 (0%) N/A = 11 (73%)	
Neonatal hearing screen recorded	Y = 6 (40%) N = 0 (0%) N UASC = 2 (13%) N/A = 7 (47%)	N/A – used for those aged 6-17 years as this not a prompt on the HAP.
Immunisations (Routine and additional immunisations)	Y = 15 (100%) N = 0 (0%) N/A = 0 (0%)	Yes - included 2 UASC on the catch-up programme.
Height, weight and BMI recorded	Y = 10 (66%) Referred to other professional or under the care of another professional for growth measurements = 3 (20%) N = 1 (7%) Discussed clothes and body shape/size, but no arrangements for growth measurements = 1 (7%) N/A = 0 (0%)	Due to virtual RHAs, the records identified the following around growth measurements: Foster Carer measured undertook weight and height measurements X 1 Recent Paediatrician appointment measurements used = 2 cases and HV measurements used = 1 case, providing a Yes answer. Arrangements made for HV, Paediatrician, and Diabetic Team to measure growth = 3 cases No arrangements or follow-up was identified or discussed for 2 cases.
Head circumference (IHA all and RHA only in <2 years)	Y = 1 (7%) N = 0 (0%) N/A = 14 (93%)	
Gives picture of development	Y = 15 (100%) N = 0 (0%)	
Educational progress (school age only)	Y = 10 (67%) - 100% of school age cases N = 0 (0%) N/A = 5 (33%) – all of these were preschool children	The HAP captured details of progress within the pre-school settings for those it was relevant to.
SDQ score available (completed prior to assessment)	Y = 4 (27%) N = 3 (20%) N/A = 8 (53%)	N/A rationale: Global developmental delay = 1 case so not appropriate for use.

		Not age appropriate = 8 cases (too young or too old). No answer – 1 HAPs stated that the SDQ was completed OOA, but did not show any score.
If not available, SDQ given to carers /young person	Y = 4 (27%) 100% of those with outstanding SDQ N = 0 (0%) N/A = 11 (63%)	
Emotional well-being discussed	Y = 15 (100%) N = 0 (0%) N/A = 0 (0%)	There was evidence of consideration and discussions at an age-appropriate level for each child/young person. The detail recorded was personal to each child/young person.
CRAFFT screening used	Y = 0 (0%) N = 0 (0%) N/A = 15 (100%) Questions about drugs, alcohol and sex were recorded = 5 (33%)	N/A rationale: LD, non-verbal = 1 Age of child/young person = 9 Cases where age appropriate to have discussions re drugs, alcohol, and sex = details of appropriate questions, discussions and information provided were recorded = 5 (33% of sample) / 100% of appropriate cases.
Child/young person's view	Y = 9 (60%) N = 0 (0%) N/A = 6 (40%)	Y = Child young person involved in the assessment or view included in the HAP. Voice of child/young person captured. Child/young person has severe development delay or not able to provide own view, but the essence of each child clearly captured = 6 cases.
Lifestyle discussed > 10y	Y= 4 (27%) N = 0 (0%) N/A = 11 (63%)	
Health issues documented in Action Plan	Y = 15 (100%) N = 0 (0%) N/A = 0 (0%)	
Health Action Plan SMART	Y = 15 (100%) N = 0 (0%) N/A = 0 (0%)	
Referral made	Y = 3 (20%) N = 0 (0%) N/A = 12 (80%)	Yes, in all cases were identified as required.
Are health professional's details clearly documented and paperwork dated?	Y =15 (100%) N = 0 (0%) N/A = 0 (0%)	
Name//NHS Number	All personal information redacted	

Evidence has been gathered from S1/ Medical Records	No access to SystmOne to enable checking	

Findings

The overall quality of the cases reviewed was found to be good, and in all cases the HAPs and Leaving Care Health Assessment/Passport felt personal to the individual child/young person.

4.2.2 In cases where children were younger than 11 years of age, assessments were undertaken with the foster carer in the presence of the child in all cases except one, as the child was asleep.

It was identified that where appropriate, children above the age of 11 were asked questions directly and were very much included in their assessment.

In the 0–5-year age range, information relating to birth history and family history was limited in 2 cases, however it is recognised that this may be reflective of the auditors only having access to the HAP and the information may have been available at the time of the assessment on the health electronic record. This was an improvement from the previous year's audit.

Neonatal blood spot testing in the 0 – 5-year age range was 100%. For those aged 6- 17 years the N/A option was utilised as the Neonatal blood spot testing is not a prompt on the HAP.

Immunisation uptake was found to be 100% across the age ranges. This included 2 UASC who were undergoing the catch-up programme.

Growth measurement performance has improved greatly from the previous year's audit where performance was impacted negatively by most health assessments been undertaken using a virtual platform. In this audit period more children and young people were seen face to face, and where they were seen virtually better use of other health professional's growth measurements of the child/young person were utilised. However, in one case the nurse had entered "Not known, no concerns" within this section.

Head Circumference measurement was undertaken for each case where the child was age appropriate.

There was clear evidence of discussions around dental care and routine appointments in each case, with records identifying 2 young people who were awaiting a dental appointment at the time of their assessment; this action was captured in the HAP.

SDQ was completed in only 3 of the 6 cases were the SDQ was applicable. There is recognition that the Children in Care Health Team email the SDQ to the foster carer for each case where it is appropriate, but that there is an issue with the number of returns the team receive from the foster carers. Health and Social Care colleagues are working together to address this issue, and this includes further developing the SDQ Pathway and working with the Fostering Service around training for foster carers. Where seen face to face, the foster carer is requested to complete the SDQ during the health assessment appointment, however due to the scoring process, the score is not available at the time of the assessment.

There was evidence of consideration and discussions regarding emotional wellbeing at an age-appropriate level for each child/young person. The detail recorded was personal to each child/young person.

The HAPs reviewed all felt personal to the child/young person and included the views of the older child and young person. For the younger child or those who were non-verbal due to disability, the HAPs clearly captured the essence of child.

100 % of cases demonstrated that children/carers had been asked about vision and hearing.

Appropriate lifestyle conversations were evidenced in 100% (4) of cases where this was age appropriate.

100 % of cases showed health issues documented in the Action Plan.

100 % of cases had a SMART health Action Plan.

Referrals were made in 100% of cases where the need was identified, which was 3 of the 15 cases reviewed.

100 % of cases showed that the health professional's details were clearly documented, and paperwork dated.

Recommendations

4.2.3 The Covid-19 pandemic greatly impacted on dental provision, and although provision is increasing, the back log still has implications for access to routine care. Urgent care is always accessible via NHS 111 and no concerns around accessing this was identified in this audit.

NHSE Regional Dental Services are working with the Designated Professionals to ensure that children and young people in care can access routine dental treatment, with data around need being collected and collated, and General Dental Practices being approached to provide this service to children and young people who they would not normally see. Social Workers and health professionals should continue to escalate issues of non-access to routine dental care to the Designated Professionals so that they can support management of this issue by escalating to NHSE Dental Services for support.

SDQ: There is a need to improve performance for completion of SDQs for all children who are aged 5-17 years, and 4-year-oldsif they are in full-time education. There is evidence via data reporting, that the Children in Care Health Team email the SDQ to the foster carer for each case where it is appropriate, but that there is an issue with the number of returns the team receive from the foster carers. Health and Social Care colleagues are working together to address this issue, which includes further developing the SDQ Pathway and working with the Fostering Service around training for foster carers.

Where seen face to face, the foster carer is requested to complete the SDQ during the health assessment appointment, however due to the scoring process, the score is not available at the time of the assessment; health practitioners should continue to do this so that they questionnaire is completed, and the score is available shortly after the health assessment but can be incorporated into the overall assessment.

Growth measurement should be undertaken for each child/young person, it is not sufficient to record "Not known, no concern". If not seen in face to face, arrangements should be made for growth measurements to be undertaken and recorded in the health record. If a young person declines, this should be identified in the record.

Conclusion for IHA and RHA Audits

4.3 The audit of the IHAs and RHAs reviewed assessments that were undertaken during the second year of the COVID-19 pandemic, a time when all services within the NHS continued to be under extreme pressure, and mandated restrictions varied according to need throughout the year. The overall quality of the cases reviewed was found to be good, and in all cases the HAPs and Leaving Care Health Assessment/Passport felt personal to the individual child/young person.

There were improvements in performance compared to the previous year's audit, including the number RHAs completed face to face, birth and family history available, and completion of growth measurement.

Ongoing partnership working will contribute positively to the required improvements around accessing routine dental care and improving the number of SDQs completed by foster carers and

returned to the Children in Care Health Team so that they are available at the health assessment. The Children in Care Team Manager participates in the partnership working, where her expertise informs practice and improves health outcomes for children and young people in care.

The 2022/23 audit will need to include 10 IHA cases and 30 RHA cases (as per 2020/21), to ensure a wider review of cases. Quality control of both IHAs and RHAs is performed in real time within the Children in Care Team via peer review and use of a standardised template, thus providing the opportunity to identify any gaps and learning as they occur.

5. CONSULTATION

N/A

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 To improve health and well-being, and health outcomes for children in care by ensuring that health assessments are of a satisfactory standard, that previously identified health needs have been addressed, that new health needs are identified, appropriate referrals or interventions are instigated and followed-up, and that all aspects are health are captured with a plan to ensure improved health outcomes for all our children and young people. Questions to ensure that safeguarding, physical health, emotional wellbeing, and health promotion are integral to each health assessment and that partnership working is captured are included within the audit tool.

6.2 The audit report provides the findings and recommendations to enable improvements and service

7. REASON FOR THE RECOMMENDATION

7.1 The Corporate Parenting Committee can receive assurances about the quality of health assessments, and the robust audit process that is in place.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 N/A

9. IMPLICATIONS

Financial Implications

9.1 N/A

Legal Implications

9.2 N/A

Equalities Implications

9.3 N/A

Other Implications

9.4 This report supports the health needs of Children in Care and Care Leavers with the service supporting them to live a healthy lifestyle and ensure they are offered regular health checks and support to attend these.

10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 None

11. APPENDICES

11.1 Appendix 1 – N/A
Appendix 2 – N/A