Middlesbrough moving forward

Legal and Governance

CORPORATE PARENTING BOARD

Date: **Tuesday 18th January, 2022**
Time: **2.00 pm**
Venue: **Virtual meeting**

Please note this is a virtual meeting.

The meeting will be livestreamed via the Council's YouTube channel at Middlesbrough Council - YouTube

AGENDA

1. Apologies for Absence

2. Declarations of Interest

   To receive any declarations of interest.

3. Minutes- Corporate Parenting Board- 30 November 2021 — 3 - 14

4. Covid -19 Update

   The Director of Children's Services will provide a verbal update to the Board.

5. Children in Care in Middlesbrough- The role of the CCG and the Designated LAC (Children in Care) Team — 15 - 148

   Nicki Ayres, Interim Designated Nurse CIC and Safeguarding Children and Kelly Dudding, Named Nurse Children in Care (LAC), will provide information with regard to the initial health assessment for children looked after in Middlebrough.

6. Participation of Children and Young People in Middlesbrough — 149 - 168

Hannah Wiseman, Progamme Manager - Specialist and Targeted will provide an update to the Board.

7. Corporate Parenting Board Strategy Action Plan- Review of the Permanency action plan — 169 - 176

The Head of Looked after Children and Corporate Parenting will present the action plan to the Board.

8. Corporate Parenting Board Strategy Action Plan- Review of the Sufficiency action plan — 177 - 182

Claire Walker, Specialist Commissioning Manager will present the Sufficiency action plan to the Board.

9. Performance against Corporate Parenting Strategy — 183 - 192

The Director of Children's Care and the Analytics Manager will present the performance scorecard to the Board.

10. Any other urgent items which in the opinion of the Chair, may be considered.

Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Monday 10 January 2022

MEMBERSHIP

Councillors C Hobson (Chair), L Garvey (Vice-Chair), A Hellaoui, T Higgins, Z Uddin, M Saunders, B Cooper, D Davison and J Walker

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Susie Blood, 01642 729645, susie_blood@middlesbrough.gov.uk

CORPORATE PARENTING BOARD

A meeting of the Corporate Parenting Board was held on Tuesday 30 November 2021.

PRESENT: Councillors C Hobson (Chair), A Hellaoui, T Higgins, M Saunders and B Cooper

PRESENT BY INVITATION: Councillors J Walker

ALSO IN ATTENDANCE:

OFFICERS: S Blood, V Banks, R Brown, S Butcher, K Dargue, T Dunn, P Jemson, T Parkinson, P Rudd, S Davies, Rowan, Davies, Jefferson and C Breheny

APOLOGIES FOR ABSENCE: Councillors Z Uddin, C Wright, R Farnham, N Ayres, R Scott, D Davison, L Garvey and A Preston (The Mayor)

21/1 **APOLOGIES FOR ABSENCE**

Apologies were received from the Mayor, Councillor Davison, Garvey, Uddin and Wright.

21/2 **DECLARATIONS OF INTEREST**

The following members declared an interest:

Councillor	Type of interest	Reason
A Hellaoui	Non Pecuniary	School Governor
T Higgins	Non Pecuniary	School Governor

21/3 **MINUTES- CORPORATE PARENTING BOARD- 19 OCTOBER 2021**

The minutes from the Corporate Parenting Board held on 19 October 2021 were submitted and approved as a true record.

21/4 **PARTICIPATION OF CHILDREN AND YOUNG PEOPLE- PARTICIPATION PEOPLE**

The Chair welcomed Hannah Wiseman- Specialist and Targeted from Participation People to the meeting. Hannah firstly showed a video which provided information and feedback from Middlesbrough Council's Big takeover.

The Big takeover was aimed at engaging young people from across Middlesbrough to get involved in decisions within Middlesbrough Council and took over the role of a Head of Service. 32 young people took part in the takeover and 5 where from care experienced backgrounds. The Board heard about the experience of the care leavers during the Big Takeover week and about their big business challenges.

The feedback from the young people and Head of Service has been excellent.

Board members outlined that they were excited to see the project develop and from speaking to young people they had enjoyment the week and were asking about the next take over. The Board learnt that all the young people who took part had been invited to attend a young champions group, to ensure the young people could get involved in future projects.

<u>What it was like to be child in care workshop</u>

A councilor workshop took place on Monday 25 October 2021, during Care Leavers week and was facilitated by care leavers. Part of the session asked the participates of the group to make

pledges to the children in care in Middlesbrough.

The Pledges were shared with the Board and would be circulated.

AGREED- That the update be noted.

21/5 **COVID 19- UPDATE**

The Director of Children's Services provided a verbal update in respect to Covid 19.

Main areas were as follows:

- Covid levels had remained lower than in previous months
- There was pressure within schools due to covid and winter sickness bugs
- Storm Arwen had caused some damage to schools, leading to the closure of Priory Woods School and partial closure of Outwood Academy Acklam.
- All secondary school students and teachers were now wearing masks in communal areas, as per guidance issued by the Department of Education.
- Social work practice was continuing, however extra precautions were being taken due to the rising rates of covid infection.
- Those staff who have signed the blended working agreement will look to start returning to the office in December, however this may change depending on rise of infection. Staff have been advised of the new office arrangements to ensure we comply with covid guidance.

Following the update, the Chair asked if a further reminder could be circulated to parents of primary school children to ensure they wear masks when entering school premises. This would be followed up by the Head of Access to Education.

AGREED- That the update be noted.

21/13 **SUSPENSION OF COUNCIL PROCEDURE RULE NO.5- ORDER OF BUSINESS**

AGREED - in accordance with Council Procedure Rule No. 5, the Chair agreed to vary the order of business to agenda item 7, 8, 6, 10, 11,12, 9 and 13.

21/7 **INDEPENDENT VISITOR REPORT TO CHILDREN'S HOMES (REGULATION 44 VISITS)**

The Head of Residential Services provided the 6 month Regulation 44 key themes to the Board.

For clarity, the Head of Services outlined that from April 2015, the Children's Homes Regulations and Quality Standards came into force. Regulation 44 requires an independent person to visit at least once a month to make a rigorous and impartial assessment of the home's arrangements for safeguarding and promoting the welfare of the children in the home's care.

Since April 2021 there have been 42 regulation 44 inspections completed. These are all forwarded to Ofsted as part of the inspection process.
Each month, the visits have a theme; for example, in May 2021- Safeguarding, June 2021 – engaging with the wider system and most recently in October 2021- risk assessments.

The Head of Service provided some of the comments which have been received; examples if which were as follows:

1. It remains evident that the home is making significant efforts to support young people's input and have consideration for their views, wishes and feelings.
2. Gleneagles has been a life line for my children who speak so fondly of the service and the staff (parent)
3. I love it here the staff take care of me (young person)

The Head outlined to the Board, that over the past month, 2 of the services had been inspected and there had been positive comments made.
There have been a number of recommendations following the visits, however these are few. The recommendations were as follows:

- Ensure to record duration of fire drill evacuation CHR 12. Next fire drill rectified this.
- Ensure reg 40s, missing and BASE forms are sent for review next visit. Include a clear rationale as to why regulation 40 notifications have not been submitted when this has been considered. This was with the Head of Service for sign off.
- Ensure to send BASE 78 for review. Reg 11 – again this was with the Head of Service for sign off.
- Seek to identify some training for staff in relation to a condition displayed by one young person Reg 13 – this was completed within 4 weeks of the recommendation.

Following the presentation, clarity was sought as to where the Independent reviews came from. In response, the Head of Service advised that all reviews were recruited by the National Youth Advocacy Service (NYAS). The most recent Independent Visitor was an ex- social worker for Middlesbrough who had s good understanding of the children's homes and national standards.

A Board member also questioned what the Head of Service deemed to be the challenges and how the service would move forward. The Head of Service outlined that it had been a very challenging year as in terms of covid and there were major staffing issues due to isolation. The service was currently looking to recruit members of staff and it was felt this would lead to a better service for our young people.

AGREED- That the presentation be noted.

21/8 **FOSTERING REPORT- QUARTER 1 AND QUARTER 2**

The Service Manager for Fostering provided a presentation in relation to the quarter 1 and quarter 2 fostering data.
The following areas were discussed:

- Number of carers and places
- Number of Carers by Primary Care type
- Number of Carers approved
- Placements, and
- Recruitment
-

The Service Manager advised what was working well within the service, these were as follows:

- The service has successfully appointed permanent experienced social workers
- The leadership within the fostering service was stable
- The fostering academy was being developed and was due to be launched early 2022. This has been bought it as there has been reports across the whole Country that foster carers need the right foundations in terms of support and assessments. The Academy would continue this support.
- The service was heavily focusing on staff development and have a plan for this learning throughout 2022. This would provide in-depth training for staff.
- The Service will be implementing the Mockingbird model of practice, which is evidence based for creating stability for our children. Funding has been approved and further information would be provided at the next meeting.
- Assessments under regulation 24 are reducing in timescale from referral to completion. Previously this has been an areas of vulnerability.
- Training support and development offer to Kinship/connected carers continues to increase and this is further supported through working with kinship carer groups.

In terms of communication, a Board member queried how we receive feedback from foster carers with regard to the provision Middlesbrough offers.

- Methods of communication was as follows:
- Monthly supervision with supervising social worker
- Management team always accessible and Duty system is available in the absence of their supervising social worker.
- Monthly consultations
- Number of social workers now attend the foster carers association meetings (held monthly)
- Facebook page
- Quarterly newsletter
- Slido questionnaire (digital questionnaire)- this will be repeated in the New Year
- Support groups for connected and mainstream carers.
-

The Head of Service further outlined that a communication strategy was being finalised which would bring together all of these key communication strands.

A Board member outlined it would be interesting to view feedback /analysis from the online questionnaires. This information be provided at a later date.

AGREED- That the information be noted.

21/6 **MIDDLESBROUGH CHILDREN'S SERVICES- VIRTUAL SCHOOL- INTERIM ANNUAL REPORT 2020/ 21**

The Head of Virtual schools was in attendance to provide information in relation to the Virtual Schools Interim report. The Boars were advised that all Virtual Schools Heads were expected to present an Annual report, which will be submitted in March 2022.

The Interim report was not a statutory requirement, however it was felt Corporate Parents should be informed how children looked after are academically progressing prior to March 2022.

The Head outlined some of the highlights from the report:

- Work of the staff within the virtual school must be recognised
- Middlesbrough schools should also be congratulated for ensuring our children looked after receive the best possible education. All Children looked after have a Personal Education Plan (PEP) and the Virtual schools tried to ensure that they are present at every review meeting so that the PEP can be challenged and support schools to provide the best education.
- In terms of PEP completion, 100% of children had a plan within the timescales provided
- Children received many challenged in 2020, especially in relation to social, emotional and mental health and it was recognised that support young people and support schools.
- Headstart (managed by Wendy Kelly) provides an excellent service, however virtual schools wanted to ensure they knew what support children were receiving. The Virtual schools commissioned ABC counselling to ensure children looked after were fast tracked to receive the correct mental health support. The virtual schools also offers the attach, aware and trauma informed programme. 2 schools had completed the programme and a further 6 schools had signed up to complete this.
- Online training has continued and we offered more indepth support by ensuring PEP advisors contacted schools weekly to offer additional support if required.
- Middlesbrough Virtual Schools is rare in that it offers an Intervention Centre, which offers 1:1 tuition to children who are not meeting academic levels and who can assess the provision.
- The Virtual schools also celebrate success and were able to take a group of young people to Darlington Hippodrome to see Horrible Histories. It has been rare over the past year to do face to face activities and enrichment so this was a lovely experience for the young people and staff involved.
- In terms of academic outcomes, it was difficult due to the variables which need to be taken into consideration. The Head of Virtual schools outlined that normally there would be national and local benchmarks for children looked after and children not looked after. These benchmarks were not currently available.

- There had been a dip in Key stage 2 and within early years, but at key stage 4, outcomes appear to be higher than pre covid. However the Board were made aware that making year on year comparisons was difficult to make good inferences. Many factors affect the academic achievement of a child looked after all affect the outcomes.
- In terms of the gap at key stage 2, all children looked after are given £1,000 grant for their transition to key stage 3 (secondary). For those children not meeting targets, the virtual schools meet with secondary schools and individuals are offered 1:1 support within the intervention centre. The areas of concern are also identified within their PEP and monitored regularly. This key stage cohort, struggled with transition and had historical attendance records and well as a high level of SEN.
- There have been 0% looked after children permanently excluded from Middlesbrough schools in the past 4 years.
- Through Covid, it was also noted that children looked after do better academically with higher adult ratios. Fixed terms exclusions deceased during covid for children looked after, however increased when all children returned to school.
- A Care leaver also congratulated the service in securing laptops for all children looked after during the lockdown, as this tackled digital inequality.
- Attendance for children looked after was higher than children not looked after.
- It was important to celebrate achievement of children looked after. During Care leavers week, the Virtual School worked with colleagues in Children's Services to ensure that all children received a package in the post with a gift and a personalised card noting how we, as corporate parents are proud of them for their individual achievement. Individual achievements are celebrated through awards and there is an attendance award for any child looked after who had 100% attendance.

The Board noted the excellent achievements of Key stage 4, but had concerns that these were teacher assessed grades (TAG) but these were potentially over inflated, and therefore these may vary when the routine GCSE papers return to be externally marked.

The Head of Virtual schools also outlined that the service had been successful in receiving Post 16 pilot bid of £64,000, which meant post 16 could continue with their next stage of education.

The Head of Virtual schools was thanked for her presentation.

AGREED- That the information be noted.

21/10 **SOUTH TEES YOUTH OFFENDING SERVICE**

The Chair welcomed the Head of Partnerships to the meeting to provide an overview of the South Tees Youth Offending Service (STYOS) and its support for children looked after.
A briefing paper had been circulated prior to the meeting and therefore the Head of Service outline she would provide the key points to the Board.

In terms of the National context, the Youth Justice Board (YJB) for England and Wales is an independent public body appointed by the Secretary of State for Justice, who have a statutory responsibility to oversee the whole of the youth justice system. The YJB published their Strategic plan 2021-2024 in October 2021 and the document outlines their vision, mission statement, and three strategic priorities which are underpinned by the central guiding principle of a 'Child First' youth justice system.

The YJB are clear that the justice system must see "*children as children first, and offenders second".* In line with the Child First vision, the YJB wants to make sure that children are not unnecessarily criminalised as a result of their vulnerabilities and the challenges they face.
In order to achieve these strategic aims, Youth Offending Service's are required to produce a Youth Justice Plan each year which details their local priorities. South Tees Youth Offending Service has developed a strategic youth justice plan for 2021-22 aligned to the values of the YJB, and as part of this will look to embed the child first principle in to operational practice.
Youth Offending Service's have three key strategic priorities on which they are measured;

- To reduce first time entrants to the youth justice system
- To prevent re-offending by children and young people
- Reduce the use of custody for young people (both sentenced and remanded)

Quarterly performance data is returned to the YJB in relation to the three national outcome measures, and also reported to the STYOS Management Board along with a number of other performance indicators.

In terms of the role of Youth Offending Services;

- Youth offending teams (YOTs) supervise 10–18-year-olds who have been sentenced by a court, or who have come to the attention of the police because of their offending behaviour but have not been charged – instead, they were dealt with out of court (Out Of Court Disposal).
- YOTs are statutory partnerships, and are multidisciplinary, to deal with the needs of the whole child.
- The service was required to have staff from local authority social care and education, the police, the National Probation Service and local health services
- The Youth Justice Board (YJB) provides some funding to YOTs. The YJB also monitors our performance and issues guidance about how things are to be done (for example National Standards)
- HMIP are their regulating body

In terms of the Youth Justice Plan, The STYOS 2021-2022 Youth Justice Plan was submitted to the YJB in June 21. The Plan details:

- YOS Performance 2020-21
- The YOS Budget for 2021-22
- Details of Service Structures
- Staffing Arrangements
- Partnership Arrangements
- Risks to Service Delivery
- Service Priorities for 2021-22

In terms of caseload demographics, the Head of service showed a table which showed a data snapshot, which outlined that the majority of young people who have been open to the service within this six month time frame were white British boys aged 17, 15% of whom were looked after children, however this figure is changeable.
The profile of the types of offences committed by young people and the factors impacting on the offending by young people were detailed in the STYOS Youth Justice Plan.

In terms of what STYOS can offer children looked after, the Head of service outlined that: STYOS:

- Work with care home staff and Police to identify appropriate responses to young people who offend in residential settings, including the use of restorative intervention as a solution to challenging behaviours
- Ensure active STYOS attendance at all planning or strategy meetings for young people with CLA status
- STYOS safeguarding case managers provide an essential link to Children's Services teams in both Local Authorities as well as providing advice and guidance to colleagues on safeguarding issues and processes.
- Ensure all Intervention Plans for CLA are shared with young people, their carers and colleagues from Children's Services
- Developed joint supervision arrangements between STYOS and Middlesbrough Children's Services
- Developed a working agreement between STYOS and Early Help to ensure joint planning and supervision arrangements are in place, the aim being to reduce

escalation in the criminal justice and / or looked after system by working collaboratively.

- STYOS provide a 'single points of contact' for the Multi Agency Children's Hub to provide information and advice on young people known to STYOS.

- Reciprocal arrangements are in place to offer access to case management systems and this allows the MACH to ascertain if the case is open to STYOS and/or YOS staff to systems to identify if new referrals are known to children's services and ensure that joint working commences at the earliest opportunity.

In terms of key development over the past year towards supporting children looked after.
In 2019, STYOS was inspected and HMIP recommended that 'there is specialist education provision, in the Youth Offending Service to meet the needs of children and young people who are not accessing suitable education'. The link between education and YOS was key as we know there is a risk of 'NEET' young people becoming involved in criminality. A member of staff was employed to specifically look at this and there have been three key developments in the last 12 months:

1. Strengthened the relationship with the Virtual school and have developed a joint protocol. This joint working improves communication and supports the Virtual school to create robust Personal Education Plans, and enables young people to be identified for support at an earlier point.

2. They have developed a Children looked After (CLA) 'NEET' forum – Information Sharing Agreement in place with Middlesbrough College has been written which enables Looked After Children to be supported by the College to reduce their risk of becoming NEET.

3. Joint Custody protocol - for young people who are given custodial sentences. Protocol aims to improve information flow, and robust planning in place to improve the transition between the community and custodial establishment to aid resettlement.

STYOS recognises the needs to offer an 'over and above' service to our Looked After Children.

- Caseloads are monitored to ensure we do not have over representation in the criminal justice system

- Systems and processes in place to robustly manage our CLA in our service

- Collaborative and joined up work with partners. Protocols and joint working arrangements ensure clear lines of accountability.

- Young people are offered a good service, appropriate to their need and supported by trained, skilled professionals

<u>Challenges and next steps:</u>

- Covid – adapted ways of working with our young people, and will continue to ensuring the right digital solutions are in place.

- Developing understanding and responding to the risks presented by young people at risk of or involved in serious violent crime and exploitation. This was a strategic priority.

- Prevention – longer term sustainability of the current model to divert young people including CLA away from the criminal justice system. Prevention is not a statutory function and YOTs do not receive specific funding, therefore we are exploring longer term funding solutions and continue to work with colleagues in community safety and the police to try and divert young people from the CJS.

- Embed the positive developments in ETE and monitor the impact of this work

- Progress will be monitored via YOS Management, YOS Board and YJB.

Following the presentation, a Board member queried whether the service sees new cases or generally repeat offenders. In response, the Head of Service advised it was a mix, as they do

have a reduction of first time entrants coming through the system but have a challenge as have about 50% who come through as repeat offenders.

Another Board member asked for clarity in terms of STYOS partners and what were the consequences for the young people who did not comply to their terms.

In terms of Statutory partners, STYOS link with the Local Authority, collegues in Social Care, Cleveland police, the national probation service, and health but also have partnerships with numerous voluntary services e.g. who deal with substance misuse.

In terms of the consequences for young people, it depends at what starting point they come in to the system. There are numerous sanctions and disposals (out of court/ in court). Regardless, the disposals and outcomes are carefully considered to ensure the decision is right for the young person and also the community, SYTOS have offending behavior programmes (1:1 or group) and restorative justice practitioners engage with all identifiable victims of youth crime, restorative practice was a strategic priority for STYOS in 21/22 and the service is working towards an accreditation status. In terms of consequences for those who don't comply with their disposal they are either returned to Police (if on an out of court disposal), or dealt with via breach process in the Court arena. Non-compliance is taken very seriously and the service ensure that enforcement action is taken where appropriate.
A Board member also asked whether it would be possible to look at the reoffending rates of when they do end the order, looking at the whole situation and why they do reoffend.
STYOS carefully track and monitor re-offending however are not currently informed of offences committed by a young person after the age of 17. These post-18 offences impact the reoffending data and so is not comparable with nationally published reoffending statistics. Re-offending figures are reported to the Board and YJB on a quarterly basis.

The Head of Service was thanked for her presentation.

AGREED- that the information be noted.

21/11 **PERFORMANCE AGAINST CORPORATE PARENTING STRATEGY**

The Head of Looked after Children and Corporate Parenting was in attendance and provided the Board with information relating to the Corporate Parenting Board scorecard.

The Director advised that the scorecard was in place for the Corporate Parenting Board to see how our performance was progressing and have the opportunity to challenge anything where you saw wasn't meeting target.

The main points to note were as follows:

Demand

- There has been an 18.1% reduction in overall numbers of children looked after since November 2020, evidenced on graph 1.
- Since the height of 702 looked after children during September 2020, there has been a reduction of 167 looked after children.
- The rate of looked after children per 10,000 of the population has reduced from 165.1 in September to 159.4 on 29 November.
- This remains higher than our statistical neighbour where the rate of looked after children per 10,000 is 125.5.
- 125 children and young people have ceased to be looked after in the last 6 months. 103 children have become looked after in the same period

In November 2020 the data evidences that for every child ceasing to be looked after, 1.8 children started to become looked after. This means that more children were becoming looked after than ceasing and the looked after population continued to increase.

There has been a month on month reduction in this throughout the year until March 2021 when improvements resulted in less children becoming looked after than those ceasing. This progress has continued. In June 2021 for every child ceasing to be looked after 0.6 children became looked after. This has remained static for the last 4 months.

Permanency

- In October 25 children ceased to be looked after. Data evidences that the average number of days that these children were looked after was 151.8 days. A review of the data shows that of these 25 children 5 had been looked after for 5 years or over. 3 of which had turned 18 years.
- This evidences improvements from last month when permanence was secured for children who had been looked after for long periods of time.
- There have been 9 SGO/CAOs granted in October and a further SGO at the end of September granted that was not recorded in the September performance report. This is largely due to Innovate Phase 2 working through assessments and reaching the stage where applications are lodged and considered by the court.
- 34 SGOs have been secured in the last 6 months leading to permanence for looked after children, 90 SGOs have been secured in the last 12 months.
  Placements with Parents – There were currently 51 children placed with parent. 39 of these children are subject to a full Care Order. All are tracked by Permanence Monitoring Group through to revocation of Care Order.
- In September 2020 there were 99 children living at home and subject to a Care Order. This has reduced to 51 children in September 2021. This is 51.5% reduction. 6 children ceased to be looked after from a placement with a parent in October.
- Data shows an ongoing downward trend.

Adoption

- There is a 56% increase of number of adoption orders in the year 20/21 (25) compared to 2019/2020 (16).
- In this year to date 17 Adoption Orders have been secured. There are currently a further 32 children progressing to adoption with Placement Orders. Only 2 children are not linked to adopters
- The local authority is on track to increase the number of children subject to adoption orders significantly in this financial year.
- Data evidences that the number of days between children entering care and being placed in an adoptive placement has reduced from 641 in January 2021 to 382 days.

Placements

- The Head of service advised that Graph 1 data shows an increase in the number of children in placed outside of a 20 mile radius.
- 33 children commenced a new placement in October. Of which 18 children were placed in Middlesbrough and a further 8 in the Teesside region.
- Of the 7 children that were placed outside of Teesside – 1 child was adopted, 1 placed in a Young Offenders Institute and 4 children were placed in external residential placements. These were 4 complex young people.
- Targeted work is underway to move children in a planned way to in-house residential placements.
- In terms of Graph 2 – Data shows an increase in the number of children placed with in-house foster carers. 20.4% of looked after children are placed in in-house placements which is 0.6% below target and improved performance.
- There has been a reduction in the number of children in Connected Carers placements, evidencing more children securing permanence. The performance in this area is exceeding the target. Of 29% of children in care being in Connected Carer placements. There are currently 24.3% with less being better.

Placement Stability

- The data evidences that of all the children currently in Middlesbrough care, 65.9% have had only one placement in the last 12 months. This was 4.1% below the target of 70%
- At the end of October 2021 – 37 children looked after by Middlesbrough had experience 3 or move placement moves in the last 12 months. (6.9% of the cla population).
- Positively this has reduced from 39 in September 2021. This has reduced from 136 in the same period last year. There has been a 71.3% reduction in the number of children experience experiencing multiple moves. This is lower than

the regional and statistical neighbours and the England average and is very strong performance.

Finally the Head of Service outlined some of the quality and impacts:

Visits
96% of looked after children have been seen within the last 6 weeks.
This was a 1% decrease from last month. This has been consistently high at over 90% since May.

Supervision/Management Oversight
91% of looked after children have had a supervision within the month of October 2021. There were 36 children who have not been supervised within October.
This was a 3% decrease from last month. This has been consistently high at over 90% since May.

Personal Education Plans
Performance in relation to PEPs remains high at 94% of children having a recorded PEP within the last 6 months. This performance has remained consistently high and has not dropped below 93% for the last 12 months.

Health Assessments
90.8% of health checks have been conducted and recorded within the last 12 months. This does not take in to account those older children who have refused a medical assessment. This has been a 0.7% reduction since September 2021. Performance has been consistently high at over 90% for the last 12 months.

Following the presentation, a Board Member asked whether it would be possible to view other data sets linked to the scorecard, e.g. gender/ ethnicity/ aspects of special educational needs to view targeted statistics.

The Head of Service advised that at present there are more males in care than females, however would be happy to provide closer analysis.

The Director of Children's Services advised that it would be useful for the next scorecard to focus on slightly varied data, provided a different range (as discussed), which would widen discussion. This would cover why children come into care and the number of children who have been prevented coming to care due to the edge of care service.

AGREED
- That the information be noted
- That the information be provided in another form at the next meeting.

21/9 **INDEPENDENT REVIEWING OFFICER (IRO) ANNUAL REPORT**

The Interim Principe Social Worker was in attendance to provide an overview of the Independent reviewing officers' (IRO's) annual report.

The report was a statutory requirement and provided information on the Independent Reviewing Officers (IROs) and their contribution to improving outcomes for children in care, care leavers. In Middlesbrough the IROs have a dual role and therefore the report included those children subject to a Protection Plan. The report focuses on the reporting year April 2020 to March 2021.

. The statutory duties of the IRO are set out in Section 25B (1) Children Act 1989;

- Monitor the performance by the Local Authority of their functions in relation to the child's case;
- Participate in any review of the child's case;
- Ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the appropriate authority; and
- Perform any other function which is prescribed in Care Planning Regulations.

There are two clear and separate aspects of the function of an IRO:

1. Chairing the child's review; and
2. Monitoring the child's case on an ongoing basis.

In Middlesbrough there are 14 IROs overseen by 2 team managers. The service has increased in capacity.

Over the year period, there has been a significant demand on the service. As the IRO's have a dual role, there was also a demand and there was a larger number of children requiring a child protection plan and therefore the caseloads for an IRO increased to just over 100 during the reporting period.

This has been addressed by introducing the team managers and there is additional agency staff to reduce the number of children per IRO.

The report was based on - If Middlesbrough was a village of 100 population, what would that mean for our children, in terms of number and performance and what does that performance mean for our children?

The Officer provided the Board with key messages about children in care and what the quality assurance tells us about children in care, all details were included within the report.

In terms of improvements for children in care, the service wishes to:

- Ensure children to have plans of permanence as early as possible, and to be part of developing their own plan.
- That all children (at least 95%) to be seen before their review by their IRO, as well as keeping in touch between reviews to make sure that children and young people benefit from having a relationship with their IRO. For children who are not living in their forever home, this should be more often so that the IRO knows that the plan for the child is progressing, and if it's not, then this can be addressed as soon as possible.
- That IROs to raise issues (using the Issues Resolution Process) when there are concerns about the timeliness and quality of all plans for children, this includes care plans for permanence, EHCPs, PEPs and Health plans.
- IROs will be working on making sure everyone who cares for the children and works with children has high aspirations, which means have high hope, dreams and goals.
- If IROs make recommendations about what should happen for you, they need to make sure they are SMART
  Feedback regarding IROs has been reassuring, and comments have included for example:

My IRO is great I have had her for a while now and she always makes sure I'm heard and my wishes are pushed f My IRO is great I have had her for a while now and she always makes sure I'm heard and my wishes are pushed forward. I think the IRO system is very useful - ***CHILD***

The Interim Principle Social Worker further discussed the key messages for children on a child protection plans.

In terms of improvements, the Board were made aware that the service wish to:

- Ensure all children have a child protection in conference in timescales, unless there is exceptional circumstances (so 95% of the time).
- When the conference takes place, the service want everyone to feel properly prepared, particularly parents and the child. The service want children to feel able to attend and speak at their conference, but if this isn't possible we want to make sure that children's views are gathered by professionals or an advocate and meaningfully contribute to the conference.
- The service want to make sure that between conferences, the conference chair continues to check on the progress of plans, and if there is any worries about the plan not achieving the agreed outcomes, then the IRO will swiftly raise an issue. It's

important this is done in a constructive way as a critical friend, working with the Social Worker and other professionals to address issues as early as possible for children. This will include making sure that Core Group Meetings happen regularly.

- The service want children to have child protection plans that quickly make a positive difference, this means we will have less children with plans that last over 15-months. And want less children to have more than 1 child protection plan.

To achieve the goals for children with a protection plan the service will hold regular challenge clinics to increase oversight from Managers and Senior Managers. These clinics help us to understand any patterns in practice that we might need to change. During 2020/21 there has been challenge clinics on;

- Children with a protection plan over 15-months
- Children who have had more than 1 protection plan.

In terms of priorities for 2021/22 the Interim Principle Social worker outlined that the IRO improvement journey will remain closely linked to the Children's Services Improvement Plan and the priorities for 2021/22 will be;

- Maintain compliance with KPI's (ICPC, RCPC, CLA Review timeliness)
- Increase child participation, including visits before reviews
- Mid-way reviews for all children is a minimum standard, with increased continuous oversight for those without stability and permanence
- Increased scrutiny and challenge when permanence is not achieved in a timely way
- Strengthen the impact of IRO Challenge and demonstrate IROs have high aspirations for Middlesbrough children
- Create specialisms within the IRO Service, to better support particular groups of children i.e. care leavers, unaccompanied asylum seeking children
- Increase support and feedback mechanisms for parents
- IROs contribute to overall practice priorities by monitoring quality of performance

Following the presentation, the foster carer outlined that we need to ensure children in care are addressed the way they wish. In response, the Chair agreed and advised that further work was progressing on this.

The officer was thanked for her excellent report.

AGREED
That the report be noted.

21/12 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED.**

Foster Carers and social workers

The Chair addressed the public advising that if anyone wished to become a foster carer or social worker to please contact Middlesbrough Council.

Royal College of Nursing

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Looked after Children: roles and competencies of healthcare staff

December 2020

INTERCOLLEGIATE DOCUMENT

Published by the Royal College of Nursing on behalf of the Royal College of Paediatrics and Child Health

Acknowledgements

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Contents

Key definitions

Children and young people

We define children and young people as all those who have not yet reached their 18th birthday.[1] The unborn child must also be considered.

The changing scope of service provision increasingly however encompasses care leavers and young people in education, as well as young adults up to the age of 25 years.[2]

Looked after children[2]

This term is used to describe any child who is in the care of the local authority or who is provided with accommodation by the local authority social services department for a continuous period of more than 24 hours. This covers children in respect of whom a compulsory care order or other court order has been made, including those on an adoption pathway. It also refers to children that are accommodated voluntarily, including under an agreed series of short-term placements which may be called short breaks, family link placements or respite care, as well as those who are on remand.

Care leavers[3,4]

Those children and young people formerly in care before the age of 18 years of age. Such care could be in foster care, residential care (mainly children's homes), or other arrangements outside the immediate or extended family.

Corporate parenting

The term in England set out in the Children Act 2004 refers to the collective responsibility of the local authority and partner agencies including health to provide the best possible care and protection for looked after children and to act in the same way as a good parent/ birth parent would.

1 There is no single law that defines the age of a child across the UK. The UN Convention on the Rights of the Child, ratified by the UK government in 1991, states that a child "means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier" (Article 1, Convention on the Rights of the Child, 1989 https://www.unicef.org.uk/what-we-do/un-convention-child-rights). In the UK, specific age limits are set out in relevant laws or government guidance. There are, however, differences between the UK nations." In England, Working Together (2018) refers to children up to their 18th birthday. In Wales, for example, the All Wales Child Protection Procedures (AWCPP2008) "A child is anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout. The fact that a child has become sixteen years of age, is living independently, is in further education, is a member of the Armed Forces, is in hospital, is in prison or a young offenders institution does not change their status or their entitlement to services or protection under the Children Act 1989." www.childreninwales.org.uk/policy-document/wales-child-protection-procedures-2008. The NSPCC website contains a helpful outline of differences in legislation across the four countries of the UK https://learning.nspcc.org.uk/child-protection-system/?_ga=2.259743619.82790662.1537439358-153728393.1485944624. The Mental Capacity Act 2005 applies to children who are 16 years and over. Mental capacity is present if a person can understand information given to them, retain the information given to them long enough to make a decision, can weigh up the advantages and disadvantages of the proposed course of treatment in order to make a decision, and can communicate their decision. The deprivation of liberty safeguards within the Mental Capacity Act 2005 (MCA) do not apply to under 18s www.legislation.gov.uk/ukpga/2005/9/contents; The Children and Social Work Act 2017 www.legislation.gov.uk/ukpga/2017/16/contents/enacted. In Scotland, The Age of Legal Capacity (Scotland) Act 1991 (c.50) www.legislation.gov.uk/ukpga/1991/50/contents is an Act of the Parliament of the United Kingdom applicable only in Scotland which replaced the pre-existing rule of pupillage and minority with a simpler rule that a person has full legal capacity, with some limitations, at the age of 16. In Northern Ireland, Mental Capacity Act (Northern Ireland) 2016 www.legislation.gov.uk/nia/2016/18/section/1/enacted.

2 The term Looked After Children is used throughout the document for consistency, recognising that varying terms maybe used. For example in Scotland the term 'looked after and accommodated children' is used and in some parts of the UK children and young people have expressed a preference for the term 'children in care' and for care leavers, the term care experienced is also used.

3 The term care experienced is also used in some parts of the UK.

4 www.legislation.gov.uk/uksi/2010/2571/made

Competence

The ability to perform a specific task, action or function successfully.

Designated professional

In England, the term designated doctor or nurse denotes professionals with specific roles and responsibilities for looked after children, including the provision of strategic advice and guidance to service planners and commissioning organisations.[5] In England, designated professionals (doctors and nurses) are statutory roles (see Appendix 4).

In Wales, designated professionals for safeguarding (including looked after children) are employed by Public Health Wales and have national roles. The strategic overview of health services for looked after children within each health board is fulfilled by the named doctors for looked after children with additional responsibility (named doctor for looked after children, strategic role).

In Scotland, specialist paediatricians, GPs and nurses deliver services for looked after and accommodated children/young people, including health assessments and provide medical advice to fostering and adoption panels. The lead paediatrician for each area has a strategic overview and responsibility. In addition, NHS health boards have a nominated board director with corporate responsibility for looked after children, young people and care leavers CEL 16 (2009).

In Northern Ireland, designated professionals provide strategic advice about safeguarding children and looked after children to key regional bodies including public health agency and Safeguarding Board Northern Ireland.

Specialist medical, nursing and health professionals for looked after children, including named nurse/doctor and nurse specialists[6]

These terms refer to registered nurses with additional knowledge, skills and experience, GPs or paediatricians that have a particular role with looked after children and are the health specialist for these children.

In England, the term named doctor/nurse denotes an identified doctor or nurse with additional knowledge, skill and experience in working with looked after children who is responsible for promoting good professional practice within their organisation, providing supervision, advice and expertise for fellow professionals, and ensuring that looked after children awareness training is in place.

5 Designated professionals should have regular, direct access to the CCG accountable officer or chief nurse to provide expert advice and support for looked after children matters, and they should also be invited to all key partnership meetings.

6 In Scotland titles include specialist nurse looked after children; specialist nurse looked after and accommodated children, health liaison officer through care; public health nurse/looked after children; public health nurse/looked after and accommodated children; public health nurse/through care and after care; through care/after care health practitioner; specialist nurse through care/after care titles include clinical nurse specialist/co-ordinator looked after children; public health facilitator. In Northern Ireland there are lead clinicians and specialist nurses promoting the health and wellbeing of looked after children. In Wales: clinical nurse specialist for looked after children, named doctors and nurses/lead professionals and medical advisers for looked after children. In England, titles include named nurse for looked after children, specialist nurse children in care, nurse health advisor looked after children.

Safeguarding/contextual safeguarding

Safeguarding is a term used in the UK and Ireland to denote measures to protect the health, wellbeing and human rights of individuals, which allow people – especially children, young people and vulnerable adults – to live free from abuse, harm and neglect.

Any child can be considered to be at risk of harm or abuse, regardless of age, ethnicity, gender or religion. The UK government has enacted legislation and published guidance to protect children from maltreatment, prevent the impairment of children's health or development, ensure children grow up in circumstances consistent with the provision of safe and effective care, and enable children and young people to have the best outcomes. Responsibility for these aims is deemed to lie with everyone who comes into contact with children and families.

Contextual sfeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. **www.csnetwork.org.uk/en/about/what-is-contextual-safeguarding**

Trauma informed care

Trauma informed care is an organisational structure and treatment framework that involves understanding, recognising, and responding to the effects of all types of trauma. Trauma informed care also emphasises physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

Glossary

ACEs	Adverse childhood experiences
CCG	Clinical commissioning group
CPD	Continuous professional development
CSA	Child sexual abuse
CSE	Child sexual exploitation
CQC	Care Quality Commission
DNA	Did not attend (may also be 'was not brought (WNB)' in paediatric population)
FGM	Female genital mutilation
FNP	Family Nurse Partnership
GDPR	General Data Protection Regulation
GMC	General Medical Council
GPs	General practitioners
HCPC	Health and Care Professions Council
LA	Local authority
LSCB	Local safeguarding children's boards (now referred to as partnerships, LSCP in England)
LSP	Local safeguarding partnerships
NHS	National Health Service
NMC	Nursing and Midwifery Council
OfSTED	Office for Standards in Education, Children's Services and Skills
PHE	Public Health England
PRUDIC	Procedural response to unexpected deaths in children
PTSD	Post-traumatic stress disorder
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and child Health
SAS	Specialty and Associate Specialists
SCR	Serious case review
SUDIC	Sudden unexpected death in childhood
UASC	Unaccompanied asylum-seeking child
UN	United Nations

Foreword

Over recent years there has been a significant rise in the number of looked after children across the UK, although there are variations in trends between the four nations. The number of looked after children has however increased steadily each year and is now higher than at any point since 1985.[7] For the majority, this is as a result of abuse or neglect, although there is an increasing number of unaccompanied asylum seekers and children who have been trafficked from abroad. Looked after children and young people have greater mental health problems, as well as developmental and physical health issues such as speech and language problems, bedwetting, co-ordination difficulties and sight problems. They are more likely to be involved in risk taking behaviour, the youth justice system and have poorer educational attainment.

Health professionals must also be mindful of the increased needs of care experienced children and young people which can be during childhood but also after 18 years old. Carers and professionals should practice trauma informed care and at all times be aware of new safeguarding needs. We also have a duty to profile contextual safeguarding of care leavers.

Healthcare staff working with this group of children and their carers[8] must have the right knowledge, skills, attitudes and values, particularly as access to highly skilled and knowledgeable health practitioners results in improved outcomes, enabling young people to achieve their full potential. In order to achieve the required improvement in outcomes for these vulnerable children and young people, there continues to be the need for health staff working in dedicated roles for looked after children at specialist, named and designated level. Such postholders require specific knowledge and skills that are distinct from individuals whose primary focus may be centred on child protection and safeguarding.[9]

The Royal Colleges recognise the importance of education and training to prepare practitioners for the roles and responsibilities entailed in working with looked after children and care leavers. Recognising work previously undertaken in Scotland,[10] the review of the intercollegiate safeguarding competences framework[11] continued to highlight that whilst many children and young people move in and out of the looked after children system there is a need for a separate, specific framework to be developed for looked after children, outlining key roles, and the knowledge and skills required.

7 Department for Education. SFR 36/2013. Statistical First Release. Children looked after in England (including adoption and care leavers) year ending 31 March 2013. September 2013. www.gov.uk/government/uploads/system/uploads/attachment_data/file/244872/SFR36_2013.pdf

8 GPs are often asked to provide detailed health information to contribute to the health assessment for those applying to be foster carers. The GMC guidance on writing references applies – GMC (2010) Good Medical Practice www.gmc-uk.org/guidance/ethical_guidance/writing_references.asp

9 Mooney A, Statham J, Monock E. *Looked after children: a study to inform revision of the 2002 guidance*. Institute of Education, University of London. 2009. www.education.gov.uk/publications/eOrderingDownload/DCSF-RR125.pdf

10 NHS Education Scotland. *A capability framework for nurses who care for children and young people who are looked after away from home*. 2009.

11 See *RCN Safeguarding Children and Young people: roles and competences for healthcare staff 4th Ed.* 2019. www.rcn.org.uk/professional-development/publications/pub-007366

We urge health service planners, commissioners and provider organisations to recognise the importance of enabling staff to access education and training, as well as flexible learning opportunities to acquire and maintain knowledge and skills to improve outcomes for looked after children and young people.

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Background

A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Each nation within the UK has a slightly different definition of a looked after child and will follow its own legislation and guidance. Looked after children are also often referred to as children in care and this is a term that many children prefer.[12]

Looked after children fall into five main groups:

- children who are accommodated under a voluntary agreement with their parents
- children who are subject to a compulsory care order, interim care order or supervision order staying with birth family or other legal orders
- children who are the subject of emergency orders for the protection of the child
- children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a Youth Rehabilitation Order with a residence requirement
- children in respite/short breaks who are subject to the same statutory reviews as looked after children.

You are advised to refer to the respective legislation and statutory guidance in the country in which you are practising as there are slight differences in the definition of a looked after child across the four nations of the UK. According to the United Nations Conventions on the rights of the child, a child is defined as everyone under 18 years old, unless "under the law applicable to the child, majority is attained earlier".[13]

The number and rate of children looked after in the UK are increasing overall, although trends vary between the four nations. The numbers of children looked after in England, Wales and Northern Ireland has continued to increase:

- in England this is up by 4% to 78,150 at March 2019[14]
- in Wales this is up by 7% to 6,846 at March 2019[15]
- in Northern Ireland At 31 March 2019, 3,281 children were in care.[16] This was the highest number recorded since the introduction of the Children (Northern Ireland) Order 1995

In contrast:

- in Scotland, the number of looked after children peaked at 16,248 in 2012 and was down to 14,897 by 2017.[17]

This is partly due to differences between the nations around when children are counted as being 'in care', and what this means in practice. Because of these differences, rates cannot be directly compared between nations.

12 NSPCC. 2019, *Statistics Briefing: looked after children.* https://learning.nspcc.org.uk/media/1622/statistics-briefing-looked-after-children.pdf

13 United Nations Office of the High Commissioner. 1990, *Convention on the Rights of the Child.* www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

14 Department for Education (DfE). 2019, *Children looked after in England (including adoption) year ending 31st March 2019.* December 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/850306/Children_looked_after_in_England_2019_Text.pdf

15 Llywodraeth Cymru, Welsh Government. 2019, *Statistical First release; children looked after by local authorities 2018-19.* https://gov.wales/sites/default/files/statistics-and-research/2019-10/children-looked-after-local-authorities-april-2018-march-2019-964.pdf

16 Department of Health Northern Ireland (DoHNI). 2019, Information Analysis Directorate; *Children's social care statistics for Northern Ireland 2028/19.* www.health-ni.gov.uk/sites/default/files/publications/health/child-social-care-18-19.pdf

17 Scottish Government. 2018, *Children's social work statistics Scotland, 2017/18.* www.gov.scot

The different UK nations publish datasets at different times of the year, so available data will not always be for the same year across the UK.

However we can't say for sure whether it is trending in the right or wrong direction; we don't know if a rise in numbers is because of a higher incidence of, say, neglect, or because the services that exist are getting better at identifying and dealing with need. Depending on what and how you are discussing it can be positive or negative that more children are in care. In either case, the message is consistent—there is a rising demand for services to support children in care.

The main reason for children being in care remains as a result of abuse and neglect, but only England and Wales publish information on why children are looked after.

Other reasons for being looked after include:

- family dysfunction (England: 15%, Wales 14%)
- family in acute stress (England: 8%, Wales: 8%)
- child's disability (England: 3%, Wales: 4%)
- parent's illness or disability (England: 3%, Wales: 3%)
- socially unacceptable behaviour (England: 1%, Wales: 2%).

This is important as children's pre-care experience can continue to affect them for many years after[18] and children remain vulnerable within the care system, with many children experiencing numerous placement moves. The *NHS Long Term Plan* recognises this vulnerability which includes care leavers and is a particular risk during periods of transition.[19]

Looked after children are over four times more likely to have an emotional or mental health need than their non looked after peers.[20]

According to the Centre for Social Justice, nearly a quarter of girls in care become teenage mothers and at least one in 10 care leavers aged 16-21 years who are parents have had a child taken into care in the last year.[21]

In 2017, the Care Leavers Association published a report containing a number of recommendations designed to improve the commissioning process and ultimately the health outcomes for care leavers.[22]

In addition, it is now more widely understood how adversity in pregnancy, childhood and adolescence can negatively impact on long-term health outcomes across a lifetime.

18 Rahilly T and Hendry E. 2014, *Promoting the wellbeing of children in care; messages from research*, NSPCC. http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2

19 NHS. 2019, *The NHS Long Term Plan*, www.longtermplan.nhs.uk/online-version

20 Bazalgette L, Rahilly T, Trevelyan G. 2015, *Achieving emotional wellbeing for looked after children; a whole system approach.* https://learning.nspcc.org.uk/research-resources/2015/achieving-emotional-wellbeing-looked-after-children-whole-system-approach/

21 Centre for Social Justice. 2019, Nearly a quarter of girls in care become teenage mothers reveals CSJ; Press release. www.centreforsocialjustice.org.uk/press-releases/nearly-a-quarter-of-girls-in-care-become-teenage-mothers-reveals-csj

22 The Care Leavers' Association/Department of Health. 2017, *Caring for Better Health: An investigation into the health needs of care leavers*. www.careleavers.com/wp-content/uploads/2017/12/Caring-for-Better-Health-Final-Report.pdf

A shift in focus is needed to include prevention of adverse childhood experiences (ACEs), resilience building, and a trauma informed approach to service provision.[23]

Local authorities with a strong corporate parenting ethos recognise that taking children into care is not just about keeping children safe, but also for promoting recovery, resilience and wellbeing. Partner agencies such as health, education and police services should understand how they can apply these principles to the services that they provide.[24]

The majority of children in the UK are looked after by foster carers. In Scotland where the care system is significantly different to the rest of the UK, a higher proportion (25%) of children are living at home with their own parents. The commonest reason for children to cease to be looked after is that they go back home to live with their parents.

A child ceases to be looked after when they are adopted, return home without a care order in place or turn 18 years old. However local authorities in all the nations of the UK are required to support children leaving care at 18 until they are at least 21 or to 25 years if in full time education or if the young person has a disability.[25,26] This may involve them continuing to live with their foster family. Local authorities should have a published care leavers offer detailing support available.

Local authorities and commissioners and providers of healthcare have statutory duties to co-operate to ensure that looked after children have their health needs fully assessed. There should be a health plan in place which is regularly reviewed and they should have access to a range of health services which meet their needs.[27]

Across the UK, specialist health professionals provide expertise and have specific roles and responsibilities for looked after children. In England, Northern Ireland, and Wales, specialist nurses, named professionals, medical advisors for fostering and adoption and designated professionals perform this function and in Scotland looked after and accommodated children's nurses and lead clinicians fulfil specialist roles. All specialist professionals must be allowed sufficient time and resources to undertake their duties, and their roles and responsibilities should be explicitly defined in job descriptions.

23 Hughes Karen, Bellis M, Hardcastle KA, Dinesh S, Butchart A, Mikton C, Jones L, Dunne MP. 2017, *The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis.* www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext

24 Department for Education. 2018, *Applying corporate parenting principles to looked after children and care leavers; statutory guidance for local authorities.* www.gov.uk/government/publications/applying-corporate-parenting-principles-to-looked-after-children-and-care-leavers

25 https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children

26 https://local.gov.uk/sites/default/files/documents/15.12%20Support%20for%20care%20leavers%20resource%20pack_02_1WEB.pdf

27 Department for Education/Department of Health. 2015, *Promoting the health and wellbeing of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England.* www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

Services and responsibilities for looked after children/looked after and accommodated children are underpinned by legislation, statutory guidance and good practice guidance which include:

England

- Children Acts 1989[28] and 2004[29]
- NICE Public health guidance, Looked after children and young people 2010[30]
- NICE *Quality standard for the Health and wellbeing of looked after children* 2013[31]
- *Care Leaver Strategy* 2013[32]
- Children and Families Act 2014[33]
- *Promoting the health and wellbeing of looked after children* 2015[34]
- Children and Social Work Act 2017[35]
- *Working together to safeguard children* 2018[36]

Scotland

- Adoption and Children (Scotland) Act 2007[37]
- Looked after Children (Scotland) Regulations 2009[38]
- *A capability framework for nurse who care for looked after children and young people away from home* 2009[39]
- Children and Young People (Scotland) Act 2014[40]
- *Guidance on health assessments for looked after children in Scotland* 2014[41]
- *Child Protection Guidance for health professionals* 2013[42]

28 www.legislation.gov.uk/ukpga/1989/41/contents

29 www.legislation.gov.uk/ukpga/2004/31/contents

30 National Institute for Health and Care Excellence (NICE). 2010 (updated 2015), *Looked after children and young people. Public Health Guidance*. www.nice.org.uk/guidance/ph28/chapter/1-recommendations

31 www.nice.org.uk/Guidance/QS31

32 www.gov.uk/government/publications/care-leaver-strategy

33 www.legislation.gov.uk/ukpga/2014/6/contents/enacted

34 www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

35 www.legislation.gov.uk/ukpga/2017/16/contents/enacted

36 www.gov.uk/government/publications/working-together-to-safeguard-children--2

37 www.legislation.gov.uk/asp/2007/4/contents

38 Scottish Government. 2010, Guidance on Looked after Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007. www.gov.scot/publications/guidance-looked-children-scotland-regulations-2009-adoption-children-scotland-act-2007/

39 NHS Education for Scotland. 2009, *A Capability Framework for Nurses Who Care for Looked After Children and Young People Away From Home.*

40 www.legislation.gov.uk/asp/2014/8/contents/enacted

41 Scottish Government. 2014, *Guidance on Health Assessments for Looked after Children in Scotland*. www.gov.scot/publications/guidance-health-assessments-looked-children-scotland/pages/6/

42 www.scotland.gov.uk/Resource/0041/00411543.pdf

Northern Ireland

- The Children (Northern Ireland) Order 1995[43]
- The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003[44]
- *Promoting the health and wellbeing of looked after children and young people: guidance for health visitors, school nurses, family nurses (Family Nurse Partnership) and looked after children nurse specialists* 2014/15[45]
- *Co-operating to safeguard children and young people in Northern Ireland* 2017[46]
- *Healthy child, healthy future; a framework for the Universal Child Health Programme in Northern Ireland*, Pregnancy to 19 years[47]
- *Safeguarding Board for Northern Ireland Procedures Manual*[48]

Wales

- Children Acts 1989[49] and 2004[50]
- All Wales Child Protection Procedures November 2019[51]
- The Social Services and Wellbeing Act (Wales) 2014[52]
- Part 6 and 9 Codes of Practice; Care Planning, Placement and Case Review (Wales) Regulations 2015[53]
- *When I am Ready* 2016 guidance for care leavers[54]

43 www.legislation.gov.uk/nisi/1995/755/contents/made

44 www.legislation.gov.uk/nisi/2003/417/part/III/made

45 www.publichealth.hscni.net/sites/default/files/directorates/files/LAC%20Regional%20Guidance%20March%202014%20V1%20Final.pdf

46 Department of Health Northern Ireland. 2017, *Co-operating to Safeguard Children and Young People in Northern Ireland.* www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland

47 Department of Health, Social Services and Public Safety. 2010, *Healthy Child, Healthy Future; A Framework for the Universal Child Health Programme in Northern Ireland, Pregnancy to 19 years.* www.health-ni.gov.uk/sites/default/files/publications/dhssps/healthychildhealthyfuture.pdf

48 www.proceduresonline.com/sbni/

49 www.legislation.gov.uk/ukpga/1989/41/contents

50 www.legislation.gov.uk/ukpga/2004/31/contents

51 www.childreninwales.org.uk/our-work/safeguarding/wales-safeguaring-procedures/

52 www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf

53 www.legislation.gov.uk/wsi/2015/1818/contents/made

54 https://gov.wales/sites/default/files/publications/2019-05/when-i-am-ready-good-practice-guide-march-2016.pdf

Competency framework

The framework

The competencies encompassed in the framework are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare, health and wellbeing of looked after children and young people, as well as care leavers. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice. *Promoting the health of looked after children*[55] refers to this specific intercollegiate framework stating 'health professionals contributing to the care planning cycle for looked after children should have the appropriate skills and competences and receive continuing professional development'. Looked after children still need safeguarding and therefore *Working together*[56] also signposts healthcare organisations to the intercollegiate safeguarding framework[57] and states that 'All staff working in healthcare services – including those who predominantly treat adults – should receive training to ensure they attain the competencies appropriate to their role and follow the relevant professional guidance'. Similarly, the GMC signposts to this document for all doctors and in Wales the Chief Nursing Officer has recommended the intercollegiate framework for NHS Wales.

Different staff groups require different levels of competence depending on their role and degree of contact with looked after children, young people and care leavers, the nature of their work, and their level of responsibility.[58] In response to the Laming Report, Independent Inquiry into Child Sexual Abuse[59] and other evidence such as serious case reviews or child practice reviews in Wales, there has been recognition of the importance of the level of competence of some practitioner groups, for example GPs and paediatricians.

This framework identifies five levels of competence and gives examples of groups that fall within each of these.[60]

Level 1: all staff including non-clinical managers and staff working in healthcare settings.

Level 2: minimum level for all non-clinical and clinical staff who, within their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children.

Level 3: all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the health needs of a looked after child/young person or care leaver.

Level 4: specialist medical, nursing and health professionals for looked after children and adoption, including named professionals and medical advisors for fostering and adoption.

55 Department of Health, Department for Education. *Promoting the health and welfare of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England.* 2015. www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

56 *Working Together to Safeguard children and young people.* www.gov.uk/government/publications/working-together-to-safeguard-children--2

57 See *RCN Safeguarding Children and Young people: roles and competences for healthcare staff 4th Ed.* 2019. www.rcn.org.uk/professional-development/publications/pub-007366

58 Department of Health, Department for Education. *Promoting the health and welfare of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England.* 2015. www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

59 www.iicsa.org.uk

60 The framework does not include roles which may be in place to meet local circumstances and need, such as nurse consultant or advisory roles.

Level 5: designated professionals.

Each level builds upon the competencies, knowledge and skills of the proceeding levels within the framework.

In addition, this version of the framework also provides specific detail for chief executives, chairs, board members including executives, non-executives, lay members and commissioning group leads.

Those requiring competences at Levels 1 to 5 should also possess the competencies at each of the preceding levels. It is important for practitioners to be aware of the overarching content of the framework in addition to any specific section related to their roles.

Annual appraisal is crucial to determine individuals' attainment and maintenance of the required knowledge, skills and competence. Employers and responsible officers should assure themselves that appraisers have the necessary knowledge, skills and competence to undertake appraisals and in the case of medical or nursing staff to oversee revalidation. This may involve engaging expertise from outside of organisational boundaries.

Education and training principles

The key issues related to acquiring and maintaining relevant knowledge and skills are outlined, appreciating that practitioners work and study in a variety of settings. The underpinning principles include:

- acquiring knowledge, skills and expertise in safeguarding/child protection including looked after children should be seen as a continuum. It is recognised that students and trainees will increase skill and competence throughout their undergraduate programme and at postgraduate level as they progress through their professional careers
- the learning outcomes describe what an individual should know, understand, or be able to do as a result of training and learning, particularly in light of the experiences of looked after children exposed to abuse and neglect and other ACEs
- training needs to be flexible, encompassing different learning styles and opportunities. The education, training and learning hours stated at each level are therefore indicative recognising that individuals' learning styles and the roles they undertake vary considerably, as well as the need to recognise new and emerging issues for which staff need to acquire additional knowledge and skills
- inter-professional and inter-organisational training and education is encouraged in order to share best practice, learn from serious incidents and to develop professional networks, this should include both independent and voluntary sector healthcare providers
- those leading and providing multidisciplinary and inter-agency training must:
  - demonstrate knowledge of the context of health participants' work
  - provide evidence to ensure the content is approved and considered appropriate against the relevant level

  - ensure that education and training is delivered by a registered healthcare worker (in partnership with other specialists as appropriate), who has qualifications and/or experience relevant to safeguarding/child protection and looked after children
  - tailor training sessions to the specific roles and needs of different professional groups at each level, and where possible provided by or in conjunction with local safeguarding and looked after children's teams.

- the effectiveness of training programmes and learning opportunities should be regularly monitored. This can be done by evaluation forms, staff appraisals (encompassing a collaborative review of education, training and learning logs/ passport), e-learning tests (following training and at regular intervals), and auditing implementation, as well as staff knowledge and understanding
- education and training passports will prevent the need to repeat learning where individuals move organisations and are able to demonstrate up to date relevant competence, knowledge and skills, except where individuals have been working outside of the area of practice and the new role demands additional knowledge and skill or individuals have had a career break and are unable to do so
- all health staff should complete a mandatory session regarding child protection/ safeguarding[61] of at least 30 minutes duration in the general staff induction programme or a specific session within six weeks of taking up post within a new organisation. This should provide key safeguarding/child protection information, including vulnerable groups such as looked after children, the different forms of child maltreatment, and appropriate action to take if there are concerns. This mandatory induction session is separate and a pre-cursor to level 1 training,[62] although many may choose to incorporate this within a level 1 training package
- any professional moving to a new post or a locum position must be able to demonstrate an appropriate level of safeguarding education and training[63] for the post (individuals may use their passport as evidence of the date and level of training where deemed transferable for the post in question). They should be informed of and updated with any trust/organisation/practice/agency specific safeguarding concerns for that specific role. Those commencing a new role at a trust/organisation require mandatory safeguarding education and training and where relevant specific education and training regarding looked after children
- staff should receive refresher training every three years as a minimum[64] and training should be tailored to the roles of individuals. Individuals should be encouraged to maintain their education, training and learning log to capture all education, training and learning opportunities to demonstrate acquisition and up to date knowledge, skills and competencies

61 As per as per the *Safeguarding children and young people: roles and competencies for health care staff* intercollegiate document.

62 As per as per the *Safeguarding children and young people: roles and competencies for health care staff* intercollegiate document.

63 Looked after children may be incorporated into think family or general safeguarding training.

64 Refresher training should link to adult safeguarding and encompass areas such as vulnerable adults, domestic violence, learning disability, disabled children, working with families who are difficult to engage, child maltreatment and key principles of advocacy and human rights, documentation, dealing with uncertainty, and individuals' responsibility to act. The training may take a particular focus depending on the speciality and roles of participants.

- e-learning is appropriate to impart knowledge at level 1 and 2. E-learning can also be used at level 3 and above as preparation for reflective team-based learning, and contribute to appraisals and revalidation when linked to case studies and changes in practice
- while e-learning is important it should not be the only form of learning undertaken at level 3. It is expected that around 50% of indicative education, training and learning time will be of a participatory nature, interactive and involve the multi-professional team wherever possible. This includes for example formal teaching/education, conference attendance and group case discussion
- named professionals should ensure timely updates for all staff where necessary, such as where there are changes in legislation, local policies, updates from serious case reviews
- those working with looked after children and young people should take part in clinical governance including holding regular case discussions, critical event analysis, audit, adherence to national guidelines (National Service Frameworks, National Institute of Health and Care Excellence, Scottish Intercollegiate Guideline Network), analysis of complaints and other patient feedback, and systems of supervision[65] and/or peer review. Level of participation should be as appropriate to role. Individual clinical units/departments should have access to feedback from looked after children and a yearly review of safeguarding/child protection cases relevant to their field of work, so as to facilitate case discussion and improvement in practice
- information about accredited training and education programmes can be found at local health websites and royal college websites and includes e-learning eg, **www.e-lfh.org.uk/projects/safeguarding-children** and Learning@Wales.

Within each level there is an indication of the indicative content and time needed by practitioners.[66] Maintaining and updating knowledge and skill should be a continuous and ongoing process. Regulatory and inspection bodies such as the NMC, GMC, Health and Care Professions Council (HCPC) and CQC require evidence of completion of key refreshing and updating for revalidation and inspection purposes.[67,68] Ultimately employing organisations are responsible for assuring that their employees have the knowledge, skills and competence to undertake their roles, ensuring that sufficient time is afforded to employees to enable acquisition and maintenance relevant to their area of practice. Organisations therefore need to consider the commissioning and provision of the required training. Organisations can if they wish seek accreditation from a professional body for any programme of study, however they must assure themselves that any e-learning programme or externally contracted provider of safeguarding education and training explicitly states how any course or learning opportunity meets

65 Supervision is a process of professional support, peer support, peer review and learning, enabling staff to develop competencies, and to assume responsibility for their own practice. The purpose of clinical governance and supervision within safeguarding practice is to strengthen the protection of children and young people by actively promoting a safe standard and excellence of practice and preventing further poor practice.

66 It is anticipated that where appropriate for many practitioners, specific education and training content regarding looked after children maybe encompassed within safeguarding training but must be in enough depth to enable the practitioner to meet the knowledge, skills and competencies required for their particular role.

67 www.gmc-uk.org/doctors/revalidation.asp and www.nmc-uk.org/Registration/Revalidation

68 www.cqc.org.uk/news/stories/cqc-updates-information-safeguarding-children-adults-england

the required intercollegiate framework level. Employers must also give consideration to assessing learning and the long-term impact of education and training provided.

Individual professional bodies and Royal Colleges may provide specific additional guidance for members regarding education, training and learning content and indicative hours.

Level 1: All staff working in healthcare services[69,70]

Competence at this level is about all clinical and non-clinical staff being aware of the processes and terminology relating to looked after children.

Staff groups

This includes, for example, board level executives and non-executives, lay members, receptionists,[71] administrative,[72] caterers, domestics, transport, porters, community pharmacist counter staff and maintenance staff, including those non clinical staff working for independent contractors within the NHS (such as GPs, optometrists, contact lens and dispensing opticians, dentists[73] and pharmacists) within the NHS, as well as volunteers across healthcare settings and service provision.

Core competencies

Competence at this level is about individuals having an understanding of what it means to be a looked after child or care leaver and also what it means for health professionals and their role in working together with other professionals to meet the needs of this group of vulnerable children and young people (including those that are fostered, adopted and in residential care).

Knowledge, skills, attitudes and values

All staff at Level 1 should be able to demonstrate the following:

Knowledge

- Know and understand the legal definition/term of who looked after children, young people and care leavers are.
- Awareness of impact of abuse and family disruption on looked after children, young people and care leavers.
- Awareness of adverse childhood experiences and potential range of health problems of a looked after child necessitating the potential need for longer appointments.

69 This is the minimum entry level for all staff working in healthcare settings regarding the specific needs of looked after children and is encompassed within training and education to safeguard children and young people.

70 As appropriate to role.

71 Except for GP reception manager and GP practice manager who should be at level 2.

72 In particular administrators supporting teams who work with looked after children and provide support for fostering/adoption processes will need a greater understanding of issues related to consent, confidentiality, adoption processes and the management of clinical records of looked after children. Specific training and education will need to be provided for administrative staff to ensure additional knowledge, understanding, skills and competence required.

73 Child protection and the dental team www.cpdt.org.uk https://bda.org/childprotection

- Awareness that children in care may still be vulnerable and at risk of abuse and/or neglect.
- Know what to do if there are safeguarding concerns about a looked after child, young person or care leavers including local policies and procedures around who to contact, where to obtain further advice and support, including contact details for the looked after children's team.
- Know about the importance of sharing information (including the consequences of failing to do so).
- Know what to do if they feel that their concerns are not being taken seriously or they experience any other barriers in reporting their concerns about a looked after child, young person or care leaver.
- Know the risks associated with the internet and online social networking in particular the increased vulnerability of looked after children and young people to criminal exploitation and sexual exploitation.

Skills

- Able to seek appropriate advice and report concerns, and feel confident that they have been listened to.

Attitudes and values

- Willingness to listen to looked after children, young people and care leavers, with respect, ensuring their dignity, and acting on issues and concerns.

Education and training requirement

The knowledge and skills should be developed and encompassed as part of the safeguarding children and young people education and training programme for level 1,[74] unless the individual is in a focused specialist role or a looked after children team whereby additional education and training maybe required.

Learning outcomes

- To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers.
- To be able to demonstrate an understanding of appropriate referral mechanisms and information sharing i.e. know who to contact, where to access advice and how to report.

74 See *RCN Safeguarding Children and Young people: roles and competences for healthcare staff 4th Ed.* 2019. www.rcn.org.uk/professional-development/publications/pub-007366

Level 2: All non-clinical and clinical staff who have some degree of contact with looked after children, young people/care leavers and/or parents/carers

Staff groups[75]

This includes administrators for looked after children and safeguarding teams,[76] GP practice safeguarding administrators,[77] GP reception managers, GP practice managers, clinic reception managers and receptionists, healthcare students including medical, relevant allied health professional students and nursing students, patient advocates, phlebotomists, pharmacists,[78] ambulance staff (paramedics require level 3),[79,80] dentists,[81,82] dental care professionals,[83,84] audiologists, eye clinic liaison officers, optometrists, contact lens and dispensing opticians,[85] adult physicians and surgeons, anaesthetists,[86] radiologists, nurses working in adult acute/community services (except mental health nurses, practice nurses and nurse practitioners who require level 3), non-medical neurophysiologists, allied healthcare practitioners[87] and all other adult orientated secondary care healthcare professionals, including technicians and interpreters.

75 This includes all staff working with the transition agenda (0-25 years).

76 In particular administrators supporting teams who work with looked after children and provide support for fostering/adoption processes will need a greater understanding of issues related to consent, confidentiality, adoption processes and the management of clinical records of looked after children.

77 'Member of the practice administrative team who, depending on size of practice and structure, either manages or oversees, the recording and coding of safeguarding information coming in and out of the practice e.g. safeguarding/child protection case conference reports, MARAC notifications, summarising safeguarding information in new patient records. The safeguarding administrator will work closely with the GP Practice Safeguarding Lead.'

78 The minimum level that should apply to pharmacists is level 2. Those pharmacists undertaking professional care activities and services in care homes, urgent and emergency care settings, GP practices and out of hours services require level 3 competency.

79 This includes staff in non-patient facing roles – ambulance communication centre staff.

80 Except paramedics who are at level 3.

81 Child protection and the dental team www.cpdt.org.uk and https://bda.org/childprotection

82 The majority of dentists and dental care professionals will require level 2; in larger organisations, including hospital and community based specialist services (paediatric dentistry or other relevant dental specialties such as orthodontics) the precise number of dentists and dental care professionals requiring level 3 competencies should be determined locally based on an assessment of need and risk. For further information see supplementary guidance from the British Dental Association (www.bda.org/safeguardingcompetencies) and the British Society of Paediatric Dentistry (www.bspd.co.uk/Resources/Partner-Guidelines).

83 Dental nurses, hygienists and therapists.

84 Child protection and the dental team www.cpdt.org.uk and https://bda.org/childprotection

85 Optical Confederation. 2017, *Guidance on safeguarding Children and Vulnerable Adults*. https://guidance.college-optometrists.org/guidance-contents/safety-and-quality-domain/safeguarding-children-and-vulnerable-adults/.

86 See www.rcoa.ac.uk/sites/default/files/documents/2020-02/GPAS-2020-10-PAEDIATRICS.pdf and www.rcoa.ac.uk/safeguardingplus. The minimum level for the majority of anaesthetists (including trainees) will be level 2, with the lead paediatric anaesthetist for safeguarding/child protection requiring level 3. Some departments may, according to size and paediatric workload, require more than one anaesthetist at level 3 (core). This should be determined locally.

87 Diagnostic radiographers generally will require minimum of level 2 but those involved full time or significantly in paediatric radiography or are involved in Imaging for suspected physical abuse require level 3.

Core competencies

- As outlined for Level 1.
- Uses professional and/or clinical knowledge, understanding who constitutes a looked after child, young person and care leaver so as to identify any healthcare issues that may relate to previous maltreatment or life experience.
- Able to identify and refer a looked after child, young person and care leaver suspected of being an unaccompanied asylum seeking child/young person, a victim of trafficking or child sexual exploitation; criminal exploitation/county lines/gangs and radicalisation; at risk of FGM or having been a victim of FGM, at risk of exploitation by radicalisers.
- Understand the specific health needs and vulnerabilities of unaccompanied asylum seeking children.
- Acts as an effective advocate for the looked after child, young person or care leaver.
- Recognises the potential impact of previous maltreatment on the health and wellbeing of a looked after child, young person, or care leaver including possible speech, language and communication needs and that reasonable adjustments may need to be made.
- Clear about own and colleagues' roles, responsibilities, and professional boundaries, including raising concerns about the care received by the looked after child, young person or care leaver.
- As appropriate to role, able to refer to social care if a safeguarding/child protection concern identified in relation to a looked after child, young person or care leaver (aware of how to refer even if role does not encompass referrals).
- Documents safeguarding/child protection/care concerns in relation to the looked after child, young person or care leaver in order to be able to inform the relevant staff and agencies as necessary, maintains appropriate record keeping, and differentiates between fact and opinion.
- Shares appropriate and relevant information with multi-disciplinary professionals.
- Acts in accordance with key statutory and non-statutory guidance and legislation including the UN Convention on the Rights of the Child and Human Rights Act.

Knowledge, skills, attitudes and values

All staff at Level 2 should have the knowledge, skills, attitudes and values outlined for Level 1 and should be able to demonstrate the following:

Some of the following may be more relevant to those staff engaged in clinical practice.

Knowledge[88]

- Awareness that certain factors may be associated with child maltreatment, such as child disability and preterm birth, special educational needs and disability, and living with parental mental health problems, other long-term chronic conditions, drug and alcohol abuse, and domestic abuse.

88 We have endeavoured to place those we consider relevant to non-clinical staff at the beginning of the section, appreciating that each service and setting will need to ascertain the knowledge and skills required as appropriate.

- Awareness of the increased needs and vulnerability of looked after children, care leavers and youth offenders and their increased risk of further maltreatment such as child sexual exploitation, criminal exploitation/county lines/gangs/radicalisation and children who go missing.
- Awareness of confidentiality, and consent issues including parental responsibility and court orders related to looked after children and young people.
- Understand the role of the Looked After health team, how to contact them and know that children should be recorded as a Looked After Child with social worker details recorded.
- Awareness of the normal development of children and young people (if unsure of childhood development know who to contact) and the impact of previous abuse and neglect, including the short and long term impact of domestic abuse on the child's behaviour and mental health, as well as parental mental and physical health. Speech, language and communication needs could be an indication of the impact of previous abuse, particularly neglect. Impact of ACEs.
- Awareness of the legal, professional, and ethical responsibilities around information sharing,[89,90] including the use of electronic records, information governance, GDPR,[91] local authority databases, directories and assessment frameworks.
- Know best practice in documentation, record keeping, and understand data protection issues in relation to information sharing[92] for safeguarding purposes and in order to promote the health and wellbeing of looked after children, young people and care leavers, including post-adoption.
- Understand the purpose and guidance in relation to looked after children, young people and care leavers around conducting serious case reviews/case management reviews/ significant case reviews, individual management reviews/individual agency reviews/ internal management reviews, and child death review processes.
- Know about court reports for Care, Placement and Adoption Orders (and equivalent Orders).[93]
- Awareness of the paramount importance of the looked after child, young person or care leavers' best interests as reflected in legislation and key statutory and non-statutory guidance (including the UN Convention on the Rights of the Child and the Human Rights Act).

89 HM Government. 2018, *Guidance on Information Sharing*. www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

90 *Processing and storing of information in Primary Care – RCGP Safeguarding Adults at Risk of Harm toolkit.* www.rcgp.org.uk/sarh

91 http://gdpr-legislation.co.uk

92 *Processing and storing of information in Primary Care – RCGP Safeguarding Adults at Risk of Harm toolkit.* www.rcgp.org.uk/sarh

93 Medical advisers compile court reports for Placement and Adoption orders.

Skills[94]

- Able to modify approaches to meet the needs of looked after children.
- Able to identify where further support is needed, when to take action, and when to refer to managers, supervisors or other relevant professionals, including referral to social services.
- Able to document health and wellbeing/safeguarding/child protection concerns, and maintain appropriate record keeping, differentiating between fact and opinion.
- Able to share appropriate and relevant information between teams – in writing, by telephone, electronically, and in person.

Attitudes and values

- Recognises how own beliefs, culture, experience and attitudes relating to the life experiences of looked after children, young people, and care leavers might influence professional involvement in caring for this vulnerable group.

Education and training requirement

The knowledge and skills should be developed and encompassed as part of the safeguarding children and young people education and training programme for level 2,[95] unless the individual is in a focused specialist role or a looked after children team whereby additional education and training maybe required.

Learning outcomes[96]

- To be able to demonstrate awareness of the need to alert primary care professionals (such as the child's GP), universal services (such as the child's health visitor or school nurse), local authority children's services/social services about health and wellbeing/safeguarding concerns.
- To be able to demonstrate accurate documentation of concerns.
- To be able to document appropriate consent, legal orders/parental responsibility, who is accompanying CYP.
- To be able to demonstrate an ability to recognise and describe a significant event for the looked after child, young person or care leaver in child protection/safeguarding to the most appropriate professional or local team.

94 We have endeavoured to place those we consider relevant to non-clinical staff at the beginning of the section, appreciating that each service and setting will need to ascertain the knowledge and skills required as appropriate.

95 See *RCN Safeguarding Children and Young people: roles and competences for healthcare staff 4th Ed.* 2019. www.rcn.org.uk/professional-development/publications/pub-007366

96 We have endeavoured to place those we consider relevant to non-clinical staff at the beginning of the section, appreciating that each service and setting will need to ascertain the knowledge and skills required as appropriate.

Level 3: All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a looked after child/young person or care leaver

Staff groups

This includes all clinical staff who may contribute regularly to addressing the health needs of a looked after child or young person. This includes:

- GPs
- practice nurses (including nurse practitioners within primary care)
- forensic physicians
- forensic nurses
- paramedics[97]
- urgent and unscheduled care staff[98]
- all mental health staff (adult[99] and child and adolescent mental health staff)
- child psychologists
- child psychotherapists
- adult learning disability staff
- learning disability nurses (children and adult)
- specialist nurses for safeguarding
- health professionals working in substance misuse services
- youth offending team staff
- paediatric allied health professionals/allied health professionals working with children[100]
- special educational needs and disabilities leads
- paediatric neurophysiologists

97 The intercollegiate framework needs to be viewed as a continuum, enabling staff to develop and acquire additional knowledge, skills and competencies throughout their career – with ambulance staff in patient facing roles crossing level 2 and 3 according to service specifications and as appropriate to the role they are undertaking. Currently some ambulance staff may be commissioned according to level 2 and others level 3. With increasing autonomy and decision making of all frontline practitioners it is acknowledged that more healthcare staff will need to acquire some of the knowledge, skills and competencies at level 3. The 2018 version of the framework therefore emphasises 'as appropriate to role' in many places for this very reason.

98 This refers to medical and registered nursing staff who work in accident and emergency departments/emergency departments, urgent care centres, minor injury/illness units and walk in centres, including emergency department liaison staff.

99 All psychiatrists provide care to adults with a history of substance misuse or severe mental illness and often there are dependent children.

100 Includes amongst others paediatric dieticians, paediatric physiotherapists, paediatric occupational therapists, speech and language therapists, orthoptist, portage workers and other allied health professionals working with children.

- child play therapists/specialists
- sexual health staff
- school nurses including those working in independent schools
- health visitors
- family nurses (FNP)
- all children's nurses
- perinatal staff
- midwives
- obstetricians
- neonatologists
- all paediatricians
- paediatric radiologists
- diagnostic radiographers
- paediatric surgeons[101]
- lead paediatric anaesthetists for safeguarding/level 3 anaesthetists[102]
- paediatric intensivists
- physician's assistants working in any level 3 speciality
- pharmacists[103]
- specialist paediatric dentists[104]
- specialty and associate specialists (SAS) doctors working in any level 3 speciality listed above
- all doctors/health professionals working exclusively or predominantly with children and young people.[105]

It is expected that doctors in training (including foundation level doctors) who have posts in these level 3-affiliated specialties/with significant children/young person contact, will also require level 3 training.

101 Those with a mixed caseload (adults and children) should be able to demonstrate a minimum of level 2 and be working towards attainment of level 3 core knowledge, skill and competence.

102 See www.rcoa.ac.uk/sites/default/files/documents/2020-02/GPAS-2020-10-PAEDIATRICS.pdf and www.rcoa.ac.uk/safeguardingplus. The minimum level for the majority of anaesthetists (including trainees) will be level 2, with the lead paediatric anaesthetist for safeguarding/child protection requiring level 3. Some departments may, according to size and paediatric workload, require more than one anaesthetist at level 3 (core). This should be determined locally..

103 The minimum level that should apply to pharmacists is level 2. Those pharmacists undertaking professional care activities and services in care homes, urgent and emergency care settings, travel clinics, GP practices and out of hours services require level 3 competency.

104 Guidance for dentistry requires a safeguarding lead for every dental practice. Child protection and the dental team: www.cpdt.org.uk and https://bda.org/childprotection. In larger organisations, including hospital and community based specialist services (paediatric dentistry or other relevant dental specialties such as orthodontics) the precise number of dentists and dental care professionals requiring level 3 competencies should be determined locally based on an assessment of need and risk. For further information see supplementary guidance from the British Dental Association and the British Society of Paediatric Dentistry www.bspd.co.uk/Resources/Partner-Guidelines.

105 Adult physicians with significant caseloads involving young people may need to also demonstrate working towards level 3.

Core competencies, knowledge and skills across all professional and staff groups at level 3

Core competencies

- As outlined for Level 1 and 2.
- Able to respond appropriately when working with looked after children to the impact of adverse life events, including how family health history, mental health and parental lifestyle impact on the child's health and development.
- Able to apply knowledge of the physical, developmental, emotional and mental health needs/risks for looked after children and unaccompanied asylum-seeking children and young people and offer appropriate health promotion advice as appropriate to role.
- Able to initiate interventions to improve child resilience and reduce risk of emotional harm as appropriate to role.
- Able to recognise the potential impact of a parent's/carer's physical and mental health or lifestyle on the wellbeing of a child or young person.
- Able to work in partnership with other agencies who may be involved with the child including, but not limited to, social care, education, police, probation, youth offending teams to understand the importance of this multi-agency working.
- Able to demonstrate an understanding of the interdependence between health, education and social care with regard to looked after children.
- Knows own capabilities and when to seek support from the specialist looked after children team.
- Able to share information appropriately, taking into account consent and confidentiality issues related to looked after children.
- Able to contribute to inter-agency assessments as appropriate to role, the gathering of information, using interpreters as needed and where appropriate analysis of risk.
- Able and willing to provide empathy and support for care leavers, looked after children and their carers.

Knowledge, skills and attitudes and values

All staff at Level 3 should have the knowledge, skills, attitudes and values outlined for Level 1 and 2 and should be able to demonstrate the following:

Knowledge

- Understands as appropriate to role, the impact of contextual safeguarding including ante-natal factors and adverse childhood experiences on a child's development, physical health, emotional wellbeing, cognition and behaviour and be able to respond appropriately.
- Understands the increased vulnerability of this group to substance misuse, self-harm, sexual exploitation, criminality, teenage pregnancy, exclusion from education, mental, emotional and behavioural difficulties and the use of Trauma informed approaches to promote positive outcomes for this client group.

- Understands issues around consent, confidentiality and the implications of data protection relevant to their own role.
- Know who to share information with and when, understanding the difference between information sharing on individual, organisational and professional level.s
- Understand the specialist role of primary carers who do not hold parental responsibility.
- Know the contact details of relevant looked after children's and care leavers' health and social care teams locally, including personal advisors for care leavers as appropriate to role.
- Understands own role within the multi-agency framework, assessment, care planning and monitoring.
- Know statutory and non-statutory health, education and social care processes and practices relevant to own role.

Clinical knowledge

- Clinical knowledge and expertise to a level required to detect health problems with appropriate escalation and referral as required.

Skills

- Able to conduct developmental assessments and emotional wellbeing health screening across the age range as appropriate to role.
- Able to contribute to the statutory health processes and implementation of healthcare plans, undertaking review health assessment when delegated by a lead health professional (a looked after children specialist nurse/named nurse for looked after children/paediatrician) for the area and when requested contribute via report or attendance at statutory looked after children review.
- Able to identify and advise local authorities in respect of special educational needs as appropriate to role.
- Able to communicate and engage effectively with looked after children, ensuring that they have the opportunity to participate in decisions affecting them as appropriate to their age and ability.
- Able to build positive relationships with parents/carers and be skilled in managing conflict and difficult behaviours.
- Able to act as an advocate for the child's rights and welfare.
- Able to communicate effectively and share appropriate information with multiagency colleagues and partners and promote trauma informed practice.
- Able to identify the need for further specialist support, advice, assessment and supervision in situations where the looked after child's problems require further expertise or intervention such as in relation to sexual health, emotional or mental health, developmental difficulties and/or the disabled children including understanding issues around decision making – Mental Capacity Act/Liberty Protection Safeguards and take appropriate action.

Attitudes and values

- As outlined in level 1 and 2.

Education and training requirements

The knowledge and skills should be developed and encompassed as part of the safeguarding children and young people education and training programme for level 3,[106] unless the individual is in a focused specialist role or a looked after children team whereby additional education and training maybe required to attain the knowledge, skills and competencies for looked after children.

It is expected that those individuals who have not yet attained the knowledge, skills and competence for level 3 should acquire these within a pre-defined timeframe as agreed with their employer/mentor/appraiser. The timeframe for this initial training should not exceed a 12-month period and will be significantly shorter for those undertaking job rotations.

The knowledge and skills should therefore be developed as part of the safeguarding education and training programme for level 3, unless the individual is in a focused specialist role or a looked after children team. Training arrangements should therefore be determined locally based on the development needs of individuals working with looked after children but should encompass programmes to increase knowledge about the effects of abuse and neglect, attachment theories, resilience building, promoting mental health and psychological wellbeing, substance abuse and sexual health.

Paediatricians should be able to demonstrate training to Level 3 Community Child Health competencies[107] and GPs should demonstrate the requirements encompassed within the RCGP framework.[108,109,110]

Learning outcomes

- As outlined for Level 1 and 2.
- Demonstrates knowledge of patterns and indicators of child maltreatment.
- Demonstrates understanding of appropriate information sharing in relation to child protection, children in need and looked after children.
- Demonstrates an ability to assess risk and need and instigates processes for appropriate interventions.
- Demonstrates knowledge of the role and responsibilities of each agency, as described in local policies and procedures.
- Demonstrates critical insight of personal limitations and an ability to participate in peer review.

106 See *RCN Safeguarding Children and Young people: roles and competences for healthcare staff 4th Ed.* 2019. www.rcn.org.uk/professional-development/publications/pub-007366

107 General Medical Council. *Community child health curriculum.* www.gmc-uk.org/education/25364.asp

108 Knowledge of child development and child health as described in RCGP curriculum statement www.rcgp.org.uk/gp-training-and-exams; Knowledge of safeguarding and child protection to level 3 and level 2 of Community Child Health competences in Child Public Health, Behavioural Paediatrics and Safeguarding.

109 www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/january/007-366.pdf

110 www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/august/pdf-007069.pdf

Additional knowledge, skills and competencies required for specific roles at level 3

There are specialist specific requirements for the following roles:

- paediatric trainees undertaking statutory health assessments
- consultant paediatricians
- named safeguarding professionals (doctor, nurse, GP, midwife)
- GPs undertaking adult health reports for potential foster carers and prospective adopters.

The additional requirements for those paediatric trainees undertaking statutory health assessments include awareness of competence, consent, adverse childhood experiences and clinical skills in keeping with level 4 acknowledging that they will be supervised.

Consultant paediatricians looking after children in care need to be more mindful of level 1 and level 2 and additional adverse childhood experiences, consent and liaison as they may be asked to contribute to looked after children reviews and reports including for Court. In addition, requirements include awareness of additional needs of care leavers and children and young people in care with longer appointments, support with compliance/attendance and contextual safeguarding.

Named safeguarding professionals (doctor, nurse for children and adults), GPs, and midwives require awareness of the impact of health conditions which may affect parenting ability, as well as implications for children and their long-term placement.

GPs may be asked to contribute to looked after children reviews and reports including for Court. In addition, requirements include awareness of additional needs of care leavers and CYP in care with longer appointments, compliance/attendance and contextual safeguarding.

Level 4: Specialist medical, nursing and health professionals for looked after children, including named professionals and medical advisors for fostering and adoption[111,112]

Staff groups

All health professionals who have responsibility for working specifically with looked after children, either full time or as a specifically defined part of another role. For example, this includes specialist nurses for looked after children,[113] specialist child psychologists, specialist child psychiatrists, named nurses and doctors for looked after children, GPs with a defined role,[114] health professionals undertaking Initial Health assessments, including named professionals and medical advisers for adoption and fostering agencies.

Core competencies

- As outlined for Level 1, 2 and 3.
- Able to undertake statutory looked after children/adoption health assessments,[115] including those with complex healthcare needs.[116]
- Able to review all health needs including a physical examination and formulate appropriate health management plans including for new conditions, and onward referrals and assessment.
- Able to recognise needs based on the history and assessment of a child/young person and to initiate appropriate health interventions and communicate effectively the complex interplay of factors for a child with multi-agency colleagues.
- Able to analyse holistic health chronologies and provide a written comprehensive report detailing the implications of the information for the child's current and future health and wellbeing.
- Able to formulate a meaningful individual, SMART healthcare plan/adoption report and monitor its implementation.

111 Includes those with specific roles such as Named Looked After Children's Nurses, Named Looked After Children's Doctors, lead Looked After Children health professionals, specialist nurses for Looked After Children.

112 See Appendix 1, Appendix 2 and Appendix 3.

113 The specialist nurse role may provide specific duties for example to residential homes, secure children's homes as well as foster carers.

114 GPs who provide specialist services such as Looked After Children health assessments or child adoption medicals should be Level 4.

115 In Wales, both Initial Health Assessments and Review Health Assessments may be undertaken by a Registered Medical Practitioner or Registered Nurse or Midwife. (Care Planning, Placement and Case Review (Wales) Regulations 2015 www.legislation.gov.uk/wsi/2015/1818/made). In Scotland legislation initial health assessments can be undertaken by a registered medical practitioner or registered nurse. The regulations in England have not yet been amended to enable Advanced Nurse Practitioners to undertake initial health assessments. At the current time all initial health assessments must be undertaken by a medical practitioner in England. If relevant regulations in England are amended it is expected that initial health assessments must be undertaken by a medical practitioner or an advanced paediatric nurse practitioner with the equivalent knowledge, skills and competencies.

116 For example physical, psychological, behavioural and emotional assessments related to disability, attachment disorders and unaccompanied asylum seeking children and inter-country adoptions.

- Able to identify the need for assessment of and support the management of attachment disorder, special educational and disability needs and emotional trauma
- Able to initiate interventions to improve child resilience and reduce risk of emotional harm.
- Able to act as a key conduit and contact point between the child or young person and their carer, where they have difficulties accessing health services.
- Able to demonstrate the ability to work with carers/residential units and families
- Able to work with child mental health services to provide support and interventions to meet the needs of looked after children.
- Able to advise other agencies regarding the health management of individual looked after children.[117]
- Able to interpret and communicate on a broad range of health information in a social and education context.[118]
- Able to contribute to court reports for Care, Placement and Adoption Orders (and equivalent Orders).[119]
- Able to confidently manage, provide or ensure supervision is provided from a health perspective for looked after children where safeguarding issues arise within the care system.
- Able to act as a resource and source of support for those working at Level 3 and/ or supervise staff working with looked after children.
- Able to contribute to multi-agency meetings or reviews.
- Able to interpret regional, national and local policy documents/reports and their implications for looked after children's health and service provision.
- Able to work creatively with other specialist areas to deliver high quality services specific to the needs of looked after children.
- Able to identify and lead on relevant audits of service provision, including multiagency audits in conjunction with others.
- Able to work with multiagency colleagues to support young people leaving care, providing support to access specialist advice on contraception and sexual health, promoting physical and mental health, enabling access to primary care services and facilitating seamless transfer of care leavers with complex needs, including those with disabilities to seamlessly transfer to adult services.[120]

117 Department for Education. *Statutory guidance SEND code of practice: 0 to 25 years*. 2014 www.gov.uk/government/publications/send-code-of-practice-0-to-25

118 For example, this may include provision of advice on prospective carers to an adoption/fostering panel, advice to social worker on impact of living arrangements on health conditions.

119 Medical advisers compile court reports for Placement and Adoption orders

120 Department of Health, Department for Education. *Statutory guidance for local authorities, clinical commissioning groups and NHS England 2015. Promoting the health and welfare of looked-after children*. www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

Medical advisor (MA) for adoption

The medical adviser will act in the best interests of the child or young person by providing a high-quality service to meet their needs, to enable them to achieve lifelong optimum health and well-being. The adoption service encompasses close multi-agency working, which is essential to effective delivery. There are statutory requirements that determine aspects of the role, specified by legislation in the adoption agency regulations (AAR) and accompanying guidance in the four UK nations. (Adoption Agencies (Scotland) Regulations 2009;[121] Adoption Agencies (England) Regulations 2005;[122] Adoption Agencies (Wales) Regulations 2005;[123] Adoption Agencies (Northern Ireland) Regulations 1989[124]).

The medical advisor for adoption must be a registered medical practitioner (as specified clearly in the adoption regulations). Usually they will be a senior paediatrician with appropriate knowledge and training in Looked after children and young people. There should be adequate time for the clinical, operational, and strategic elements of the role. Ideally, they should be undertaking medical assessments (IHAs) and working within the looked after children team.

There are some circumstances where medical advisers are only responsible for the element of the role which pertains to the assessment and approval of prospective carers and are not involved in the preparation of the child adoption medical report or matching decisions. The medical advisor in these circumstances must be a registered medical practitioner. They must have training in, and an understanding of the health needs and complexities of looked after children and young people.

The medical advisor will incorporate a child centred, strength-based approach and should be:

- able to provide an adoption medical report referring to all previous health assessments, analysing past medical health and commenting on future implications to the child. The requirements for the minimum information to be provided are listed in the adoption agency regulations (England AAR Schedule 1 part2, Wales AAR part2 reg15, N. Ireland Schedule 1 Part2)
- able to present health information in a way that can be understood by a layperson and provide advice to inform adoption support plans
- able to provide a written report to the agency on the health of prospective adopters, analysing impact on child's health and wellbeing, and impact on parenting capacity of applicants
- able to support adoption (permanence) panel by reviewing all medical reports (adults and children) on the panel agenda, identifying any issues that require specific advice and facilitating discussion at panel (Adoption Statutory Guidance England (DfE 2013) p67[125]). NB. Attendance at adoption panel is per the adoption regulations and guidance for the country where agency is situated (Regulation 3(1) (b) of the Adoption

121 www.legislation.gov.uk/ssi/2009/154/contents/made
122 www.legislation.gov.uk/uksi/2005/389/contents/made
123 www.legislation.gov.uk/wsi/2005/1313/contents/made
124 www.legislation.gov.uk/nisr/1989/253/contents/made
125 www.gov.uk/government/publications/adoption-statutory-guidance-2013

Agencies and Independent Review of Determinations (Amendment) Regulations 2011[126] requires an agency in England to include on its panel central list the medical adviser to the adoption agency (or at least one if more than one medical adviser is appointed). Members from the central list will form an adoption panel. In Northern Ireland and Wales, the medical adviser is required to be a full panel member (Adoption Agencies Regulations (Northern Ireland) 1989;[127] Adoption Agencies (Wales) Regulations 2005[128]). Guidance on the Looked After Children (Scotland) Regulations 2009[129] and the Adoption and Children (Scotland) Act 2007 (2011)[130] states the Medical Advisor has a specified role on panel and the agency will decide if the Medical Advisor is a full voting member of panel)

- able to meet with prospective adopters and share information in a way they will understand; keeping appropriate records
- offer support and training to professionals involved in adoption process; service design and policy/process development
- able to contribute to identification of adoption support needs/services.

Knowledge, skills, attitudes and values

All staff at Level 4 should have the knowledge, skills, attitudes and values outlined for Level 1, 2 and 3 and should be able to demonstrate the following:

Knowledge

- Understand how birth family health history, mental health and parental lifestyle choices impact on the child's health and development.
- Understand how a child's primary carers (birth parent/foster carer/adopter) health and lifestyle issues impact on children and young people.
- Know and understand normal and disordered attachment of babies and the lifelong impact of disordered attachment, including the long-term implications of becoming looked after.
- Know about common psychological and emotional disorders, as well as intellectual disability prevalent in looked after children and young people.
- Know about the needs of specific groups such as children with disability, those with special educational needs, unaccompanied asylum seekers, minority ethnic groups and adoptees, including inter-country adoptions.
- Knowledge of Mental Capacity Act/Liberty Protection Safeguards and how this might apply to 16 and 17 year olds and care leavers.
- Understand the complexity of healthcare provision and resources required to provide a comprehensive health service for looked after children.

126 www.legislation.gov.uk/uksi/2011/589/contents/made
127 www.legislation.gov.uk/nisr/1989/253/contents/made
128 www.legislation.gov.uk/wsi/2005/1313/contents/made
129 www.gov.scot/publications/guidance-looked-children-scotland-regulations-2009-adoption-children-scotland-act-2007
130 www.legislation.gov.uk/ukdsi/2011/9780111512333

- Understand research evidence[131] and best practice in promoting the health and wellbeing of children in care and those undergoing adoption e.g. NICE/SCIE and SIGN guidelines.
- Understand relevant child-care legislation, information sharing, information governance, confidentiality and consent in relation to looked after children.
- Knowledge of relevant regional, national and international issues, policies and implications for practice.
- Knowledge of current commissioning and planning of looked after children/adoption health services and have knowledge of methods for support by other agencies such as education/social care/disability support locally and nationally.
- Understand, lead and contribute to processes for auditing the effectiveness and quality of looked after children/adoption services on an organisational level, including audits against national guidelines.
- Understand the needs and legal position of young people, particularly those aged 16 years and over and the transition between children's and adult legal frameworks including respective service provision.
- Understand the processes and legislation for looked after children, unaccompanied asylum-seeking children and those undergoing adoption including after-care/adoption services.
- Have knowledge of the impact of adult health issues on caring/parenting capacity
- Understand relevant aspects of the criminal justice system.
- Understand how the special educational needs and disability assessment and planning frameworks affect looked after children.

Skills

- Able to review, summarise, interpret and communicate effectively with children and young people including those with complex needs eg, language difficulties, learning and behavioural difficulties and where English is not their first language use appropriate resources including interpreters to do so.
- Able to support effective transition planning.
- Able to effectively engage with birth parents, involving them as appropriate in health assessments alongside foster parents.
- Able to adapt and be sensitive and flexible to meet the particular needs of the child and in particular adolescents.
- Able to review, summarise and interpret information from a range of sources (e.g. write a chronology/summary for adoption report).
- Able to analyse and evaluate information and evidence to inform inter-agency decision making across the organisation.[132]

131 NHS Education Scotland. *A capability framework for nurses who care for children and young people who are looked after away from home.* 2009.

132 NHS Education Scotland. *A capability framework for nurses who care for children and young people who are looked after away from home.* 2009.

- Able to convey complex information in an accessible manner to other professionals and adults involved in the care of looked after children, including those undergoing adoption.
- Able to advise other agencies about the health management of looked after children
- Able to support colleagues in constructively challenging other professionals, when appropriate, in the best interest of children.
- Able to contribute effectively to a single assessment and plan for looked after children who are also part of the local special educational needs process.
- Able to give advice about policy and legal frameworks in relation to looked after children.
- Able to undertake quality assurance measures and processes.
- Able to participate in organisational training needs analysis, and to teach and educate health service professionals and multi-agency partners as part of a team.
- Able to review, evaluate and update local organisational guidance and policy in light of research findings.
- Able to work effectively with colleagues in wider networks.
- Able to ensure mechanisms are in place to effectively enable the consultation, participation and involvement of looked after children/young people and service users in the planning and delivery of services.
- Able to effectively provide, support and promote appropriate supervision in respect of the health of looked after children for colleagues across the health community.

Named professionals for looked after children

The named nurse and named doctor for looked after children are leaders in their provider organisation to ensure that looked after children's issues are reflected in policies, and service delivery across the provider organisation. They also have a responsibility to support the trust/health provider for managing, and quality assurance of health assessments for children placed out of area.

It should be noted that the named and designated professional are distinct roles and as such should be separate post holders to avoid potential conflict. It is recognised that named professionals for looked after children within organisations are usually also clinically working in the field and therefore consideration needs to be made to managing potential areas of conflict in discussion with the designated doctor for looked after children. Additional support and review with designated professionals may be required to ensure no conflict of interests.

It should also be noted that these roles are dedicated posts and should not be combined with responsibilities for adult or child safeguarding.

Staff groups

This level applies to named doctors and nurses for looked after children. These roles move beyond generic care to a higher level of operational expertise achievable through extensive experience and a higher level of education. The named nurse/doctor seeks

to improve the health outcomes for looked after children and care leavers by working with the individual, their carers, the corporate family and the wider community to affect change via innovative practice and collaborative working to stimulate the awareness of the health needs of this client group, influencing policies that affect health and the facilitation of health enhancing activities.

The named nurse/doctor role includes the provision of specialist advice and supervision to staff who have direct contact with looked after children and care leavers. The post holder will ensure a high standard of care is achieved and maintained within their organisation demonstrating effective management and leadership skills.

Additional competencies

Named professionals should have the core competencies, knowledge, skills and attitudes as outlined for level 4. In addition they should be able to:

- engage in effective strategic planning of services for looked after children with commissioners and the designated professionals for looked after children
- identify and take responsibility for developing, implementing and reviewing policies, procedures and quality standards that reflect statutory requirements and recommendations of national guidance for looked after children[133,134,135]
- monitor trends, quality and appropriateness of referrals and identify gaps, duplications, and blockages to systems and take appropriate action.
- attend appropriate strategy meetings and planning meetings to provide an expert assessment of health risk for looked after children and ensure effective multi-agency working
- work effectively on an inter-professional and interagency basis
- identify unmet health needs/gaps in service provision and promote innovative service solutions
- ensure legal processes and requirements for looked after children including after care are appropriately taken.
- advise other agencies about the health management of looked after children
- lead on investigations and significant incidents, including individual management reviews and support designated professionals with statutory reviews eg, serious case reviews and domestic homicide
- apply lessons learnt from audit, case management reviews, significant case reviews to improve practice
- participate in and chair multi-disciplinary meetings as required.

133 NICE. *NICE public health guidance 28: Looked-after children and young people.* May 2015. www.nice.org.uk/guidance/ph28

134 Department of Health, Department for Education. *Promoting the health and welfare of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England.* 2015. www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

135 Department of Education. *Statutory guidance, Children Act 1989: care planning, placement and case review.* 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/441643/Children_Act_Guidance_2015.pdf

Attitudes and values

- As outlined in level 1, 2 and 3.

Education and training requirements

- Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period.[136] This could include non-clinical knowledge acquisition such as management or resources, appraisal, and supervision training, as well as skills based such as motivational interviewing.[137]
- Training and education may be multidisciplinary or inter-agency, with practitioners accessing relevant training provided by local authorities through multi-agency partnerships.
- Named professionals responsible for the training of doctors are expected to have appropriate education for this role.
- Named professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and national level, according to professional guidelines (attendance should be recorded).
- Named professionals should complete a management programme with a focus on leadership and change management[138] within three years of taking up their post
- Training at level 4 will include the training required at level 1-3 and will negate the need to undertake refresher training at levels 1-4 in addition to level 4.
- In England, the current legal position states that all initial health assessments must be undertaken by a medical practitioner.[139] For paediatricians, they must demonstrate Level 3 Community Child Health competencies[140] and additional training/experience in respect of looked after children.

136 Training can be tailored by organisations to be delivered annually or once every 3 years and encompass a blended learning approach.

137 Those undertaking level 4 training do not need to repeat level 1, 2 or 3 training as it is anticipated that an update will be encompassed in level 4 training.

138 This could be delivered by Health Boards/Authorities, in house or external organisations.

139 At the current time all initial health assessments must be undertaken by a medical practitioner in England. If relevant regulations in England are amended it is expected that initial health assessments must be undertaken by a medical practitioner or an advanced paediatric nurse practitioner with the equivalent knowledge, skills and competencies. In Wales, both Initial Health Assessments and Review Health Assessments may be undertaken by a Registered Medical Practitioner or Registered Nurse or Midwife. (Care Planning, Placement and Case Review (Wales) Regulations 2015 www.legislation.gov.uk/wsi/2015/1818/made). In Scotland legislation initial health assessments can be undertaken by a registered medical practitioner or registered nurse.

140 General Medical Council. *Community child health curriculum.* www.gmc-uk.org/education/25364.asp

Learning outcomes

- As outlined for Level 1, 2 and 3.
- Demonstrates completion of a teaching and assessment programme[141] within 12 months of appointment.
- Demonstrates an understanding of appropriate and effective training strategies to meet the competency development needs of different staff groups.
- Demonstrates completion of relevant specialist looked after children education within 12 months of appointment.
- Demonstrates understanding of professional body registration requirements for practitioners, including revalidation.[142,143]
- Demonstrates an understanding and experience of developing evidence-based clinical guidance.
- Demonstrates effective consultation with other healthcare professionals and participation in multi-disciplinary discussions.
- Demonstrates participation in audit, and in the design and evaluation of service provision, including the development of action plans and strategies to address any issues raised by audit and serious case reviews/internal management reviews/ significant case reviews/other locally determined reviews related to looked after children.
- Demonstrates critical insight of personal limitations and an ability to participate in peer review.
- Demonstrates practice change from learning, peer review or audit.
- Demonstrates contributions to reviews have been effective and of good quality.
- Demonstrates use of feedback and evaluation to improve teaching in relation to looked after children.

141 This programme could be provided by a professional organisation or a higher education institution.

142 www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation

143 http://revalidation.nmc.org.uk

Level 5: Designated professionals for looked after children

Staff groups

This applies to designated doctors and nurses for looked after children.[144,145,146,147]

As highlighted earlier the child protection system including that related to the care of looked after children and care leavers is the responsibility of the government of each of the UK's four nations: England, Northern Ireland, Scotland and Wales. There may therefore be specific duties relating to Designated roles in each nation.

Designated professionals for looked after children are required to also have advanced knowledge of safeguarding children and young people.

Appendix 3 describes the key duties and responsibilities of designated professionals.

Core competencies

- As outlined for Level 1, 2 3 and 4.
- Clinically competent in meeting the health needs of looked after children, including those undergoing adoption as *appropriate to role*.
- Effective strategically, raising key issues with service planners, commissioners and service providers to ensure the needs of looked after children are taken into account locally including those placed out of the area.
- Gives appropriate advice to looked after children professionals working within organisations delivering health services and to other agencies.
- Takes a strategic and professional lead across the healthcare services,[148] including public health services commissioned by local authorities, and provided by independent/private health care providers on all aspects of looked after children
- Provides expert advice to increase quality, productivity, and to improve health outcomes for looked after children and care leavers.
- Able to clearly articulate and provide sound policy advice across interagency and corporate parenting partnership and appropriate structures such as health and wellbeing boards or equivalents.

144 In Wales, this term refers to the named doctor for looked after children strategic role across the health board area. There is no named nurse identified.

145 In Wales, within the National Safeguarding Team (Public Health Wales) there is one designated doctor and one designated nurse for looked after children.

146 In Scotland, this would refer to the lead paediatrician for looked after and accommodated children/clinical nurse specialist.

147 In England, designated nurses and doctors sit with the CCG to advise commissioners of services to improve the health of looked after children. It should be noted that named and designated professionals are distinct roles and as such should be separate postholders to advice potential conflict.

148 This also includes public health and LA commissioning, and private healthcare and Independent providers.

- Able to develop, lead and monitor relevant quality assurance processes and service improvement of health services for looked after children across the healthcare services,[149] including public health services commissioned by local authorities, and provided by independent/private healthcare providers.
- Able to influence change across internal and external organisations, as well as allied agencies.
- Able to effectively challenge colleagues in health and social care about the health and wellbeing of looked after children.
- Able to provide an effective contribution to the strategic corporate parenting agenda, the wider children's plan and NHS priorities.[150]
- Able to provide, support and ensure contribution to the appraisal of health professionals for looked after children and appropriate supervision for colleagues across healthcare services,[151] including public health services commissioned by local authorities, and provided by independent/private healthcare providers.
- Able to conduct training needs analysis, and commission, plan, design, deliver, and evaluate looked after children training and teaching for staff across healthcare services,[152] including public health services commissioned by local authorities, and provided by independent/private healthcare providers.
- Able to lead innovation and change to improve looked after children services across health care services,[153] including public health services commissioned by local authorities, and provide by independent/private healthcare providers.
- Able to provide expert advice to service planners and commissioners, ensuring all services commissioned meet the statutory requirement to promote the welfare of looked after children to include:
  - taking a strategic professional lead across every aspect of health service contribution to looked after children within all provider organisations which are commissioned to undertake this service
  - ensuring robust systems, procedures, policies, professional guidance, training and supervision are in place within all provider organisations commissioned to undertake this service, in keeping with Statutory Guidance recommendations
  - provide specialist advice and guidance to the Board and Executives of commissioner organisations on all matters relating to looked after children including regulation and inspection
  - be involved with commissioners, providers and partners on the direction and monitoring of looked after children standards and to ensure that looked after children standards are integrated into all commissioning processes and service specifications.

149 Designated professionals should have regular, direct access to the CCG accountable officer or chief nurse to provide expert advice and support for looked after children and care leavers, and they should also be invited to all key partnership meetings.

150 NHS plan, Strategic Transformation and Integrated Care System plans and priorities.

151 This also includes public health and LA commissioning, and private healthcare and Independent providers.

152 This also includes public health and LA commissioning, and private healthcare and Independent providers.

153 This also includes public health and LA commissioning, and private healthcare and Independent providers.

- Able to monitor services across health care services[154] to ensure adherence to legislation, policy and key statutory and non-statutory guidance.
- Able to clearly articulate and provide sound policy advice across interagency and corporate parenting partnership and appropriate structures such as health and wellbeing boards or equivalents.
- Able to provide an effective contribution to the strategic corporate parenting agenda and the wider children's plan.
- Able to advise and influence service planners/commissioners to promote the coordination and delivery of health services for looked after children across professional and geographic boundaries.
- Able to ensure mechanisms are in place to effectively enable the consultation, participation and involvement of looked after children/young people and service users in the planning and delivery of services.
- Ensure robust governance arrangements are in place for commissioning of specialist placements where a child or young person is placed away from the responsible local authority to provide continuity of healthcare.[155]
- Have expert knowledge regarding quality of practice and the looked after children journey for looked after children and care leavers.
- Ensure systems for individual children and young people placed both locally and out of the area are consistent with the guidance on establishing the responsible commissioner.

Knowledge, skills, attitudes and values

Level 5 professionals should have the knowledge, skills, attitudes and values outlined for Levels 1, 2, 3 (core and specialist where appropriate) and 4, and be able to demonstrate the following areas:

Knowledge[156]

- Advanced and indepth knowledge of relevant national and international policies and implications for practice.[157]
- Advanced expert knowledge regarding quality of practice and the journey for looked after children and care leavers.
- Advanced understanding of the legal processes underpinning care planning for looked after children and children with an adoption plan and how they relate to other statutory processes such as special educational needs and disability processes.

154 This also includes public health and LA commissioning, and private healthcare and Independent providers.

155 In Scotland, looked after and accommodated children health teams often retain responsibility for their out of area placements to ensure continuity. The child will be registered with local GP etc and can access other local services if required.

156 *National Workforce Competences*: DANOS BC4 Assure your organisation delivers quality services; PH08.01 Use leadership skills to improve health and wellbeing; PH02.06 Work in partnership with others to protect the public's health and wellbeing from specific risks; ENTO L4 Design learning programmes (also HI 39); ENTO L6 Develop training sessions (also HI 40); ENTO L10 Enable able learning through presentations (also HI 42); PH 06.01 Work in partnership with others to plan, implement, monitor and review strategies to improve health and wellbeing.

157 Designated professionals should have regular, direct access to the CCG accountable officer or chief nurse to provide expert advice and support for looked after children and care leavers, and they should also be invited to all key partnership meetings.

- Advanced understanding of the processes and legislation for looked after children, care leavers, unaccompanied asylum-seeking children and those undergoing adoption including after-care/adoption services.
- Know how to lead the implementation of national guidelines and audit the effectiveness and quality of services across all healthcare services[158] against quality standards.
- Advanced understanding of management and strategic roles within the corporate parenting partnership and local strategic structures.
- Advanced understanding of curriculum planning and effective delivery of training.

Skills

- Able to develop, implement and undertake quality assurance measures and processes.
- Able to plan, design, deliver and evaluate inter-agency looked after children training for staff across healthcare services,[159] in partnership with colleagues in other organisations and agencies.
- Able to develop, implement, review, evaluate and update local guidance and policy in light of research findings.
- Able to advise, inform and influence others about regional, national and international issues and policies and the implications for practice.[160]
- Able to work effectively across management and strategic roles within the corporate parenting partnership and across organisational boundaries.
- Able to access and interrogate relevant health and local authority information systems and database(s) as appropriate, in adherence with information sharing arrangements and legislation in relation to looked after children where it impacts on health provision for looked after children.
- Able to oversee looked after children quality assurance processes across healthcare services,[161] including public health services commissioned by local authorities, and provided by independent/private healthcare providers.
- Able to reconcile differences of opinion among colleagues from different organisations and agencies.
- Able to proactively deal with strategic communications and the media on looked after children across healthcare services,[162] including public health services commissioned by local authorities, and provided by independent/private healthcare providers.
- Able to work with public health officers to undertake robust looked after children population-based needs assessments that establish current and future health needs and service requirements across healthcare services,[163] including public health services commissioned by local authorities, and provided by independent/private providers.

158 This also includes public health and LA commissioning, and private healthcare and Independent providers.

159 This also includes public health and LA commissioning, and private healthcare and Independent providers.

160 Designated professionals should have regular, direct access to the CCG accountable officer or chief nurse to provide expert advice and support for looked after children and care leavers, and they should also be invited to all key partnership meetings.

161 This also includes public health and LA commissioning, and private healthcare and Independent providers.

162 This also includes public health and LA commissioning, and private healthcare and Independent providers.

163 This also includes public health and LA commissioning, and private healthcare and Independent providers.

- Able to provide an evidence base for decisions around investment and disinvestment in services to improve the health of looked after children and care leavers and articulate these decisions to executive officers.
- Able to deliver high-level strategic presentations to influence organisational development.
- Able to work in partnership on strategic projects with executive officers at local, regional, and national bodies, as appropriate.
- Able to produce board level annual reports outlining key performance indicators, gaps in service and information to inform the commissioning cycle.
- Able to influence and negotiate collaborative approaches to development of service/ programme areas working in partnership with key stakeholders.
- Able to develop standards, quality assurance and performance frameworks.
- Able to contribute to the strategic local children and young people's plan and the Joint Strategic Needs Assessment for looked after children.

Attitudes and values

- As outlined in Level 1, 2, 3 and 4.

Education and training requirements

- Designated professionals should attend a minimum of 24 hours of education, training and learning over a three-year period.[164,165] This could include non-clinical knowledge acquisition such as management or resources, appraisal, supervision training, and the context of other professionals' work.[166]
- Training and education may be multi-disciplinary or interagency, with practitioners accessing relevant training provided by local authorities.
- Designated professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and national level, according to professional guidelines (attendance should be recorded).
- An executive level management programme with a focus on leadership and change management[167] should be completed within three years of taking up post.
- Training at level 5 will include the training required at level 1-4 and will negate the need to undertake refresher training at levels 1-4 in addition to level 5.

Learning outcomes

- As outlined in Level 1, 2, 3 and 4.
- Demonstrates advanced knowledge of national looked after children practice and an insight into international perspectives.

164 Training can be tailored by organisations to be delivered annually or once every three years and encompass a blended learning approach.

165 Individuals may need more education and training particularly if new to the post or where there is new and emerging evidence and research regarding looked after children and care leavers.

166 Those undertaking level 5 training do not need to repeat level 1, 2, 3 or 4 training as it is anticipated that an update will be encompassed in level 5 training.

167 This could be delivered by health boards/authorities, in house or external organisations.

- Demonstrates contribution to enhancing looked after children practice and the development of knowledge among staff.
- Demonstrates knowledge of strategies for looked after children management across healthcare services,[168] including public health services commissioned by local authorities, and provided by independent/private healthcare providers.
- Demonstrates an ability to conduct rigorous and auditable support and peer review for looked after children professionals, as well as appraisal and supervision where provided directly.
- Demonstrates critical insight of personal limitations and an ability to participate in peer review.

Designated professionals working within commissioning organisations in England

- Demonstrate knowledge of relevance of looked after children commissioning processes.
- Ensures a looked after child focus is maintained within strategic organisational plans and service delivery.

Board level for chief executive officers, trust and health board executive[169] and non-executive directors/ members, commissioning body directors

It is envisaged that chief executives of healthcare organisations take overall (executive) responsibility for safeguarding and child protection strategy and policy, including that for vulnerable groups such as looked after children and safe staffing levels[170] with additional leadership being provided at board level by the executive director with the lead for safeguarding and looked after children. All board members including non-executive members must have a level of knowledge equivalent to all staff working within the healthcare setting (level 1) as well as additional knowledge-based competencies by virtue of their board membership, as outlined below. All boards should have access to advice and expertise through designated or named professionals for looked after children.

Commissioning bodies have a critical role in quality assuring providers systems and processes, and thereby ensuring they are meeting their responsibilities for looked after children and care leavers. Designated professionals for looked after children within commissioning organisations provide expert advice to commissioners.

The specific roles of chair, CEOs, executive board leads and board members will be described separately:

168 This also includes public health and LA commissioning, and private healthcare and Independent providers.

169 In Scotland there is a nominated Board Director in each area with responsibility for looked after children (Looked After Children Director). There is also a Child Health Commissioner appointed in every health board, many of whom lead on board wide looked after children health strategy.

170 www.iicsa.org.uk/key-documents/5369/view/Interim%20Report%20-%20A%20Summary.pdf

Chair

The chair of acute, mental health and community trusts, health boards and commissioning bodies (and equivalent healthcare bodies throughout the UK) are responsible for the effective operation of the board with regard to child protection and safeguarding children and young people, looked after children and care leavers.

Key responsibilities for chairs

- To ensure that the role and responsibilities of the NHS organisation board in relation looked after children are met, including an understanding of their corporate parenting responsibility.
- To promote a positive culture of safeguarding looked after children across the Board through assurance that there are procedures for safer recruitment; restricted access to children's areas, unaccompanied children and whistle blowing; as well as appropriate policies for safeguarding and child protection and that these are being followed; and that staff and patients are aware that the organisation takes child protection and looked after children seriously and will respond to concern about the welfare of children.
- To ensure that there are robust governance processes in place to provide assurance on safeguarding and child protection and looked after children.
- To ensure child, looked after children and adult safeguarding policies and procedures work effectively together.
- To ensure good information from and between the organisation board or board of directors, committees, council of governors where applicable, the membership and senior management on safeguarding and child protection.

Chief executive officer (CEO) (chief/accountable officer)

The CEO of acute, mental health and community trusts, health boards and commissioning bodies (and equivalent healthcare bodies throughout the UK) must provide strategic leadership, promote a culture of supporting good practice with regard to child protection/ safeguarding and looked after children within their organisations and promote a culture of learning and professional curiosity and collaborative working with other agencies.

Key responsibilities of CEOs

- To ensure that the role and responsibilities of the board in relation to looked after children are met.
- To ensure that the organisation adheres to relevant national guidance and standards for looked after children.
- To promote a positive culture of safeguarding children to include: ensuring there are procedures for safer staff recruitment,[171] whistle blowing; appropriate policies for safeguarding and child protection (including regular updating); chaperoning[172] and that staff and patients are aware that the organisation takes child protection and looked

171 www.nhsemployers.org/RECRUITMENTANDRETENTION/EMPLOYMENT-CHECKS/Pages/Employment-checks.aspx

172 See www.iicsa.org.uk/key-documents/5369/view/Interim%20Report%20-%20A%20Summary.pdf. April 2018. See page 22 re. Chaperoning policies.

after children's issues seriously and will respond to concern about the welfare of children.

- To appoint an executive director lead for looked after children.
- To ensure good child protection and safeguarding practice throughout the organisation.
- To ensure there is appropriate access to advice from named and designated professionals for looked after children[173] or their equivalents in Scotland.
- To ensure that operational services are resourced to support/respond to the demands of safeguarding/child protection needs of looked after children effectively.
- To ensure that an effective safeguarding/child protection, looked after children training and supervision strategy is resourced and delivered.
- To ensure and promote appropriate, safe, multiagency/interagency partnership working practices and information sharing practices operate within the organisation.

Executive director lead

There should be a nominated executive director board member from a clinical background who takes responsibility for child protection/safeguarding and looked after children issues. The executive director lead will report to the board on the performance of their delegated responsibilities and will provide leadership in the long-term strategic planning for safeguarding/child protection services for children and looked after children and care leaver services across the organisation supported by the named and designated professionals for looked after children.

Boards should consider the appointment of a non-executive director (NED) board member to ensure the organisation discharges its safeguarding and looked after children responsibilities appropriately and to act as a champion for children and young people.

Key responsibilities of the board executive director lead

- To ensure that looked after children are positioned as core business in strategic and operating plans and structures.
- To oversee, implement and monitor the ongoing assurance of looked after children arrangements.
- To ensure the adoption, implementation and auditing of policy and strategy in relation to looked after children.
- Within commissioning organisations to ensure the appointment of designated looked after children professionals.
- Within commissioning organisations to ensure that provider organisations are quality assured for their looked after children arrangements.
- Within both commissioning and provider organisations to ensure support of named/designated lead professionals across primary and secondary care and independent practitioners to implement looked after arrangements.

173 Designated professionals should have regular, direct access to the CCG accountable officer or chief nurse to provide expert advice and support for looked after children and care leavers matters, and they should also be invited to all key partnership meetings.

- To ensure that there is a programme of training and mentoring to support those with responsibility for looked after children and care leavers.
- Working in partnership with other groups including commissioners/providers of healthcare (as appropriate), local authorities and police to secure high quality, best practice in safeguarding/ child protection for looked after children.
- To ensure that serious incidents relating to safeguarding are reported immediately and managed effectively.
- To ensure that the organisation has robust policies in place for managing appointments that are not attended by looked after children and care leavers.

Key responsibilities of the non-executive director board lead

- To ensure appropriate scrutiny of the organisation's safeguarding, looked after children and care leavers performance.
- To provide assurance to the board of the organisation's safeguarding performance.

Core competencies

All board members/commissioning leads should have Level 1 core competencies in safeguarding/Looked after children and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition board members/commissioning leads should have an understanding of the statutory role of the board in safeguarding and looked after children including partnership arrangements, policies, risks and performance indicators; staff's roles and responsibilities for looked after children; and the expectations of regulatory bodies for looked after children and care leaver services. Essentially the board will be held accountable for ensuring looked after children and young people in that organisation receive high quality, evidence based care and are seen in appropriate environments, with the right staff, who share the same vision, values and expected behaviours.

Knowledge, skills, attitudes and values

In addition to Level 1 board members/commissioning leads should have the following:

Knowledge

- Knowledge of the complex costs and the impact of adverse childhood experiences on public health and the health economy that the care of survivors of child maltreatment, looked after children and care leavers has.
- Knowledge of agencies involved in child protection/safeguarding and the care of looked after children and care leavers, their roles and responsibilities, and the importance of interagency co-operation.
- Knowledge about the statutory obligations to deliver health assessments and participate in adoption processes, and to work with the local or area child protection committee/safeguarding children's board/local safeguarding children partnership, safeguarding adult board, corporate parenting board and other safeguarding agencies and corporate parenting partners including the voluntary sector.
- Knowledge of the ethical, legal and professional obligations around information sharing related to looked after children.

- Knowledge about the statutory obligation to be involved, participate and implement the learning from Serious or Significant Case Reviews (SCRs)(in Wales – child practice reviews/domestic homicide reviews which include children and other review processes including for example the procedural response to unexpected deaths in children (PRUDIC).
- Knowledge about the principles and responsibilities of the organisation's/staff's participation with the Child Death Review Process and in Wales the procedural response to unexpected deaths in children (PRUDIC).
- Knowledge about the need for provision of and compliance with staff training regarding looked after children both within commissioning and provider organisations as an organisational necessity.
- Knowledge about the importance of looked after children policies with regard to personnel, including use of vetting and barring and safe recruitment and the requirement for maintaining, keeping them up to date and reviewed at regular intervals to ensure they continue to meet organisational needs.
- Knowledge about the regulation and inspection processes for looked after children's services and implications for the organisation if standards are not met by either commissioners or providers.
- Knowledge about the importance of regular reporting and monitoring of looked after children's arrangements within provider organisations.
- Knowledge about board level risk relating to looked after children and the need to have arrangements in place for rapid notification and action on serious untoward incidents.
- Knowledge, understanding and awareness about the requirement of the board to have access to appropriate high quality medical and nursing advice on looked after children from lead/named/designated and nominated looked after children specialist professionals.

Skills

- To be able to recognise possible signs of child maltreatment as this relates to their role, understanding looked after children are still in need of safeguarding.
- To be able to seek appropriate advice and report concerns.
- To have the appropriate board level skills to be able to challenge and scrutinise looked after children information to include performance data, serious incidents/serious case reviews (SCRs), partnership working and regulatory inspections to enable appropriate assurance of the organisation's performance in regard of looked after children and care leavers.
- To have highly developed skills and expertise in high level escalation in multi-agency working and internal escalation to resolve issues concerning looked after children and care leavers at an executive level supported by designated/named professionals.

Attitudes and values

- Willingness as an individual to listen to looked after children and young people and to act on issues and concerns, as well as an expectation that the organisation and professionals within it value and listen to the views of looked after children and young people.

- Willingness to work in partnership with other organisations/patients and families to promote safeguarding.
- Willingness to promote a positive culture around safeguarding within the organisation, positively adopting and promoting the concept of corporate parenting across the organisation. This includes recognising the challenges and complexity faced by front line professionals in carrying out their safeguarding duties, recognising the emotional impact that safeguarding can have on these professionals and ensuring that there is ample support available for them.
- Facilitates a no-blame culture when reviewing safeguarding cases.

Education and training requirements

This will require a tailored package to be delivered which encompasses level 1 knowledge, skills and competencies, as well as board level specific as identified in this section.

Learning outcomes

- Demonstrates an awareness and understanding of child maltreatment and the needs of looked after children and care leavers.
- Demonstrates an understanding of appropriate referral mechanisms and information sharing, including mandatory reporting requirements and statutory duties of provider team to deliver.

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Useful weblinks, resources and information

www.gov.uk/topic/schools-colleges-childrens-services/looked-after-children

www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-las-31-march-2018

www.rcpch.ac.uk/resources/workforce-census-focus-vulnerable-children-families-paediatric-workforce-2020

https://corambaaf.org.uk/about/what-we-do/policy-and-practice-development/rapid-evidence-review-special-guardianship

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https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children

www.rcn.org.uk/clinical-topics/children-and-young-people/looked-after-children

https://en-gb.facebook.com/CareLeaversAssociationUK

www.cqc.org.uk/guidance-providers/childrens-services/inspecting-childrens-services

www.scie.org.uk/children/looked-after-children

https://migration.iom.int/docs/Infographic_Children_and_UASC_overview_2017.pdf

Appendices

Appendix 1: The role of specialist medical, nursing and health advisors for looked after children[174,175]

All healthcare staff need education, support and leadership both locally and nationally in order to fulfil their duties to meet the needs of looked after children and young people, and care leavers.

This section provides additional guidance and aids interpretation of the competence statements in the competency framework. The generic model job descriptions can be amended as appropriate according to national and local context.

Model job description

The job descriptions of specialist professionals should reflect an appropriate workload, covering both roles and responsibilities for looked after children and for the rest of their work. Job descriptions should be agreed by the employing organisation

1. Person specification

The post holder must have an enhanced disclosure check. Named and designated professional posts comprise a registered activity under the Disclosure and Barring Service (DBS) for England and Wales, Disclosure Scotland (for Scotland) and Access Northern Ireland in Northern Ireland.

The **specialist doctor**[176] should:

- hold consultant status or a senior post with equivalent training and experience
- have completed higher professional training (or achieved equivalent training and experience) in paediatrics, community child health and looked after children
- have considerable clinical experience of assessing and examining children and young people as appropriate to the role
- be currently practising and be of good professional standing.[177]

The **specialist nurse** should:

- hold a senior level post. It is expected that the post would be at Band 7 dependent on the precise responsibilities outlined in the role description (the role would be subject to the usual Agenda for Change Job Evaluation process)
- have completed specific training in the care of babies/children and young people and be registered on either Part 1 of the Nursing and Midwifery Council (NMC) register as a registered children's nurse or mental health nurse (in mental health organisations) or Part 3 as a specialist community public health nurse having completed a specific programme with a child and family focus

174 Includes those with specific roles such as Named Looked After Children's Nurses, Named Looked After Children's Doctors, lead Looked After Children health professionals, specialist nurses for Looked After Children.

175 Should be read in conjunction with Level 4 competencies, knowledge and skills outlined within the document.

176 Could undertake medical advisor role for adoption and fostering.

177 Refers to doctors who are on the GMC register and who are up to date with their professional CPD – www.gmc-uk.org

- have completed specific post-registration training relevant to looked after children prior to commencement in the post (including law, policy, and practice at Level 2 or Post Graduate Diploma (PGDip))
- have a minimum of three years' experience related to caring for babies/children and young people and relevant experience with looked after children and young people.

2. Job description for all specialist LAC health professionals

- Support the named nurse and doctor to ensure that the organisation meets its responsibilities to looked after children.
- Be responsible to and accountable within the managerial framework of the employing organisation.
- At all times and in relation to the roles and responsibilities listed, work as a member of the organisation's looked after children health team.

3. Inter-agency responsibilities

- Advise local police, children's social care and other statutory and voluntary agencies on health matters with regard to individual looked after children.
- Liaise closely with other specialist services such as CAMHS, sexual health, and services for disabled children.

4. Leadership and advisory role

- Support the named nurse and doctor to advise the board of the healthcare organisation about looked after children.
- Contribute to the planning and strategic organisation of provider services for looked after children.
- Work with named and designated professionals on planning and developing strategy for services for looked after children.
- Ensure advice is available to the other professionals across the organisation on day to-day issues about looked after children and their families, including involvement in fostering and adoption panels according to local arrangements.

5. Clinical role

- Undertake health assessments for looked after children and provide written reports on the health of prospective carers as appropriate.
- Support and advise colleagues in the clinical assessment and care of children and young people, whilst being clear about others personal clinical professional accountability.
- Provide advice and signposting to other professionals about legal processes, key research and policy documents.

6. Co-ordination and communication

- Work closely with other specialist, named and designated looked after children professionals locally, regionally and nationally.

- Work closely with the lead for children and/or safeguarding within the healthcare organisation.
- Liaise with professional from other agencies, such as education and children's social care.

7. Governance: policies and procedures

- Support the named nurse and doctor to ensure that the healthcare organisation has relevant policies and procedures in line with legislation and national guidance.
- Contribute to the dissemination and implementation of organisational policies and procedures.
- Encourage case discussion, reflective practice, and the monitoring of significant events at a local level.

8. Training

- Work with named and designated looked after children professionals locally to agree and promote training needs and priorities.
- Support the named and designated professionals to ensure that there is an organisational training strategy in line with national and local expectations.
- Contribute to the delivery of training for health staff and inter-agency training.
- Support the named and designated professionals to evaluate training and adapt provision according to feedback from participants.
- Tailor provision to meet the learning needs of participants.

9. Monitoring

- With the named nurse/doctor advise employers on the implementation of effective systems of audit.
- Contribute to monitoring the quality and effectiveness of services, including monitoring performance against indicators and standards.

10. Supervision

- Engage in appraisal, support and supervision for colleagues in the team/organisation.
- Contribute to individual case supervision.

11. Personal development

- Meet the organisation's requirements for training attendance.
- Attend relevant continuing professional development activities to maintain competence.
- Receive regular supervision and undertake reflective practice.
- Recognise the potential personal impact of working with looked after children on self and others and seek support and help when necessary.

12. Appraisal

- Receive annual appraisal[178] from a professional with specialist knowledge of looked after children and with knowledge of the individual's professional context and framework.[179]

13. Accountability

- Be accountable to the chief executive of the employing body.
- Report to the named nurse/doctor with primary responsibility for children's services and looked after children within the organisation.

14. Authority

- Should have the authority to carry out all of the above duties on behalf of the employing body and should be supported in so doing by the organisation and by colleagues.

15. Resources required for the post

- Professionals' roles should be explicitly defined in job descriptions, and sufficient time and funding must be allowed to fulfil their responsibilities effectively.
- The time required to undertake the tasks outlined in this job description will depend on the size and needs of the looked after children population, the number of staff, the number and type of operational units covered by the healthcare organisation, and the level of development of local structures, process and function.
- The healthcare organisation should supply dedicated secretarial and effective support.
- Given the stressful nature of the work, the healthcare organisation should provide focused support and supervision for the specialist professional.

Looked after children's specialist nurse

A minimum of 1 WTE* specialist nurse per 100 looked after children.

*The required number of looked after children's specialist nurses will also depend on the complexity of caseload, geography, population and size of the catchment area served.

178 For nurses, midwives, health visitors and relevant health staff reference should be made to the NHS Knowledge and Skills Framework.

179 The appraiser should consult with someone with specialist knowledge and experience.

Appendix 2: Medical adviser to adoption agency[180]

All adoption agencies must have a medical adviser (Adoption Agency Regulations 2005 for England; Adoption Agencies (NI) Regulations 1989 for Northern Ireland; Adoption Agencies (Scotland) Regulations 1996; Adoption Agencies (Wales) Regulations 2005) who is fully registered with the General Medical Council and has an enhanced disclosure check under the Disclosure and Barring Service (DBS) for England and Wales, Disclosure Scotland (for Scotland) and Access Northern Ireland in Northern Ireland.

It is acknowledged that this job description is embedded within a multidisciplinary system, the aim of which is to provide an integrated service for a very vulnerable group of children. Since there is considerable regional, geographic and local variability in arrangements across the UK, this job description will need to be tailored to the demands of the particular post.[181]

This job description should be jointly agreed by the relevant health trust(s)/health boards/adoption agency(ies) covered by the post. It is important that the job plan reflects the workload, as this is frequently underestimated. Throughout this job description where the term looked after children is used this applies to children with a care plan for adoption.

1. Person specification

The medical adviser (MA) for adoption must:

- be an advocate for children for whom the care plan is adoption
- have undergone higher professional training in paediatrics. Alternatively, by virtue of experience and practice, have demonstrated appropriate competencies as advised by the designated doctor for looked after children (England and Northern Ireland)/lead clinician for looked after and accommodated children (Scotland)/named doctor for looked after children strategic role (Wales) (see relevant job description)
- have relevant experience in the clinical management of children including those with neuro-developmental, emotional, behavioural and attachment difficulties, child protection, and adult health issues pertinent to parenting[182]
- the medical adviser should ideally be involved in clinical work with looked after children. For medical advisers whose sole role is as medical adviser to panel it is important that they keep up to date with community paediatric practice
- have the ability to achieve other competencies as appropriate to the role.
- have experience of, and the ability to work in, a multi-agency setting
- have relevant knowledge of health and developmental issues of children adopted from abroad, if providing intercountry adoption services

180 Modified Model Job description from Coram/BAAF. https://corambaaf.org.uk

181 Given the different structures and the changes evolving under the Review of Public Administration in Northern Ireland, agencies may wish to modify the job description to meet local needs.

182 The role of Medical Adviser for Voluntary Adoption Agencies, who largely recruit adult carers, may be undertaken by a GP with expertise or other registered medical practitioner who has relevant specialist training. However, they should have knowledge and experience of children with very complex needs as these agencies are likely to be recruiting carers for such children.

- have good verbal and written communication skills, with an ability to express complex medical issues in lay terms.

2. Clinical role

- It is preferred practice, but not obligatory, that the medical adviser should undertake statutory health assessments of looked after children.
- The medical adviser should provide a written health report on each child being considered for adoption. This report should include comments on birth history, family history, past medical history, current physical and mental health and behaviour and, if age appropriate, a developmental assessment. This report should assess the future implications for the child of their health history, and previous family and social situation, including their experiences in the care system.
- The medical adviser should provide a written report to the agency on the health of prospective adopters, which will include interpretation of health and lifestyle information provided by the applicant and their GP. It may be necessary to liaise, with consent, with specialists about details of health problems identified.
- It is good practice for the medical adviser to share all appropriate information with prospective adopters and to meet with them to discuss the needs of the child/ren with whom they are matched. It is also good practice to provide a written report of this meeting.
- The medical adviser should be available to advise prospective adopters on health matters of children being considered for adoption from abroad, and ideally undertake health assessment of the child.

3. Panel responsibilities

- Medical adviser to the adoption panel is a full panel member. She/he has a responsibility to take part in panel consideration of cases and to contribute to the panel recommendation. Responsibilities of all panel members include attending a locally agreed percentage of all panels, attending panel training and having an annual appraisal as a panel member. The minimum attendance which is usually required at panels is 75%.[183]
- As specified in the Adoption Agency Regulations for England and Wales, and the National Minimum Standards, the medical adviser should work in partnership with the adoption agency to ensure that the written summary health report on the child and adult will be available to the agency in time to allow circulation to panel members in advance (e.g, for child, Part C of Form Initial Health Assessment – C/YP).
- The medical adviser will be available at panel to discuss their written report and to answer questions on health issues at the request of other panel members.
- The medical adviser should contribute to the identification of adoption support needs.
- The medical adviser will need to contribute to court reports on children in placement order/freeing order and adoption order applications, and on prospective adopters.

183 *Effective Panels: Guidance on regulations, process and good practice in adoption and permanence panels*, Lord and Cullen, BAAF, 2005.

4. Other professional responsibilities

The medical adviser for adoption:

- should be available to advise on particular health matters that arise in connection with the adoption process
- should support and advise other health professionals and relevant managers on health issues relevant to adoption, for example, consent issues for children placed for adoption, and adoption support including post placement
- should work closely with the local safeguarding and health professionals working with all looked after and accommodated children to ensure delivery of high quality clinical services through monitoring and audit
- should maintain contact and work closely with local paediatricians, local child and adolescent mental health services, primary care, and other relevant health professionals and specialists
- should work closely with partner agencies to address the health needs of children who have a care plan for adoption
- may offer training on adoption matters to health personnel, prospective adopters and partner agencies
- should ensure that personal practice conforms to policies and procedures relevant to adoption, as outlined in statute and professional practice guidelines.

5. Training and personal development

- This is a specialist post, and the post holder is likely to be unique within their provider service. Therefore it is essential to maintain contact with other medical advisers regionally and nationally. Membership of the Coram/BAAF Health Group is recommended as it offers professional support, notification of training opportunities, updates on policy and practice and access to national and regional meetings.
- The medical adviser should attend continuing professional development (CPD) activities in order to maintain competencies in the area, equivalent to at least 10 hours per year, in topics relevant to substitute care. The medical adviser should also attend general panel training to maintain awareness of adoption practice and legislation, including intercountry adoption where dealt with by the agency. It is the responsibility of the employer to support specialist training which is likely to be external.

6. Appraisal

- The medical adviser should have a professional appraisal on an annual basis. Ideally reference should be made to someone with specialist knowledge of adoption, particularly if there are areas of concern, in order to ensure that appraisal of the adoption role is appropriate.
- Medical advisers to panel in England and Wales will require an annual appraisal as a panel member, as required in statutory Guidance for England (Adoption and Children Act 2002 Guidance Department of Health) and Regulations for Wales (Adoption Agency (Wales) Regulations 2005.

7. Accountability

- Clear lines of accountability must be established within each job description.

8. Resources required for the post

a) Programmed activities for the post should be agreed and a corresponding adjustment made to the medical adviser's other clinical duties within the job plan (see below).

b) Appropriate administrative support for the medical adviser should be agreed, competent to manage the sensitive and specialised nature of the work.

c) There should be support and supervision for the individual. This is an acknowledgement of the sometimes stressful nature of this work.

Estimate of the time required to carry out the duties and responsibilities of the medical adviser for adoption

These recommendations have been derived by consensus from consultation with the BAAF Health Group Advisory Committee and regional health groups, and prospective audit of services. These recommendations reflect the actual time required to undertake specific tasks and should be used as a guide to long term planning for delivery of high quality services.

ACTIVITY	TIME (hours)	Per annum
Scrutiny/review of prospective adopters' health assessments (including all research needed, providing advice as required, provision of report)	½ hour per applicant	
Carrying out comprehensive paediatric health and developmental assessments, eg, completing Part B of BAAF Form IHA-C or YP	1.5 hours per child	
Collating health information and preparing a report on a child being considered for adoption (including all research needed and answering queries as required) 6 eg, completing Part C of BAAF Form IHA-C or YP	4 hours per child (not including seeing child – see above)	
Carrying out an adoption review health assessment, eg, completing Part B of BAAF Form RHA-C or YP	1 hour per child	
Preparing a report for an adoption review health assessment, eg, completing Part C of BAAF Form RHA-C or YP	1 hour per child (not including seeing child – see above)	
Scrutiny of health assessment of child to be adopted from abroad, and counselling of prospective adoptive parents, including provision of written report.	3 hours per child	
Preparation and reading papers for panel	4 hours per half day panel	
Attending panel 6 (one session)	4 hours per half day panel & travel	
Counselling prospective adopters about individual children, including provision of written report	2 hours per child	

Appendix 3: Named nurse and named doctor for looked after children[184,185]

All healthcare staff need education, support and leadership both locally and nationally in order to fulfil their duties to meet the needs of looked after children and young people, and care leavers.

This section provides additional guidance and aids interpretation of the competence statements in the competency framework.

The generic model job descriptions can be amended as appropriate according to national and local context.

It should be noted that the named and designated professional are distinct roles and as such should be separate post holders to avoid potential conflict of interest.

It should also be noted that these roles are dedicated posts and should not be combined with responsibilities for adult or child safeguarding or looked after children.

Named professional for looked after children and young people – model job description.

The job descriptions of named professionals should reflect an appropriate workload, covering both roles and responsibilities for looked after children and for the rest of their work. Job descriptions should be agreed by the employing organisation.

All provider organisations should have a named doctor or nurse for looked after children.

1. Person Specification

The post holder must have an enhanced disclosure check. Named and designated professional posts comprise a registered activity under the Disclosure and Barring Service (DBS) for England and Wales, Disclosure Scotland (for Scotland) and Access Northern Ireland in Northern Ireland.

The **named nurse** should:

- hold a senior level post. It is expected that the post would be within the Band 8 range (the role would be subject to the usual Agenda for Change Job Evaluation process)
- have completed specific training in the care of babies/children and young people and be registered on either Part 1 of the Nursing and Midwifery Council (NMC) register as a registered children's nurse or Part 3 as a specialist community public health nurse having completed a specific programme with a child and family focus
- have completed specific post-registration training relevant to looked after children prior to commencement in the post (including law, policy, and practice at Level 2 or Postgraduate Diploma (PGDip))
- have a minimum of three-years experience related to caring for babies/children and young people and relevant experience with looked after children and young people.

184 Includes those with specific roles such as Named Looked After Children's Nurses/doctors in England, lead Looked After Children health professionals, specialist nurses for Looked After Children.

185 Should be read in conjunction with Level 4 competencies, knowledge and skills outlined within the document.

The **named doctor** should:

- hold consultant status or a senior post with equivalent training and experience
- have completed higher professional training (or achieved equivalent training and experience) in paediatrics, community child health and looked after children
- have considerable clinical experience of assessing and examining children and young people as appropriate to the role
- be currently practising and be of good professional standing.[186]

2. Duties for all named professionals

The **named professionals** will:

- support all activities necessary to ensure that the organisation meets its responsibilities for looked after children and young people
- be responsible to and accountable within the managerial framework of the employing organisation
- at all times and in relation to the roles and responsibilities listed, work as a member of the organisation's looked after children's health team.

3. Inter-agency responsibilities

- Advise local police, children's social care and other statutory and voluntary agencies on health matters with regard to looked after children.
- Liaise closely with other specialist services such as CAMHS, sexual health, and services for disabled children.

4. Leadership and advisory role

- Support and advise the board of the healthcare organisation about looked after children and young people.
- Contribute to the planning and strategic organisation of provider services for looked after children.
- Work with other named, specialist and designated professionals to plan and develop the healthcare organisations strategy for services for looked after children.
- Ensure advice is available to other professionals and services across the organisation on day to-day issues about looked after children and their families, including involvement in fostering and adoption panels according to local arrangements.

5. Clinical role

- When required undertake health assessments for looked after children and provide written reports on the health of prospective carers as appropriate.
- Support and advise colleagues in the clinical assessment and care of children and young people, whilst being clear about others personal clinical professional accountability.

186 Refers to doctors who are on the GMC register and who are up to date with their professional CPD – www.gmc-uk.org

- Provide advice and signposting to other professionals about legal processes, key research and policy documents.

6. Co-ordination and communication

- Work closely with other named and designated looked after children professionals locally, regionally and nationally.
- Work closely with the lead for children and/or safeguarding within the healthcare organisation.
- Liaise with professional leads from other agencies, such as education and children's social care.

7. Governance: policies and procedures

- Work with the specialist and designated professional to ensure that the healthcare organisation has relevant policies and procedures in line with legislation and national guidance.
- Contribute to the dissemination and implementation of organisational policies and procedures.
- Encourage case discussion, reflective practice, and the monitoring of significant events at a local level.

8. Training

- Work with specialist and designated looked after children professionals locally to agree and promote training needs and priorities.
- Support the designated professionals to ensure that there is an organisational training strategy in line with national and local expectations.
- Contribute to the delivery of training for health staff and inter-agency training.
- Support the specialist and designated professionals in the evaluation of training and adapt provision according to feedback from participants.
- Tailor provision to meet the learning needs of participants.

9. Monitoring

- Advise employers on the implementation of effective systems of audit.
- Contribute to monitoring the quality and effectiveness of services, including monitoring performance against indicators and standards.

10. Supervision

- Provide/ensure appraisal, support and supervision for colleagues in the team/ organisation.
- Contribute to individual case supervision.

11. Personal development

- Meet the organisation's requirements for training attendance.
- Attend relevant local, regional, and national continuing professional development activities to maintain competence.
- Receive regular supervision and undertake reflective practice.
- Recognise the potential personal impact of working with looked after children on self and others, and seek support and help when necessary.

12. Appraisal and job planning

- Receive annual appraisal[187] from a professional with specialist knowledge of looked after children and with knowledge of the individual's professional context and framework.[188]

13. Accountability

- Be accountable to the chief executive of the employing body.
- Report to the medical director, nurse director or board lead with primary responsibility for looked after children's services within the organisation.

14. Authority

- Should have the authority to carry out all of the above duties on behalf of the employing body and should be supported in so doing by the organisation and by colleagues.

15. Resources required for the post

Professionals' roles should be explicitly defined in job descriptions, and sufficient time and funding must be allowed to fulfil their responsibilities effectively.

- The time required to undertake the tasks outlined in this job description will depend on the size and needs of the looked after children population, the number of staff, the number and type of operational units covered by the healthcare organisation, and the level of development of local structures, process and function.
- The healthcare organisation should supply dedicated secretarial and effective support.
- •Given the stressful nature of the work, the healthcare organisation should provide focused support and supervision for the specialist professional.

The tables below are a minimum guide to the resources required for the roles.

187 For nurses, midwives, health visitors and relevant health staff reference should be made to the NHS Knowledge and Skills Framework.

188 The appraiser should consult with someone with specialist knowledge and experience.

Named doctor for looked after children

Minimum requirement includes one administration session per clinic (see British Association of Community Child Health guidance). Up to four looked after children for health assessment per clinic. 42 clinics scheduled per annum.[189]

Minimum of 1 PA (equivalent to 0.1 WTE or 4 hours per week) for named doctor role per 400 looked after children. This would include training, audit and supervision.

Named nurse for looked after children

A minimum of 1 dedicated WTE named nurse for looked after children for each looked after children provider service.

If the Named Nurse has a caseload the maximum caseload should be no more than 50* looked after children in addition to the operational, training and education aspects of the role.

A minimum of 0.5WTE dedicated administrative support.

*The precise caseload of looked after children held by the named nurse will be dependent on the complexity, geography, population and size of the catchment area served.

189 The Royal College of Paediatrics and child Health is currently undertaking work to determine the workload and WTE requirements in light of the increasing complexity of looked after children caseloads. Once completed the recommendation will be amended accordingly. It is anticipated that this will be amended by the end of 2020.

Appendix 4: The role of designated health professionals[190]

All healthcare staff need education, support and leadership both locally and nationally in order to fulfil their duties to meet the needs of looked after children and young people, and care leavers

This section provides additional guidance and aids interpretation of the competence statements in the competency framework.

The generic model job descriptions can be amended as appropriate according to national and local context.

It should be noted that the named and designated professional are distinct roles and as such must be separate post holders to avoid potential conflict.

It should also be noted that these roles are dedicated posts and should not be combined with responsibilities for adult or child safeguarding.

Designated professional for looked after children and young people – model job description.

The designated doctor and nurse role is to assist service planning and in England to advise clinical commissioning groups in fulfilling their responsibilities as commissioner of services to improve the health of looked after children.[191,192]

Any job description should be jointly agreed by the local commissioning/service planning organisation for looked after children, the health organisation from which the doctor or nurse is employed, if different, and the relevant local authority.

The designated role is intended to be a strategic one, separate from any responsibilities for individual children or young people who are looked after.[193] This should be explicit in designated role descriptions.

1. Person specification

The post holder must have an enhanced disclosure check. Named and designated professional posts comprise a registered activity under the Disclosure and Barring Service (DBS) for England and Wales, Disclosure Scotland (for Scotland) and Access Northern Ireland in Northern Ireland.

190 Should be read in conjunction with Level 5 competencies, knowledge and skills outlined within the document.

191 In Wales, this term refers to the Named Doctor for Looked After Children strategic role. There is no Named Nurse identified across the health board area.

192 In Wales, The National Safeguarding Team, Public Health Wales. One Designated Doctor and one Designated Nurse take the lead role for LAC within the National Safeguarding Team.

193 For medical professionals the Designated Doctor may have a role in clinical management for children in care as the role is often incorporated as part of a fulltime consultant post and based within a Provider.

The **designated doctor** will:

- hold consultant status or a senior post with equivalent training and experience
- have undergone higher clinical/professional training in paediatrics and adolescent health
- have substantial clinical experience of the health needs of looked after children the designated doctor may have worked or be working as a named doctor or medical advisor to an adoption and/or fostering agency
- be clinically active in community paediatrics in at least part of the geographical location covered by the post
- have proven negotiating and leadership skills.

The **designated nurse**[194] will:

- be a senior nurse or health visitor
- have substantial clinical experience of the health needs of children and young people and the health needs of looked after children
- have undergone training in the specific needs of children and young people and be registered on either Part 1 of the NMC register as a registered children's nurse, or Part 3 as a specialist community public health nurse having completed a specific programme with a child and family focus
- have completed specific relevant post-registration training at Masters level or equivalent
- hold a senior level post (equivalent to consultant). It is expected that the post would be within the Band 8 range (the role would be subject to the usual Agenda for Change Job Evaluation process)
- have proven negotiating and leadership skills.

2. Job description

- At all times and in relation to the roles and responsibilities listed, lead and support all activities necessary to ensure that organisations across the health community meet their responsibilities for looked after children.
- Advise and support all specialist LAC professionals across the health community.
- Be responsible to and accountable within the managerial framework of the employing organisation.

The **designated doctor** and **nurse** work together to fulfil the following functions:

194 In England based in Clinical Commissioning Group the role is to assist service planners and commissioners, and to support providers and other nurses and health visitors who will be seeing looked after children and their carers.

3. Inter-agency responsibilities

- Be a member of the Corporate Parenting Board, Health and Wellbeing/Children's Trust Board and Local Safeguarding Partnership Board or equivalents in NI, Scotland and Wales.[195]
- Provide health advice on policy and individual cases to statutory and voluntary agencies, including the Police and children's social care.

4. Leadership and advisory role

- Provide advice to the service planning and commissioning organisation and to the local authority, on questions of planning, strategy, commissioning and the audit of quality standards including ensuring appropriate performance indicators are in place in relation to health services for looked after children.
- Work with all healthcare organisations to monitor performance of local health services for looked after children and young people.
- Ensure expert health advice on looked after children is available to children's social care, healthcare organisations, residential children's homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff.
- Advise colleagues in health and children's social care on issues of medical confidentiality, consent and information sharing.
- Work with health service planners and commissioners to ensure there are robust arrangements to meet the health needs of looked after children placed outside the local area and ensure close working relationships with local authorities to achieve placement decisions which match the needs of children.
- Work with local service planners and commissioners to advocate on behalf of and ensure looked after children benefit as appropriate from the implementation of wider health policies such as in England - any qualified provider, personal health budgets.
- Work with commissioners and providers to gain the best outcome for the child/ young person within available resources, including involvement in fostering and adoption panels according to local arrangements.

5. Governance: Policy and procedures

- Work with other professionals taking a strategic overview of the service to ensure robust clinical governance of local NHS services for looked after children.
- Work with commissioners to ensure quality assurance and best value of placements including processes of audit, follow up, and review.
- Contribute to local children and young people's strategies to ensure there is a system in place to check the implementation and monitoring of individual health plans.
- Advise and input into the development of practice guidance and policies for all health staff and ensure that performance against these is appropriately audited.
- Work with provider health organisations across the health community to ensure

195 In England, the emerging Strategic Transformation Partnerships/Integrated Care System structures may require the Designated doctor and Designated Nurse representation at additional strategic decision making groups supporting service design, development and assurance.

that appropriate training is in place to enable health staff to fulfil their roles and responsibilities for looked after children.

6. Co-ordination, communication and liaison

- Work with other professionals to agree team responsibilities.
- Work closely with other designated looked after children professionals locally.
- Liaise with, advise, and support looked after children specialist health staff across the health community.
- Maintain regular contact with the local health team undertaking health assessments on looked after children.
- Liaise with health boards, children's social care and other service planning and commissioning organisations over health assessments and health plans for out of area placements.
- Liaise with the health boards/authority child protection and safeguarding lead.
- Complete and present annual report as outlined in statutory guidance.

7. Monitoring and information management

- Provide advice to all organisations across the health community on the implementation of an effective system of audit, training, and supervision.
- Provide advice on monitoring of elements of contracts, service level agreements and commissioned services to ensure the quality of provision for looked after children including systems and records to:
  - ensure the quality of health assessments carried out meet the required standard
  - ensure full registration of each looked after child – and all care leavers – with a GP and dentist and optometric checks undertaken
  - ensure that sensitive health promotion is offered to all looked after children and young people
  - ensure implementation of health plans for individual children
  - ensure an effective system of audit is in place.
- Undertake an analysis of the range of health neglect and need for healthcare for local looked after children – ie, case mix analysis to inform service planning; contributing to the production of health data on looked after children across the health community.
- Analyse the patterns of healthcare referrals and their outcomes; and evaluate the extent to which looked after children and young people's views inform the design and delivery of the local health services for them.
- Use the above to influence local service planning and commissioning decisions; contribute JSNA?

8. Training responsibilities

- Advise commissioning bodies' on training needs and the delivery of training for all health staff across the health community including those GPs, paediatricians and nurses undertaking health assessments and developing plans for looked after children.

- Participate (as appropriate) in local undergraduate and postgraduate paediatric training to ensure health including mental health of looked after children is addressed.
- Play an active part in the planning and delivery of multidisciplinary and multi-agency training for all health professionals.

9. Supervision

- Provide advice including case-focused support and supervision for health staff at all levels within organisations across the health community that deliver health services to looked after children.
- Produce a supervision strategy for the health community which provides direction and options for supervision models, as appropriate to need.
- Provide supervision for looked after children named specialist professionals across the health community, or ensure they are receiving appropriate supervision from elsewhere.

10. Personal development

- Attend relevant regional and national continuing professional development activities in order to maintain knowledge and skills. This includes meeting professional organisation requirements as well as receiving specific training that relates to specialist activities.
- Receive supervision from outside the employing organisation (this should be funded by the employing organisation and be provided by someone with relevant expertise).

11. Appraisal

- Receive annual appraisal.[196] Appraisal should be undertaken by someone of appropriate seniority with relevant understanding such as a board level director with responsibility for looked after children, medical or nurse director and/or via an equivalent arrangement as agreed locally.[197]

12. Accountability

- Designated professionals should report to the safeguarding executive lead for the clinical commissioning group[198] and the employing health organisation if different from the clinical commissioning group, the public health lead for children in the local authority, and the corporate parenting board.
- Designated professionals should be performance managed as above in relation to their designated functions by a person of appropriate seniority such as a board level director who has executive responsibility for looked after children as part of their portfolio of responsibilities.
- Be accountable to the chief executive of their employing body.

13. Authority

- Should have the authority to carry out all the above duties on behalf of the employing body and be supported in so doing by the organisation and by colleagues.

196 For nurses, midwives, health visitors and relevant health staff reference should be made to the NHS Knowledge and Skills Framework.

197 This may require input from another designated professional from the same discipline from another locality.

198 Designated professionals should be performance managed in relation to their designated functions by a board level director who has executive responsibility for children and/or safeguarding as part of their portfolio of responsibilities.

14. Resources required for post

- Professional roles should be explicitly defined in job descriptions, and sufficient time and funding should be allowed to fulfil specialist responsibilities effectively.
- The time required to undertake the tasks in this job description will depend on the size and needs of the looked after children population, the number of staff, the number of healthcare organisations covered by the role, and the level of development of local structures, process and functions.
- The employing body should supply dedicated and effective secretarial support.
- Given the stressful nature of the work, the employing body must ensure that focused supervision and support is provided.[199]

The tables below are a minimum guide to the resources required for the roles.

Designated doctor for looked after children

A minimum of 8 hours per week or 0.2 WTE[200,201] per 400 looked after children population (excluding any operational activity such as health assessments).

Activities include provision of strategic advice to commissioners/service planners, preparation of annual health report along with designated nurse who tends to lead, advice regarding policies, adverse events, training and supervision.

Designated nurse for looked after children

A minimum of 1 dedicated WTE*[202] designated nurse looked after children for a child population of 70,000.

A minimum of 0.5WTE dedicated administrative support to support the designated nurse looked after children.

*While it is expected that there will be a team approach to meeting the needs of looked after children and young people the minimum WTE designated nurse looked after children may need to be greater dependent upon the number of local safeguarding partnership boards, sub group committees, unitary authorities and clinical commissioning groups covered, the requirement to provide looked after child supervision for other practitioners, as well as the geographical areas covered, the number of children looked after and local deprivation indices.

199 Organisations should put in place formal arrangements which may include other designated doctors or nurses from other trusts/ employing organisations to provide supervision / peer review for each other.

200 The Royal College of Paediatrics and child Health is currently undertaking work to determine the workload and WTE requirements in light of the increasing complexity of looked after children activity. Once completed the recommendation will be amended accordingly. It is anticipated that this will be amended by the end of 2020.

201 In England for CCG work and activity, ensuring visible presence of medical expertise to commissioners/service planners.

202 In England based within CCG, ensuring visible presence of nursing expertise to commissioners/service planners.

Appendix 5: Education, training and learning logs

Education, training and learning activity log – template for level 1

You will need to keep accurate records and document the following on an ongoing and continual basis:

- type of education, training and learning eg, online learning, course attendance, group case discussion, independent learning
- topic, a brief description and key points of learning activity
- the number of learning hours and the number of participatory learning hours.

Date	Type of education, training and learning activity	Topic and key points of learning activity	Number of hours	Participatory hours

Education, training and learning reflection record
(to be completed following each individual learning activity)

Date:
Topic and learning activity
What did you learn? Key points of the learning activity
How does this relate to the knowledge, skills, attitudes and values and competencies outlined in the *Intercollegiate Looked after children: roles and competencies of healthcare staff*?
How will the learning affect your future practice?

This activity has enabled achievement of the following learning outcomes (tick those that apply)

Level 1	
• To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers	
• To be able to demonstrate an understanding of appropriate referral mechanisms and information sharing ie, know who to contact, where to access advice and how to report	

Education, training and learning activity log – template for level 2

You will need to keep accurate records and document the following on an ongoing and continual basis:

- type of education, training and learning e.g. online learning, course attendance, group case discussion, independent learning
- topic, a brief description and key points of learning activity
- the number of learning hours and the number of participatory learning hours.

Date	Type of education, training and learning activity	Topic and key points of learning activity	Number of hours	Participatory hours

Education, training and learning reflection record
(to be completed following each individual learning activity)

Date:
Topic and learning activity
What did you learn? Key points of the learning activity
How does this relate to the knowledge, skills, attitudes and values and competencies outlined in the *Intercollegiate Looked after children: roles and competencies of healthcare staff*?
How will the learning affect your future practice?

This activity has enabled achievement of the following learning outcomes (tick those that apply)

Level 1	
• To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers	
• To be able to demonstrate an understanding of appropriate referral mechanisms and information sharing ie, know who to contact, where to access advice and how to report	
Level 2	
• To be able to demonstrate awareness of the need to alert primary care professionals (such as the child's GP), universal services (such as the child's health visitor or school nurse), local authority children's services/social services about health and wellbeing/safeguarding concerns	
• To be able to demonstrate accurate documentation of concerns	
• To be able to document appropriate consent, legal orders/parental responsibility, who is accompanying CYP	
• To be able to demonstrate an ability to recognise and describe a significant event for the looked after child, young person or care leaver in child protection/safeguarding to the most appropriate professional or local team	

Education, training and learning activity log – template for level 3

You will need to keep accurate records and document the following on an ongoing and continual basis:

- type of education, training and learning eg, online learning, course attendance, group case discussion, independent learning
- topic, a brief description and key points of learning activity
- the number of learning hours and the number of participatory learning hours.

Date	Type of education, training and learning activity	Topic and key points of learning activity	Number of hours	Participatory hours

Education, training and learning reflection record
(to be completed following each individual learning activity)

Date:
Topic and learning activity
What did you learn? Key points of the learning activity
How does this relate to the knowledge, skills, attitudes and values and competencies outlined in the *Intercollegiate Looked after children: roles and competencies of healthcare staff*?
How will the learning affect your future practice?

This activity has enabled achievement of the following learning outcomes (tick those that apply)

Level 1	
• To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers	
• To be able to demonstrate an understanding of appropriate referral mechanisms and information sharing ie, know who to contact, where to access advice and how to report	
Level 2	
• To be able to demonstrate awareness of the need to alert primary care professionals (such as the child's GP), universal services (such as the child's health visitor or school nurse), local authority children's services/social services about health and wellbeing/safeguarding concerns	
• To be able to demonstrate accurate documentation of concerns	
• To be able to document appropriate consent, legal orders/parental responsibility, who is accompanying CYP	
• To be able to demonstrate an ability to recognise and describe a significant event for the looked after child, young person or care leaver in child protection/safeguarding to the most appropriate professional or local team	
Level 3	
Core	
• Demonstrates knowledge of patterns and indicators of child maltreatment	
• Demonstrates understanding of appropriate information sharing in relation to child protection, children in need and looked after children	
• Demonstrates an ability to assess risk and need and instigates processes for appropriate interventions	
• Demonstrates knowledge of the role and responsibilities of each agency, as described in local policies and procedures	
• Demonstrates critical insight of personal limitations and an ability to participate in peer review	
Additional learning outcomes to be added by individual as stated in level 3	

Education, training and learning activity log – template for level 4 Named professionals

You will need to keep accurate records and document the following on an ongoing and continual basis:

- type of education, training and learning eg, online learning, course attendance, group case discussion, independent learning
- topic, a brief description and key points of learning activity
- the number of learning hours and the number of participatory learning hours.

Date	Type of education, training and learning activity	Topic and key points of learning activity	Number of hours	Participatory hours

Education, training and learning reflection record
(to be completed following each individual learning activity)

Date:
Topic and learning activity
What did you learn? Key points of the learning activity
How does this relate to the knowledge, skills, attitudes and values and competencies outlined in the *Intercollegiate Looked after children: roles and competencies of healthcare staff*?
How will the learning affect your future practice?

This activity has enabled achievement of the following learning outcomes (tick those that apply)

Level 1	
• To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers	
• To be able to demonstrate an understanding of appropriate referral mechanisms and information sharing ie, know who to contact, where to access advice and how to report	
Level 2	
• To be able to demonstrate awareness of the need to alert primary care professionals (such as the child's GP), universal services (such as the child's health visitor or school nurse), local authority children's services/social services about health and wellbeing/safeguarding concerns	
• To be able to demonstrate accurate documentation of concerns	
• To be able to document appropriate consent, legal orders/parental responsibility, who is accompanying CYP	
• To be able to demonstrate an ability to recognise and describe a significant event for the looked after child, young person or care leaver in child protection/safeguarding to the most appropriate professional or local team	
Level 3	
Core	
• Demonstrates knowledge of patterns and indicators of child maltreatment	
• Demonstrates understanding of appropriate information sharing in relation to child protection, children in need and looked after children	
• Demonstrates an ability to assess risk and need and instigates processes for appropriate interventions	
• Demonstrates knowledge of the role and responsibilities of each agency, as described in local policies and procedures	
• Demonstrates critical insight of personal limitations and an ability to participate in peer review	
Additional learning outcomes to be added by individual as stated in level 3	

Level 4	
• Demonstrates completion of a teaching and assessment programme[203] within 12 months of appointment	
• Demonstrates an understanding of appropriate and effective training strategies to meet the competency development needs of different staff groups	
• Demonstrates completion of relevant specialist looked after children education within 12 months of appointment	
• Demonstrates understanding of professional body registration requirements for practitioners, including revalidation[204,205]	
• Demonstrates an understanding and experience of developing evidence-based clinical guidance	
• Demonstrates effective consultation with other healthcare professionals and participation in multidisciplinary discussions	
• Demonstrates participation in audit, and in the design and evaluation of service provision, including the development of action plans and strategies to address any issues raised by audit and serious case reviews/internal management reviews/significant case reviews/other locally determined reviews related to looked after children	
• Demonstrates critical insight of personal limitations and an ability to participate in peer review	
• Demonstrates practice change from learning, peer review or audit	
• Demonstrates contributions to reviews have been effective and of good quality	
• Demonstrates use of feedback and evaluation to improve teaching in relation to looked after children	

203 This programme could be provided by a professional organisation or a higher education institution.
204 www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation
205 http://revalidation.nmc.org.uk

Education, training and learning activity log – template for level 5 Designated professionals

You will need to keep accurate records and document the following on an ongoing and continual basis:

- type of education, training and learning eg, online learning, course attendance, group case discussion, independent learning
- topic, a brief description and key points of learning activity
- the number of learning hours and the number of participatory learning hours.

Date	Type of education, training and learning activity	Topic and key points of learning activity	Number of hours	Participatory hours

Education, training and learning reflection record
(to be completed following each individual learning activity)

Date:
Topic and learning activity
What did you learn? Key points of the learning activity
How does this relate to the knowledge, skills, attitudes and values and competencies outlined in the *Intercollegiate Looked after children: roles and competencies of healthcare staff*?
How will the learning affect your future practice?

This activity has enabled achievement of the following learning outcomes (tick those that apply)

Demonstrate knowledge of relevance of looked after children commissioning processes

Level 1	
• To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers	
• To be able to demonstrate an understanding of appropriate referral mechanisms and information sharing ie, know who to contact, where to access advice and how to report	
Level 2	
• To be able to demonstrate awareness of the need to alert primary care professionals (such as the child's GP), universal services (such as the child's health visitor or school nurse), local authority children's services/social services about health and wellbeing/safeguarding concerns	
• To be able to demonstrate accurate documentation of concerns	
• To be able to document appropriate consent, legal orders/parental responsibility, who is accompanying CYP	
• To be able to demonstrate an ability to recognise and describe a significant event for the looked after child, young person or care leaver in child protection/safeguarding to the most appropriate professional or local team	
Level 3	
Core	
• Demonstrates knowledge of patterns and indicators of child maltreatment	
• Demonstrates understanding of appropriate information sharing in relation to child protection, children in need and looked after children	
• Demonstrates an ability to assess risk and need and instigates processes for appropriate interventions	
• Demonstrates knowledge of the role and responsibilities of each agency, as described in local policies and procedures	
• Demonstrates critical insight of personal limitations and an ability to participate in peer review	
Additional learning outcomes to be added by individual as stated in level 3	

Level 4	
• Demonstrates completion of a teaching and assessment programme[206] within 12 months of appointment	
• Demonstrates an understanding of appropriate and effective training strategies to meet the competency development needs of different staff groups	
• Demonstrates completion of relevant specialist looked after children education within 12 months of appointment	
• Demonstrates understanding of professional body registration requirements for practitioners, including revalidation[207,208]	
• Demonstrates an understanding and experience of developing evidence-based clinical guidance	
• Demonstrates effective consultation with other healthcare professionals and participation in multidisciplinary discussions	
• Demonstrates participation in audit, and in the design and evaluation of service provision, including the development of action plans and strategies to address any issues raised by audit and serious case reviews/internal management reviews/significant case reviews/other locally determined reviews related to looked after children	
• Demonstrates critical insight of personal limitations and an ability to participate in peer review	
• Demonstrates practice change from learning, peer review or audit	
• Demonstrates contributions to reviews have been effective and of good quality	
• Demonstrates use of feedback and evaluation to improve teaching in relation to looked after children	
Level 5	
• Demonstrates advanced knowledge of national looked after children practice and an insight into international perspectives	
• Demonstrates contribution to enhancing looked after children practice and the development of knowledge among staff	
• Demonstrates knowledge of strategies for looked after children management across healthcare services,[209] including public health services commissioned by local authorities, and provided by independent/private healthcare providers	
• Demonstrates an ability to conduct rigorous and auditable support and peer review for looked after children professionals, as well as appraisal and supervision where provided directly	
• Demonstrates critical insight of personal limitations and an ability to participate in peer review	

206 This programme could be provided by a professional organisation or a higher education institution.

207 www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation

208 http://revalidation.nmc.org.uk

209 This also includes public health and LA commissioning, and private healthcare and Independent providers.

• Designated professionals working within commissioning organisations in England	
• Demonstrate knowledge of relevance of looked after children commissioning processes	
• Ensures a looked after child focus is maintained within strategic organisational plans and service delivery	

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

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

March 2015

Contents

Summary

About this guidance

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

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

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

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

This guidance should be read in conjunction with:

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

Terms used in this guidance

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

How to use this guidance

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

Expiry or review date

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

What legislation does this guidance refer to?

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

Who is this guidance for?

This guidance is for:

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

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

Main points

- The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.
- The local authority that looks after the child must arrange for them to have a health assessment as required by *The Care Planning, Placement and Case Review (England) Regulations 2010*.
- The initial health assessment must be done by a registered medical practitioner. Review health assessments may be carried out by a registered nurse or registered midwife.
- The local authority that looks after the child must ensure that every child it looks after has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment. The health plan forms part of the child's overall care plan.
- When a child starts to be looked after, changes placement or ceases to be looked after, the responsible local authority should notify, among others, the CCG – or, in the case of a placement out of authority, both the originating and the receiving CCG (or local health board in the case of a child looked after by a local authority in England but living in Wales) – and the child's GP. If the child is moved in an emergency, the notifications should happen within five working days. Prompt notifications are essential if initial health assessments are to be completed in good time.[2]
- Looked-after children should never be refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.
- CCGs and NHS England have a duty to cooperate with requests from local authorities to undertake health assessments and help them ensure support and services to looked-after children are provided without undue delay.
- Local authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area.
- The health needs of looked-after children should be taken into account in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).
- Every local authority should have agreed local mechanisms with CCGs to ensure that they comply with NHS England's guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for looked-after children and to resolve any funding issues that arise.[3]

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

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

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

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

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

Supporting all looked-after children: joint responsibilities

Context

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

Overarching principles

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

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

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

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

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

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

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

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

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

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

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

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

Planning health services for looked-after children

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

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

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

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

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

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

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

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

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

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

Commissioning health services

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

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

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

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

18. CCGs should ensure:

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

19. NHS England should ensure:

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

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

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

The responsible commissioner

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

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

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

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

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

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

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

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

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

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

The role of the designated doctor and nurse

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

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

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

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

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

The care planning framework

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

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

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

Notification of placement

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

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

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

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

Information sharing

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

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

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

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

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

Health assessments, plans and reviews

Health assessments and plans

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

41. The initial health assessment should result in a health plan, which is available in time for the first statutory review by the Independent Reviewing Officer (IRO) of the child's care plan. That case review must happen within 20 working days from when the child started to be looked after.[16]

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

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

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

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

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

    - advice and guidance on promoting health and effective personal care
- any planned changes to the arrangements
- the role of the appropriate person, such as a foster carer, residential social worker, school nurse or teacher, and of any other person who cares for the child in promoting his or her health.

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

The principles of a good health assessment and planning

44. Health assessments should:

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

[18] Section 27 of the Children Act 1989.

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

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

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

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

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

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

46. The health assessment should:

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

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

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

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

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

Who should carry out the health assessment?

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

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

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

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

Reviews of the health plan

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

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

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

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

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

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

Mental health services

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

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

Special educational needs (SEN)

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

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

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

60. Local authorities and health professionals should ensure that:

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

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

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

The role of social workers in promoting health

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

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

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

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

65. Social workers should also ensure:

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

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

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

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

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

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

The role of Independent Reviewing Officers (IROs)

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

The contribution of primary care teams

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

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

71. GP practices should:

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

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

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

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

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

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

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

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

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

Placement out of authority

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

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

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

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

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

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

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

Supporting foster carers and children's homes to promote health

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

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

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

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

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

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

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

Children detained under the Mental Health Act or in custody

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

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

Transitions from care

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

Children placed for adoption

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

91. At a strategic level:

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

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

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

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

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

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

Care leavers

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

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

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

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

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

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

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

Annex A: Age-appropriate health assessments

Recommended content

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

Under-5s

For under-fives, the focus will be on:

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

Ages 5-10

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

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

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

Adolescents and those leaving care (11-18)

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

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

Annex B: Strengths and Difficulties Questionnaire (SDQ)

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

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

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

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

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

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

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

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

[33] Further information on the SDQ.

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

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

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

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

[34] Further information on the SSD903 Data Collection.

Annex C: Principles of confidentiality and consent

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

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

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

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

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

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

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

Children aged 16 and 17

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

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

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

Children aged 15 and under

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

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

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

[35] Gillick competency and Fraser Guidelines.

Annex D: Some terms used in this guidance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Further information

Useful resources and external organisations

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

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

Other relevant departmental advice and statutory guidance

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

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

Department for Education

Department of Health

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NHS
Tees Valley
Clinical Commissioning Group

Children in Care in Middlesbrough

The role of the CCG and the Designated LAC (Children in Care) Team in supporting initial and review health assessments for children in care

Nicola Ayres – Interim Designated Nurse CIC

Overview

Designated professional for Children in Care (LAC)

In England, the term designated doctor or nurse denotes professionals with specific roles and responsibilities for looked after children, including the provision of strategic advice and guidance to service planners and commissioning organisations. In England, designated professionals (doctors and nurses) are statutory roles. This means that all CCGs must have these positions in their organisational structure. (Further details can be found in *'Safeguarding Accountability and Assurance Framework NHSEI 2019, and NHS Standard Contract 2021/22).*

The Designated professionals must also meet a set of competencies and training to ensure that they meet the criteria set out in the Intercollegiate Document 2020, *(Looked after Children roles and competencies of healthcare staff December 2020).* The competency framework sets out the requirements and skills required to effectively support, promote, and protect the welfare of looked after children.

RCPCH LAC Dec 2020.pdf

The designated doctor and nurse work together to fulfil the following functions: (please note this is not an exhaustive list and further detail is contained in the referenced Intercollegiate Document above).

Inter-agency responsibilities

• Be a member of the Corporate Parenting Board, Health and Wellbeing/Children's Trust Board and Local Safeguarding Partnership Board or equivalents in NI, Scotland, and Wales

• Provide health advice on policy and individual cases to statutory and voluntary agencies, including the Police and children's social care.

Leadership and advisory role

• Provide advice to the service planning and commissioning organisation and to the local authority, on questions of planning, strategy, commissioning, and the audit of quality standards including ensuring appropriate performance indicators are in place in relation to health services for looked after children.

The role of the Designated Nurse NHS Tees Valley in quality assurance and data collection.

Middlesbrough Local Authority CIC team is supported by Harrogate and District 0-19 Team who have been commissioned to undertake the review health assessments (ALL initial health assessments must be undertaken by a medical practitioner, in Tees Valley these are undertaken by the paediatricians at James Cook hospital). The CIC health team based at James Cook are commissioned to support the data collection required contractually, as well as reviewing quality and timeliness, and coordination of the assessments, particularly those out of area.

Contractually the CIC health teams have key performance indicators (KPIs) to work to and these are aligned to those laid out in the *'Promoting the health and Wellbeing of Looked after Children Guidance – 2015'*. (Have included the guidance document for further reading and information).

Promoting_the_hea
lth_and_well-being_

Providers should work with local authorities and provider agencies to ensure that initial health assessments (IHA) and health care plans are available for the first looked after review. Therefore, the child must be seen within 20 working days following the child becoming looked after. This allows the paediatrician to have at least a summary of health needs report completed, that can be shared at the first CIC review.

In practice the following should happen:

- LA inform health team that child has become a CIC and the team then have 20 days to see the child and have a report ready by day 28 where possible, for initial meeting with child
    - Contractually this is set at 100% compliance and exceptions are reported to the Designated Team and CCG colleagues via the contracts reporting team. Any issues are then discussed with agreed solutions and resolutions as much as possible
    - Exceptions are usually due to cancellations by the carer, or a DNA/child not brought, and for the older children refusal to attend.
    - These non-attendances or cancellations are followed up to ensure that the IHA does take place
- If the child is under 5 years of age, they have a further review assessment 6 months after the first one, and every 6 months until their 5th birthday and then from 5 years these reviews are annual.
- For review health assessments (RHAs) the carer and team undertaking the review should be notified at least 3 months before the annual review date in order for an appointment to be made, within the year. For the under 5s the next date should be offered by the paediatric admin team unless indicated that the CIC nurses can complete it.
- As with the IHAs exception are reported quarterly. The main exceptions for RHAs being:
    - Delayed notification of review date to service provider thus review is outside the annual date

- Lack of capacity in CIC teams to complete these (particularly for children placed out of area (OOA). These are escalated to the CCG who support resolution.
- Refusal by the older children in particular. For these children the CCG would expect that alternative methods of engagement and completion are explored, for example asking the child to complete the RHA themselves if willing and able.
- Did not attend (DNA) or now known as child not brought in (CNB). The reasons are noted, and another appointment offered (the same as for IHAs)

Key performance indicator requirements as per commissioner contracts

Below is a table outlining the contractual requirements for the health teams who undertake these on behalf of the Middlesbrough LA and the CCG.

These are the minimum national standard indicators and behind these, within the contract, there is more detail. For example, every CIC should be registered with a GP and Dentist as minimum. Across Middlesbrough the access to these services has been good, with just occasional reporting of a child not being able to register with a dentist. Another example, in the revised contract for the providers of the RHAs there is an expectation that the RHA and any referrals will now be reviewed at 3 months to ensure that any outstanding issues have been addressed in readiness for the next review. This will apply to the annual reviews, to ensure that the child's needs are met and not delayed until the next review.

When this becomes know the designated nurse works with colleagues to resolve the issue, and through local and regional CIC networks this, and other access issues are escalated. Tees is well supported by NHSE Dental lead when issues occur. It is worth noting that access to a dentist is a national problem and CCGs are looking at innovative ways to improve this, for example enhancing an NHS dentist's contract to ensure that they have the capacity to accept CIC.

Initial Heath Assessments (IHAs)

The target threshold will always be 100% as these reviews are statutory. Exceptions to this are reported by the CIC health team to the commissioners and Designated nurse to both understand the rationale for the dip in performance as well as support resolution. Data shows that IHAs rarely drop below the threshold. Main reasons for this are:

- Lack of capacity within the medical team to accommodate within the 20 days but every effort is made to ensure the child is seen as soon as possible, and it is rare that the child is not seen within, say, a further 5 days
- Child placed out of area and the capacity within that medical team may also be limited
- Health team not always informed in a timely manner that the child has come into care and therefore 20-day target is not met
- Cancellation of appointment by carer or if the child is older, refusal to attend

Review Health Assessments (RHAs)

The above reasons for non-attendance tend to also apply to RHAs, with cancellations and an increased number of refusals being more prevalent, particularly in the 13 year+ age range. It is an expectation of the CIC health provider team to follow up these cases and offer further appointments and alternative methods to engage them in getting the review completed.

Table showing key performance contractual descriptors expected of the CIC Health providers

REFERENCE	DESCRIPTOR	TARGET / THRESHOLD	REPORTING FREQUENCY
	LOOKED AFTER CHILDREN (LAC)		
LQR.LAC.01	PROVIDERS SHOULD WORK WITH LOCAL AUTHORITIES AND PROVIDER AGENCIES TO ENSURE THAT INITIAL HEALTH ASSESSMENTS (IHA) AND HEALTH CARE PLANS ARE AVAILABLE FOR THE FIRST LOOKED AFTER REVIEW (20 WORKING DAYS FOLLOWING THE CHILD BECOMING LOOKED AFTER IN LINE WITH THE STATUTORY GUIDANCE PROMOTING THE HEALTH AND WELL-BEING OF LOOKED AFTER CHILDREN).	100%	QUARTERLY
LQR.LAC.02	PROVIDERS SHOULD WORK WITH LOCAL AUTHORITIES AND PROVIDER AGENCIES TO REQUEST THAT REVIEW HEALTH ASSESSMENTS (RHA) FOR LOOKED AFTER CHILDREN ARE UNDERTAKEN 6 MONTHLY FOR CHILDREN UNDER 5 YEARS.	100%	QUARTERLY
LQR.LAC.03	PROVIDERS SHOULD WORK WITH LOCAL AUTHORITIES AND PROVIDER AGENCIES TO REQUEST THAT REVIEW HEALTH ASSESSMENTS (RHA) FOR LOOKED AFTER CHILDREN ARE UNDERTAKEN ANNUALLY FOR CHILDREN OVER 5 YEARS.	100%	QUARTERLY
LQR.LAC.04	PERCENTAGE OF CHILDREN 16 YEARS OR ABOVE WHO ARE OFFERED A HEALTH PASSPORT.	100%	QUARTERLY
LQR.LAC.05	TO QUALITY ASSURE ALL REVIEW HEALTH ASSESSMENTS (RHA) WHERE CHILDREN HAVE BEEN PLACED OUT OF AREA.	20%	QUARTERLY

In summary

Due to the differences in reporting and contractual requirements of the CIC provider and the LA, what could be discrepancies in data, will always be present. The CIC health teams do most if not all the health-related work, reporting and quality assurance whereas the LA report on actual numbers of children who have had their relevant review(s) at the time of their reporting.

The CCG receive the data via contractual forums in order to review and follow up as necessary. The providers quality assures these through their own organisational structures also, and there is a positive approach to sharing significant concerns and exceptions to the CCG outside of the contractual requirements when necessary. An example of this being significant delays in responding to and returning RHAs from OOA.

There is a good collaborative working relationship between Middlesbrough, the health providers, and the CCG, to try and ensure that the child's health needs are met and understood.

Participation of Children in Care and Care Leavers

MIDDLESBROUGH CHILDREN MATTER

Middlesbrough moving forward

Participation People

Participation People- Who are we?

Participation People believe services improve when you work creatively with the people who use them. We care about IMPACT and the difference made to peoples' everyday lives. We want to help you and young people improving services together. Co-creating a bright and bold future, together.

We have been working with Middlesbrough Borough Council since August 2021 to make services better for the young people who live here.

We have some 5 #YouthVoice work strands, these are:

1. Middlesbrough Youth Council
2. Middlesbrough in Care Councils
3. Middlesbrough Young Champions
4. Middlesbrough Young Researchers
5. Middlesbrough Young Journalists

Participation People facilitate open, safe, and inclusive spaces with these #YouthVoice Forums regularly. Each group co-creates fun and engaging opportunities for their peers and decision-makers (like you!) to get involved in service improvement activities, campaigns and events.

Participation People - Who are we?

Our Middlesbrough Team

Antonia - CEO

Hannah- Programme Manager

Laurie
Youth Council and Young Champions Lead

Fred
Support Youth Council (Contractor)

Xavier- In Care Councils

Kathy- In Care Councils

Ed- Young Researcher Lead

Alice- Young Researcher Lead

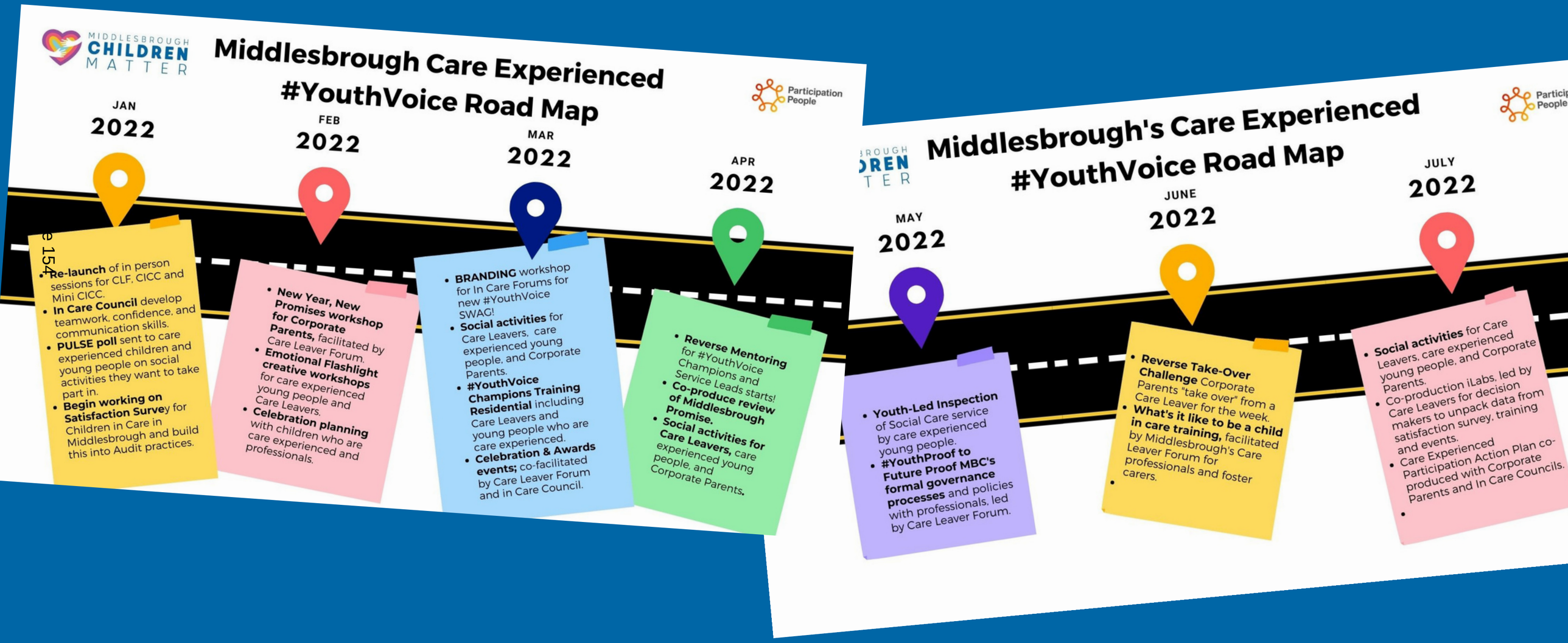
December Progress

After the Big Takeover, we have continued to support the Young People and recruit new young people to our groups.

- **The re-launch of the Care Experienced #YouthVoice Forums is here!** Activities and workshops are planned for the Children in Care Council, Care Leaver's Forum and Mini Children in Care Council (18th and 20th January 2022).
- **Celebration events (**postponed from Christmas due to the Covid-19 pandemic) have been rescheduled February half term.
- **Young Champions**- Continued support, training and development workshops have been delivered to young people who took part in BIG Takeover. Young Champions have had AQA accredited training in: teamwork, communication and confidence.
- **Young Researchers**- Middlesbrough Young Researchers launched December 2021. The group have started their training and induction into youth led participatory action research. Their remit is to find out what other Young People REALLY think about growing up, living and studying in Middlesbrough.
- **Youth Council**- Middlesbrough Youth Council are running an election to elect their next Members of Youth Parliament for Middlesbrough. These young people will represent all of Middlesbrough's voices on a regional and national stage.

Care Experienced #YouthVoice Flyers

Care Experienced #YouthVoice Roadmap for 2022



Challenges - Covid-19

We have been and continue to work with Middlesbrough's young people to support them to safely take part in activities throughout the Covid-19 pandemic. We have put extra special measuresin place to protect them (us and you!). These are:

- Pre session Covid questionnaires completed
- Temperature Checks
- Lateral flow tests
- Hand sanitizer
- Mask Wearing
- Well ventilated spaces (bring a coat!)

In the event that national or local guidance prevents us from meeting in person a virtual delivery has been and will continued to be offered.

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Middlesbrough Participation #YouthVoice Update January 2022

Participation People have been working with Middlesbrough Borough Council since August 2021 to make services better for the young people who live here.

We have some 5 #YouthVoice workstrands. These are:

1. Middlesbrough Young Champions

2. Middlesbrough Youth Council and Members of Youth Parliament for Middlesbrough

3. Middlesbrough Care Experienced Youth Voice Forums

4. Middlesbrough Young Researchers

5. Middlesbrough Young Journalists

Participation People facilitate open, safe, and inclusive spaces with these #YouthVoice Forums regularly. Each group co-creates fun and engaging opportunities for their peers and decision-makers (like you!) to get involved in service improvement activities, campaigns and events.

Who are we?

Participation People believe services improve when you work creatively with the people who use them.

We care about **IMPACT** and the difference made to peoples' everyday lives.

We help you:

- Improve organisational performance.
- Be responsive and agile to the changing needs of children, young people, families and communities.
- Increase resources and or repurpose resources to effectively meet the needs of children, young people and families.
- Improve service reputation - internally and externally.
- Improve satisfaction with staff, volunteers, young people, schools and families.
- Show the impact #YouthVoice work has and help you share this in a way everyone understands.
- Empower everyone you work with to listen to, value and act on young people's voices, perceptions and lived experiences.

All our projects are **playful in practice** and **serious about solutions**.

Our team are **kind**, **curious,** and **courageous**. We know this helps children, young people and adults feel listened to, heard, and know that their voices have been acted upon.

All of this helps:

- Everyone has fun.
- Everyone feels empowered.
- Develop an influential community voice.
- Decision makers develop actionable plans, co-produced with young people and local decision makers..
- Challenge the views and perceptions of all those engaged.
- Build projects that are self-sustaining by building capacity or securing additional funding.

Your Middlesbrough #YouthVoice Team

We have an amazing team of professionals who facilitate these groups and ensure young people are having FUN!

To contact any of the team contact Hannah at HannahW@ParticipationPeople.com who will put you in touch!

December 2021 January 2021 - A #YouthVoice Snapshot

This is what each group has what we have been getting up to and planning so we can have an amazing new year filled with #YouthVoice!

IN CARE COUNCILS

The re-launch of the Care Experienced #YouthVoice Forums is here! Activities and workshops are planned for the Children in Care Council, Care Leaver's Forum and Mini Children in Care Council (18th and 20th January 2022).

Celebration events (postponed from Christmas due to the Covid-19 pandemic) have been rescheduled February half term.

YOUNG CHAMPIONS

Continued support, training and development workshops have been delivered to young people who took part in BIG Takeover. Young Champions have had AQA accredited training in: teamwork, communication and confidence.

YOUNG RESEARCHERS

Middlesbrough Young Researchers launched December 2021. The group have started their training and induction into youth led participatory action research. Their remit is to find out what other Young People REALLY think about growing up, living and studying in Middlesbrough.

YOUTH COUNCIL

Middlesbrough Youth Council are running an election to elect their next Members of Youth Parliament for Middlesbrough. These young people will represent all of Middlesbrough's voices on a regional and national stage.

Care Experienced Youth Voice Forums - 2022's relaunch

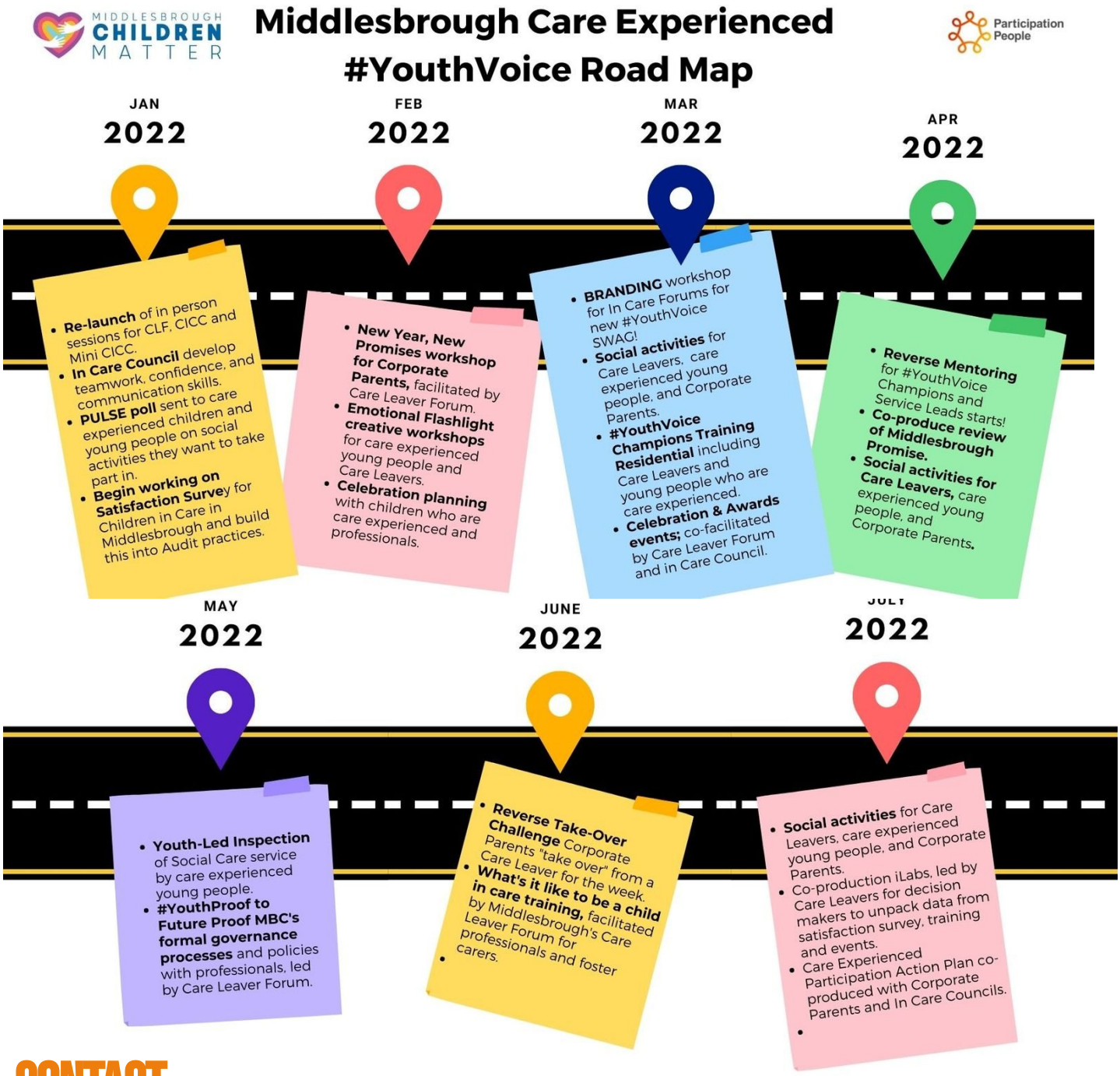
We have been busy planning the relaunch of the Mini Children in Care Council, Children in Care Council and Care Leaver Forum.

Once the groups have had their first meetings, they will be deciding what projects, events and activities they would like to prioritise.

Keep an eye out for invitations from them to you; as they would love for you to join them. This will help you listen to young people's voices who are care experienced to inform your role as a corporate parent.

Our 2022 Plan

Below is a brief snapshot of everything we have planned for your care experienced youth voice forums 2022...



CONTACT

Contact HannahW@participationpeople.com ...for more information on Middlesbrough's #YouthVoice activities, campaigns, projects, and events. We would LOVE to hear from you!

@ParticipationPP

@ParticipationPeople

Want to have Fun, meet other Young People and have a Voice?

- Are you 'Looked After'?
- Between 7-12 Years?
- Full of ideas?
- Want to be heard?

Then come and join Middlesbrough's

Mini Children In Care Council

18th, 25th January and 8th February
4 - 5.30pm

For more information contact
Xavier_davies@middlesbrough.gov.uk
or Text **I'm In,** with your name and age
to Kathy on **07926580007**

Participation People

MIDDLESBROUGH CHILDREN MATTER

Middlesbrough moving forward

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Want to have Fun, meet other Young People and have a Voice?

- Are you Care Experienced?
- Between 13 - 17 Years?
- Full of ideas?
- Want to be heard?

Then come and join Middlesbrough's

Children In Care Council

18th, 25th January and 8th February
6 - 7. 30pm

For more information contact
Xavier_davies@middlesbrough.gov.uk
or Text **I'm In,** with your name and age
to Kathy on **07926580007**

Participation People

MIDDLESBROUGH CHILDREN MATTER

Middlesbrough moving forward

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Want to have Fun, meet other Young Adults and have a Voice?

- Are you Care Experienced?
- Between 18 - 25 Years?
- Full of ideas?
- Want to be heard?

Then come and join Middlesbrough's

Care Leavers Forum

20th, 27th January and 10th February
5.30 - 7.00pm

For more information contact
Xavier_davies@middlesbrough.gov.uk
or Text **I'm In,** with your name and age
to Kathy on **07926580007**

Participation People

MIDDLESBROUGH CHILDREN MATTER

Middlesbrough moving forward

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Permanence Action Plan
Highlight Report
January 2022

Corporate Parenting Board received a full update in August 2021 with updates against all areas of the Permanence Action Plan. This report should be read in conjunction with that report and provides an update of progress since August 2021.

1.0 Ofsted November 2019

In November 2019 Ofsted reported that:

- Middlesbrough has a particularly high rate of children in care against national comparators, and this level was increasing.
- Children are experiencing longstanding neglect come into care too late, and decisions for them to do so are made in response to a crisis
- There are serious delays in achieving permanence for most children in care.
- Early permanence is not prioritised for children in Middlesbrough, and there is a lack of parallel planning, which creates delay in achieving stability. There are missed opportunities to place children early for fostering for adoption
- Children subject to care orders have lived at home for several years, without timely and purposeful review of whether the Care Order is still required.
- Children experience significant delay in securing permanence through adoption.
- Too many changes in social workers also affect the quality of decision-making because new workers do not know children well enough to be confident about the plans that are proposed and agree to changes at short notice.
- When children's placements become fragile, there is a lack of coordinated support for both children and their carers to prevent disruption. Some children, including very young children, have experienced too many changes in placement before their permanent placement is identified.
- Family arrangements are pursued sequentially, and for too long, when children cannot live at home.

- There are delays in securing special guardianship orders for connected carers, although the support provided to many of these arrangements is good.

- Insufficient attention is given to ensuring timely care planning, particularly for very young children.

- Senior management panels and inconsistent legal advice provide insufficient scrutiny for understanding children's experiences and to ensure that their needs are met in a timely way.

2.0 Our Response

The Corporate Parenting Strategy for Children and Young People in Middlesbrough was presented to and signed off by Corporate Parenting Board in December 2020.

The strategy sets out our vision and action plan for how the Council and our partners will support children and young people who are in our care, and our care leavers, to achieve the best possible outcomes in their lives. Transforming our approach to corporate parenting.

Our Permanency Action Plan for Children and Young People was developed in consultation with partners and is built around the six permanency priorities set out in our Corporate Parenting Strategy. The action plan defines how Children's Social Care will achieve the vision.

Our Permanency Action Plan will be systematically reviewed and updated as actions are completed, towards achievement of the priority outcomes we have identified over the 3-year cycle of our plan.

The overall responsible Council officer for the Permanency Action Plan for Children and Young People is the Director of Children's Services (DCS). For each of the six priority themes, a senior Council officer has been delegated by the DCS as the accountable lead for maintaining an overview of the priorities set out in the action plan.

Themes and Responsible Officers

	Theme	Lead Accountable Officer
1	Strengthening Permanency in Our Social Work Practice	Ben Short
2	Growing Our Multi-Agency Partnerships for Permanency	Siobhan Davies
3	Reducing Drift and Delay for Achieving Permanency	Paula Jemson
4	Strengthening the Voice of Children and Young People in Permanency	Siobhan Davies
5	Improving the Way we Capture and Use Our Data for Permanency	Paula Jemson
6	Supporting Permanency in Education, Employment & Training	Victoria Banks and Paula Jemson

3.0 Progress Against Each Theme

Theme 1 - Strengthening Permanency in Our Social Work Practice

- Permanency Pathway is developed and signed off
- Legal Gateway Panel is embedded
- A Legal Gateway Tracker is in place to progress and track care proceedings
- Strengthening Practice are in the process of delivering a comprehensive Permanence training programme to the workforce
- Permanence Month delivered updates procedures and internal practice guidance to staff
- Procedures for all permanence practice and pathways are being updated and relaunched and in various stages of completion
- A Workforce Recruitment Strategy has been approved and recruitment of staff is ongoing with a new offer to experienced staff
- Practice standards for Placements with Parents have been developed with staff
- Practice standards for Connected Carers have been developed
- A working party has been launched to enhance procedures regarding reunification to put a focus on reunification as a central part of sufficiency, recognising that children are best placed at home where it is safe to do so.

Theme 2 - Growing Our Multi-Agency Partnerships for Permanence

- Permanence Monitoring Group is attended by Adoption Tees Valley Service Manager.
- Strengthened reviewing processes and senior management oversight of the education of all looked after children to ensure that there is a reduction in fixed term exclusions, children accessing less than 25 hours of education and in unregistered educational provisions. This includes the SEN team, the Virtual School, Inclusion team, Early Years and Primary Inclusion team.
- Multi agency audit of Education and Health Care Plans has been conducted with lessons learnt informing improvements.
- North Yorkshire, as Partners in Practice, are supporting to develop audit work within the fostering service.

Theme 3 – Reducing Drift and Delay for Achieving Permanence

- Permanency Monitoring Group continues to be well embedded and supported by the Fostering team, Review and Development Unit and Adoption Tees Valley. This is successfully tracking all children from Care Order to permanence
- The commissioned social work team remains in place to support children to achieve permanence in a timely manner. This has developed on to a model including the support of practice development across the service.

Theme 4 – Strengthening the Voice of Children and Young People in Permanence

- Life Story work training took place in October 2021.
- Commissioned Service is in place to develop participation for looked after children and throughout the council – Participation People. The team will consider how young people are involved in changes to policy and practice.
- Recruitment for the Children in Care Council is ongoing
- A care experienced young person now attends Corporate Parenting Board
- ATV have recruited additional staff to ensure that Life Story Work is completed and in place for children who are adopted.
- Care experienced young people delivered a workshop to Corporate Parenting Board regarding communication.
- A number care experienced young person participated in The Big Take Over and were involved in projects to improve services.
- 26 Resource workers and 10 residential staff have been trained in Life Story work.

Theme 5 – Improving the way we use and Capture Data for Permanency

- Performance report is delivered to each Corporate Parenting Board to ensure that there is rigorous oversight and challenge.
- Permanence Tracker remains in place and is used to drive effective permanence planning
- Legal Tracker remains in place and is effectively used to track progression of all court cases
- LCS transformation programme is developing a pathway for Connected Carers and Special Guardianship Orders to allow for more sophisticated performance reporting, tracking and management oversight.
- Permanence dashboard and score card is in the process of being developed to ensure that that performance reporting is improved further

Theme 6 – Supporting Permanence in Education, Employment and Training

- Virtual School and Social Care delivered joint Hot Topic sessions to staff in October 2021 regarding joint working and the effective use of Personal Education Plans.
- Training scheduled for Designated Teachers in October regarding the role of education as Corporate Parents.
- Strengthened joint working with the Virtual School has led to weekly reviews of children absent from school alongside health and social care.

4.0 Impact/Performance/Data

- ✓ Overall in the lasts 12 months, the looked after populations has reduced from 654 children in November 2020 to 526 in November 2021 (19.5% reduction). There has been a 25% reduction in the overall numbers of looked after children since the height of 702 in September 2020. In the last 12 months 205 children started to be looked after compared to 344 children ceased to be looked after.

- ✓ The rate per 10,000 has reduced from 197.4 in November 2021 2020 to 158.8 in November 2021. This is the lowest rate in the last 12 months and has continued to reduce consistently.

- ✓ Since 01 April 2021 19 Adoption Orders have been secured. This includes:
  - 4 children of BAME
  - 4 sibling groups of 2

- 2 aged 4+

✓ More children have been adopted in Middlesbrough than all other authorities in Teesside.

✓ The number of days between a Placement Order being granted and a child being adopted has reduced from 558 in 209/20 to 342 in 2021/22.

✓ There are currently a further 38 children progressing to adoption with Placement Orders. Of which only 2 children do not have confirmed links.

✓ There has been a total of 76 children secure permanence through the granting of a Special Guardianship Orders in the last 12 months.

✓ Connected Carers – There are currently 124 children in connected carers placements. This has reduced from a height of 212 in 2020.

✓ Placement with Parents – There are currently 47 children placed with parents. This has reduced from 52 children in October 2021 and from a height of 99 children in September 2020 to 58 in August 2021. (52.5% reduction)

✓ There has been a reduction in the number of children in external residential placements from 74 in June 2021 to 47 in December 2021.

✓ School attendance for looked after children was 91% in November 2021.

✓ There have been no looked after children permanently excluded from school in the last 5 years.

✓ Only 3.1% of looked after children are receiving less than 25 hours education (11 children). Of which there is an action plan and oversight from Virtual School of each.

5.0 Risks

- The increase in demand across the service and across the tees valley region
- Risks associated with the recruitment of staff in the looked after and care leaving service.

6.0 Next Steps

- Data Team to develop a Permanence Dashboard and Score Card – Performance and progress to be reported to Improvement Board and Corporate Parenting Board
- Life Story Work compliance and quality to continue be driven
- The ongoing reduction and tracking of the number of children residing in external residential placements
- Progress the Permanence Action Plan and report to Improvement Board and Corporate Parenting Board
- Practice leads deployed in to the service to improve the quality of care plans for looked after children
- Participation People to develop attendance and provide Corporate Parenting Board with a proposed plan for the Children in Care Council.
- The Audit to Excellence team will carry out a deep dive audit of the looked after and care leavers service in January 2022. Audit findings to be reported back to Corporate Parenting Board.
- Recruitment of permanent staff

Owner – Rachel Farnham, Middlesbrough Council, Director of Children's Social Care

Author – Paula Jemson, Head of Service for Looked After Children and Corporate Parenting

Sufficiency Action Plan
Highlight Report
January 2022

1.0 Our Response

The Corporate Parenting Strategy for Children and Young People in Middlesbrough was presented to and signed off by Corporate Parenting Board in December 2020.

The strategy sets out our vision and action plan for how the Council and our partners will support children and young people who are in our care, and our care leavers, to achieve the best possible outcomes in their lives. Transforming our approach to corporate parenting.

Our Sufficiency Action Plan was developed in consultation and is built around the priorities set out in our Corporate Parenting Strategy. The action plan sets out actions we feel need to be undertaken in order to better meet our needs.

Our Sufficiency Action Plan will be reviewed and updated as actions are completed or as new work is identified in the event of any changes to our sufficiency needs over the 3-year cycle of our plan.

The overall responsible Council officer for the Sufficiency Action Plan for Children and Young People is the Director of Children's Services (DCS). For each of the six priority themes, senior Council officers have been delegated by the DCS as the accountable lead for maintaining an overview of the priorities set out in the action plan.

Themes and Responsible Officers

Theme		Lead Accountable Officer
1	**Strengthening Commissioning For Children & Young People**	Head of Service Futures for Families Specialist Commissioning & Procurement Senior Manager
2	**Increasing Placements Close to where Children & Young People Live and Learn**	Head of Service Future for Families Specialist Commissioning & Procurement Senior Manager
3	**Growing Early Intervention & Prevention**	Head of Prevention Specialist Commissioning & Procurement Senior Manager
4	**Improving Placements & Support for Care Leavers**	Head of Service Children Looked After Specialist Commissioning & Procurement Senior Manager
5	**Enhancing Learning Outcomes for Children & Young People**	Virtual Head Specialist Commissioning & Procurement Senior Manager
6	**Building Our Fostering Capacity and Adoption Outcomes**	Head of Service Future for Families Specialist Commissioning & Procurement Senior Manager

2.0 Progress against Each Theme

The Commissioning Action Plan has been reviewed and updated in November 2021.

Theme 1 - Strengthening Commissioning for Children and Young People

- Work continues on the implementation of Controcc (a financial system linked directly to the children's care system LCS in order to move away from direct invoicing and Council made payment runs) for Children's and due to some practice changes that may be required the full implementation date may need to be extended but this will be approved via the Change Control process in place.
- A Market Engagement Plan is being drafted and will be presented for formal endorsement by Children's DMT in February 2022.

Theme 2 – Increasing Placements Close to where Children and Young People live and learn

- Internal occupancy is on the increase with 23 young people being placed across our internal residential provision
- Regional work on the future procurement of a regional framework continues and is expected to be in place by 1st July 2022.
- Continue to work with the region in order to identify any opportunities for collaboration and still awaiting set up of a regional commissioning hub which should be imminent.

Theme 3 – Growing Early Intervention & Prevention

- PAUSE, a service working with women who have had more than two children removed in order to work with them on themselves and avoid further pregnancies or removal of children, has managed to continue to deliver services through COVID which has been really positive. This contract has also been extended by a further 6 months.

Theme 4 – Improving Placements & Support for Care Leavers

- In order to further enhance our confidence in the unregulated settings we are carrying out our own contract management visits on all placements in order to ensure value for money and high quality service deliver.
- In addition we have also introduced our own version of 'Reg 44' visits via the National Youth Advocacy Service, this will again evidence high delivery of care as well as views of the young people in placement.

Theme 5 – Enhancing Learning Outcomes for Children & Young People

- Work continues on understanding how Boarding Schools can offer placement opportunities for our children and young people.

Theme 6 – Building Our Fostering Capacity and Adoption Outcomes

- Work on the business case and new service delivery model continues.
- In-house fostering placements have overtaken the number of external IFA placements which is really positive (169 internal vs 157 external).
- Middlesbrough Council is currently running another significant recruitment campaign in order to further increase our carer numbers and further drive the in-house placement numbers.

3.0 Impact/Performance/Data

- Weekly external residential placement monitoring continues and we have seen a big swing in in-house placements following the opening of Rosecroft and Daniel Court. As at 4th January 2022 we had 68 placements of which 23 (34%) were internal, 45 (66%) were in external.

- In-house fostering placements have overtaken external IFA placements and as at 04.01.22 there were 326 fostering placements of which 169 (52%) in house and 157 (48%) external

5.0 Risks

- COVID impacting on staffing levels but this is being monitored and in the event that issues are identified we will work closely with providers and the service area to provide as much support and resilience as possible.

6.0 Next Steps

- Establish monthly Action Plan Meetings on a monthly basis for 2022
- Continue to ensure tasks are driven forward
- Ensure any change controls are secured where any changes to deadlines are identified.

Owner – Rachel Farnham, Middlesbrough Council, Director of Children's Social Care

Author – Claire Walker, Specialist Commissioning & Procurement Senior Manager

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Corporate Parenting Scorecard Highlights

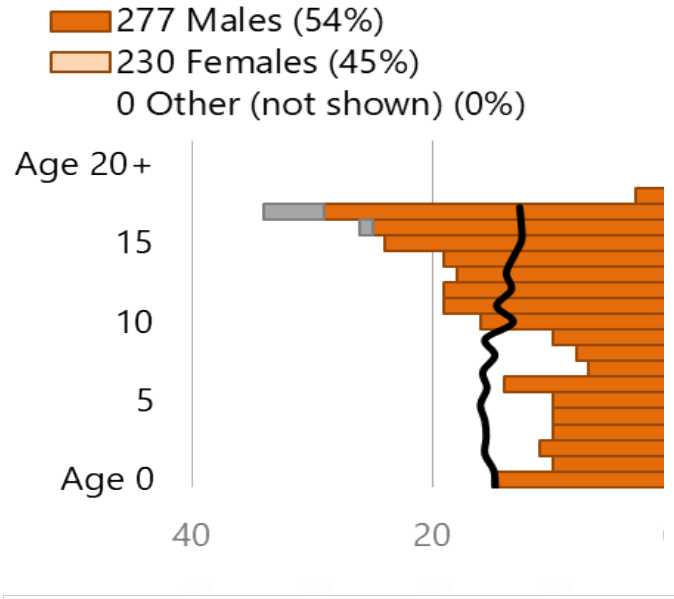
Corporate Parenting Board
11 January 2022

Demographics

Gender -54% of the current looked after population are 55% are male with 1% of these young boys being Unaccompanied Asylum Seekers. 45% of the looked after population are female.

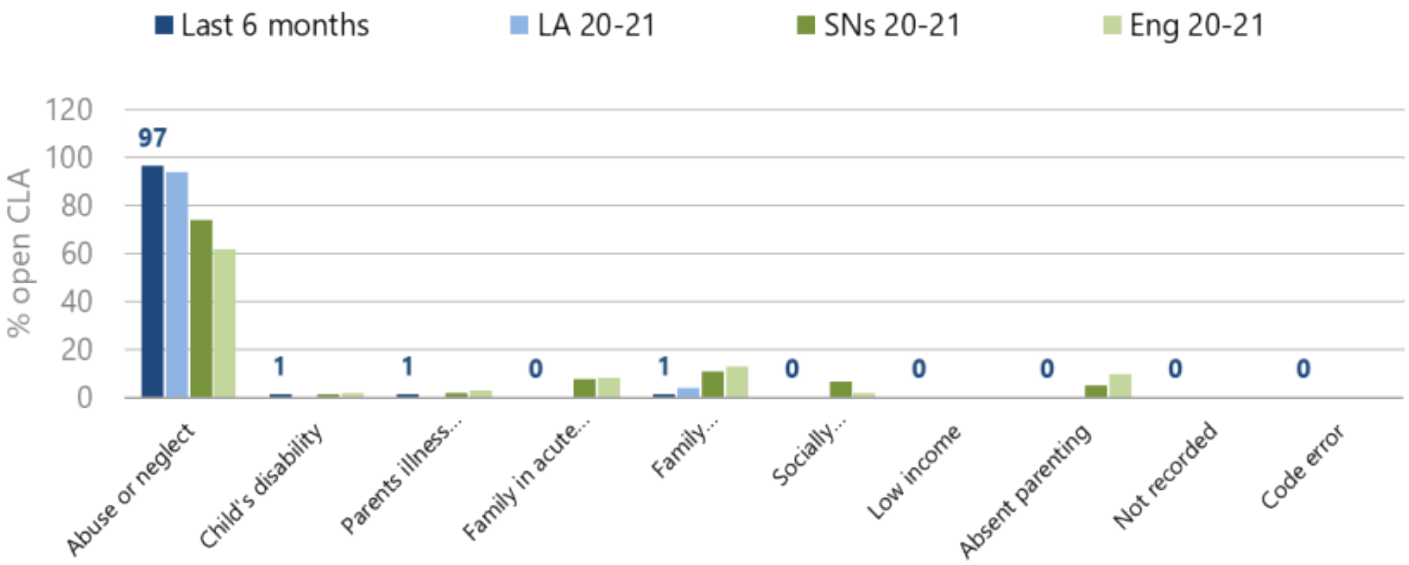
Ethnicity - The highest percentage of the children in our care are of a White British ethnicity (81%).

8% of children are of mixed ethnicity and 7% are Black or Black British.



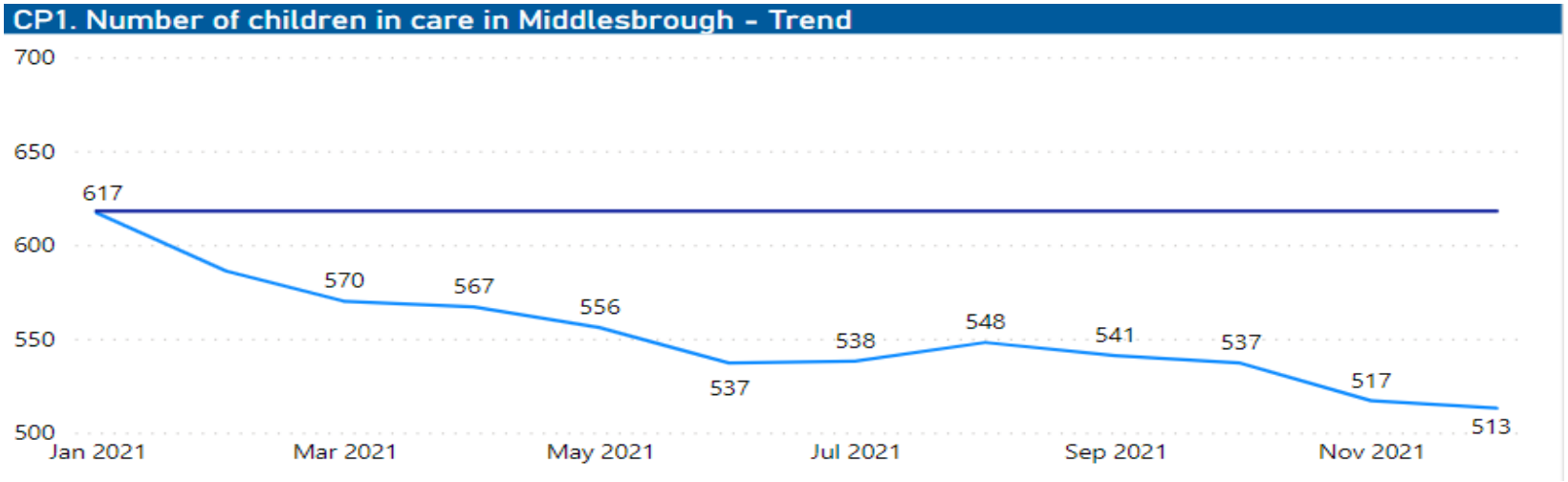
	All CLA
White	81%
Mixed	8%
Asian or Asian British	2%
Black or black British	7%
Other ethnic group	2%
Not stated	0%
Not recorded	0%

Reason for becoming looked after



The most common reason for a child to become looked after is due to abuse or neglect. 97 children have become looked after in the last 6 months to protect the from this cause. This is only a slight increase from 202/2021 however remains significantly higher that our statistical neighbours and the England average.

Demand



In January 2021 there were 617 children looked after in the authority.

There has been a rapid reduction over the year demonstrating an increase of 17% over the last 12 months and an overall 27% reduction since the height of 702 children in September 2020. For every 0.6 children entering care, one child exits care. This ratio has been maintained for 6 months.

Children Supported to not Become Looked After

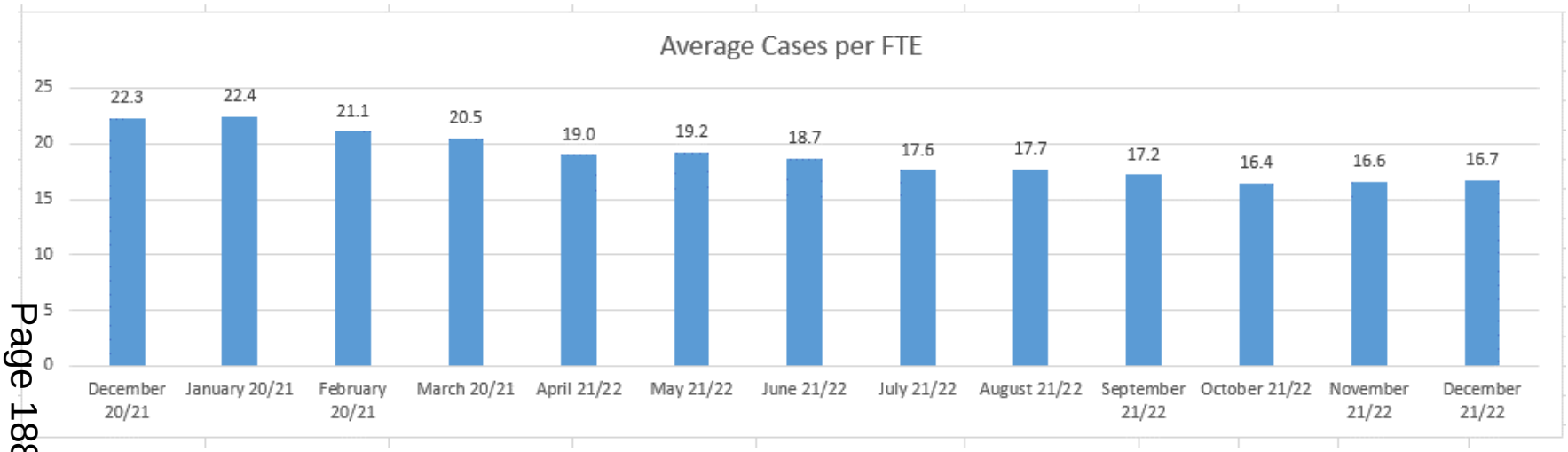
Future for Families have supported 50 young people on the edge of care since they went live.

Of the 50, 37 (74%) of these did not become looked after.

- 21 were supported on a child in need level (57%)
- 11 remain supported on a child in need level
- 10 (47%) no longer require a child in need plan and are no longer supported by the LA

- 16 were subject to child protection procedures (43%)
- 10 remain supported on a child protection level
- 4 (25%) have stepped down and receive child in need support
- 2 (13%) no longer require any service from Children's Social Care

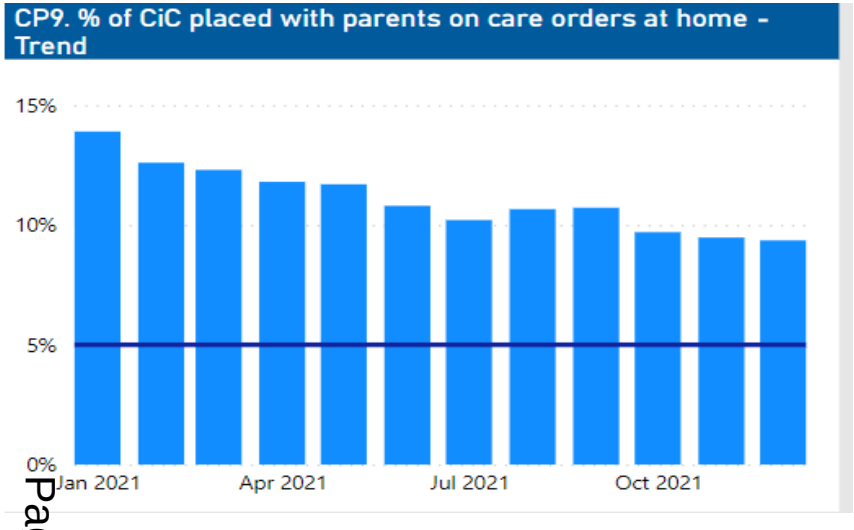
Demand - Caseloads

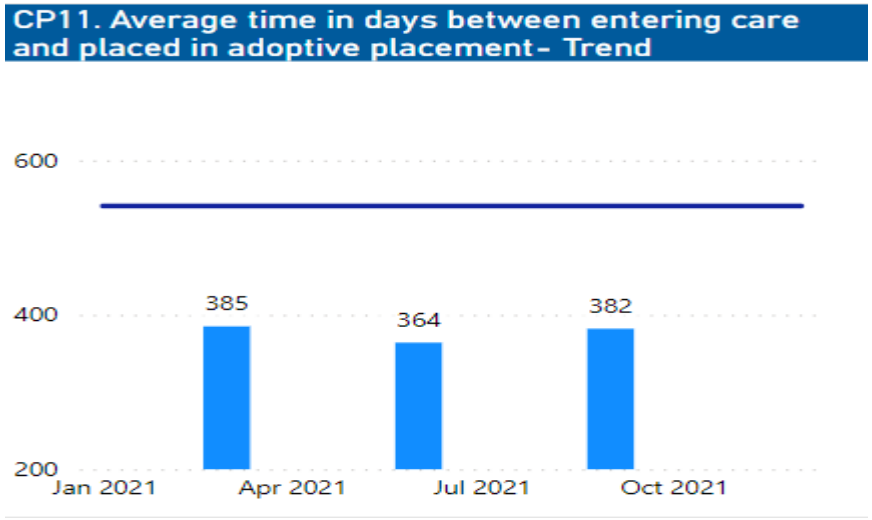


Caseloads have consistently reduced since December 2020 and throughout the improvement journey.

Whilst the average per service area varies slightly, the average caseloads across Children's social care is currently 16.7. This will support the service to drive improvements in the quality of practice.

Permanency



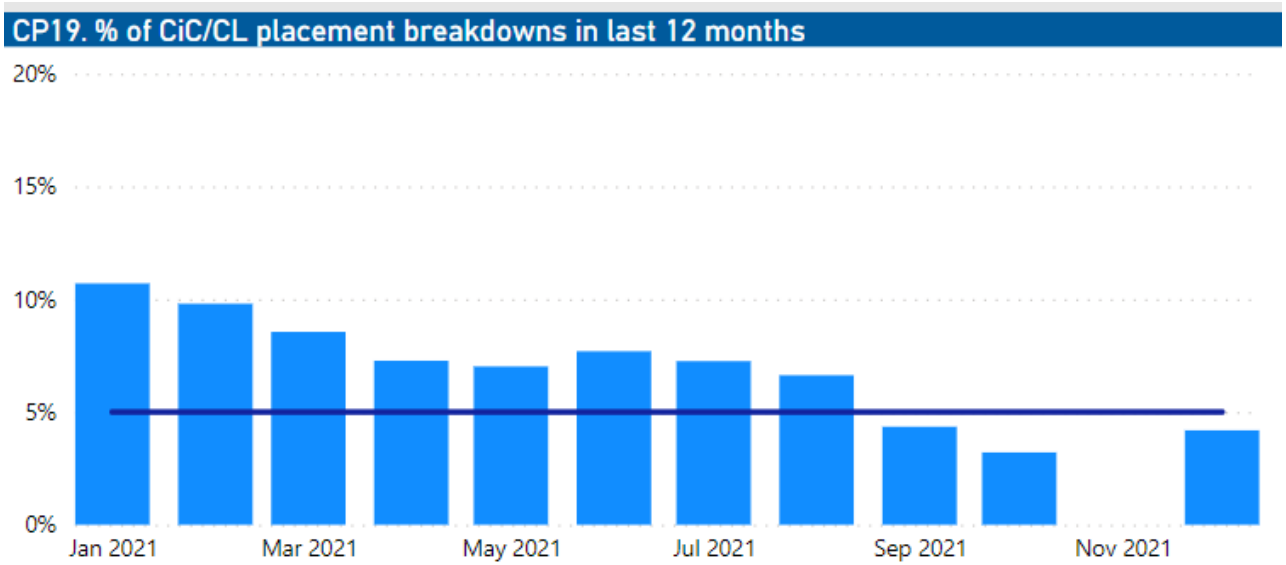


Children Placed with Parents - The number of children placed with a parent and subject to a Care Order has reduced significantly since January 2021. There are currently 47 children placed with a parent. This is a 52% overall reduction since the height on 99 children in September 2020.

Connected Carers – There are currently 114 children looked after and placed with a Connected Carer. This has reduced from a height of 212 in 2020 (46%).

Adoption - The average number of days from entering care to being placed in an adoptive placement has reduced from a height of 558 days in 2019/20 to 382 days in October 2021. (Adoption Score Care data for Q2)

Placement Stability



Less than 5% of the looked after population have experienced a placement breakdown in the last 12 months.

In January 2021, 123 looked after children had experienced three or more placements over the last twelve months. This amounted to 20% of the looked after population.

This has reduced to 36 children in December 2021. This equates to 7% of the current looked after population. We are currently below all external benchmarks, and are also below our outturn for 2020/21.

Quality and Impact

Visits
What does the performance tell us this month?
94% of looked after children have been seen within the last 6 weeks.

How does it compare to last month?
This is a 5% decrease from last month. This has been consistently high at over 90% since May.

Supervision/Management Oversight
What does the performance tell us this month?
94% of looked after children have had a supervision within the month of December 2021.

How does it compare to last month?
This is a 5% decrease from last month. This has been consistently high at over 90% since May 2021.

Personal Education Plans

What does the performance tell us this month?
Performance in relation to PEPs remains high at 99% of children having a recorded PEP within the last 6 months. This performance has remained consistently high and has not dropped below 93% for the last 12 months.

Health Assessments

What does the performance tell us this month?
90.8% of health checks have been conducted and recorded within the last 12 months. This does not take in to account those older children who have refused a medical assessment.

Performance has been consistently high at over 90% for the last 12 months.

Dental checks – 66.1% of children have had a dental check in the last 12 months.

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