NHS
Bradford District and Craven
Clinical Commissioning Group

ACTasONE

Children Looked After and Care Leavers Annual Report 2020-2021

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1. FOREWORD

This is the first annual Children Looked After and Care Leavers Annual Report provided by Bradford District and Craven Clinical Commissioning Group, written in response to the statutory guidance *'Promoting the health and well-being of looked-after children' (2015).*

It covers the period from 1st April 2020 to 31st March 2021; some data for March- April included as transition period began. The CLA Annual Report forms part of Bradford District and Craven CCG's assurance arrangements, in relation to Children Looked After and wider Safeguarding Children arrangements.

Under the Children Act 1989, a **child is looked after** by a local authority if he or she falls into one of the following:

- is provided with accommodation for a continuous period of more than 24 hours (Children Act 1989, Section 20 and 21),
- is subject to a care order (Children Act 1989, Part IV), or
- is subject to a placement order.

Wherever possible, the Local Authority will work in partnership with parents to ensure that children and young people who become CLA retain strong links with their families and many eventually return home.

A child will cease being Looked After by the Local Authority when they are adopted, return home or reach the age of 18 years.

Care leavers are those children who have previously been Looked After by the Local Authority and are now being supported to live independently. Following the publication of the Children and Social Care Act (2017), Local Authority responsibility for Care Leavers changed from 18-21 years to an age range of 18-25 years, enabling care leavers to request support up to the age of 25 years, regardless of whether or not they are in education.

2. STATEMENT OF INTENT

NHS Bradford District and Craven Clinical Commissioning Group and our system partners are committed to improving health outcomes for Children Looked After and Care Leavers.

We will achieve this by ensuring we commission and provide high quality responsive services. NHS Bradford District and Craven will continue to work closely with its providers; (Bradford District Care NHS Foundation Trust, Bradford Teaching Hospital NHS Foundation Trust and Airedale NHS Foundation Trust), Bradford City of Bradford Metropolitan District Council, North Yorkshire County Council, service users and other key partners to ensure that Children Looked After and Care Leavers have timely access to high quality health care, as and when they need it.

We will ensure robust management of any actions needed to improve performance and outcomes such as continual review of clinician time in order to fulfil our duties in a timely and effective manner especially for those children requiring an initial health assessment and adoption medical.

3. THE NATIONAL CONTEXT

In England the number of Children Looked After has increased every year since 2008. Many of the national data measures have followed that of our local area (see appendix 1 for national data).

When a child first enters the care system their primary need is identified. There are a range of reasons why a child is looked after; nationally figures have remained broadly stable over the past 3 years.

There has been a noticeable change in the legal status of CLA in recent years. Both the number and proportion of CLA under a care order have increased, while the number and proportion looked after under a voluntary agreement (under section 20 of the Children Act 1989) have decreased.

By March 2020 47,540 children were recorded as having a primary need from '**abuse or neglect'** which is the most frequently identified reason for needing to enter the care system and has been steadily rising over a number of years.
11,220 children were in need due to 'family dysfunction' and 5,950 were identified as being in need due to the 'family being in acute stress'

These children and young people experience unmet health needs such as missed immunisations, neglected dental care and missed health appointments.

They also experience a higher incidence of learning and developmental problems, emotional, behavioural and mental health problems. Most have experienced high numbers of Adverse Childhood Experiences (ACEs) which are becoming better understood as having detrimental effects on a child's long term ability to thrive and achieve successful adulthood.

Children who are looked after are 3-4 times more likely to have Special Educational Needs by 16 years of age (end of key stage 4) than all children.

Children in care show significantly higher rates of mental health disorders – 45% rising to 72% for those in residential care, compared with 10% of the general population aged 5-15 years.

There is local evidence of CLA and care leavers having higher rates of teenage pregnancy than the general population.

4. THE LOCAL CONTEXT

Bradford is the fifth largest local authority in England in terms of population size after Birmingham, Leeds, Sheffield and Manchester. The District's population is a young one, with the fourth highest proportion of under 16 - year - olds in England, with children and young people under 20 years making up almost 30% of the population. Approximately 56.7% of school children are from ethnic minority groups. The health and well-being of children in Bradford is generally worse compared with the England average, with higher levels of obesity, teenage pregnancy and accidental injury. Infant mortality rates in Bradford are also significantly higher than the comparative value for England. Childhood vaccination coverage is a particular area of strong performance, and the number of children in care receiving immunisations is significantly higher than the England average.

Craven lies within North Yorkshire Local Authority. By comparison with Bradford, it has an ageing population. Although health inequality is less pronounced in Craven, compared with Bradford, a significant number of children grow up in poverty.

Clinical acute and community paediatric services to children looked after are provided by paediatricians within Bradford Teaching Hospital NHS Foundation Trust and Airedale NHS Foundation Trust.

Health visitor and School nursing services are provided by Bradford District Care NHS Foundation Trust. CAMHS services, the CLA specialist nursing team and as of May 2021 CLA specialist GPs are also provided by Bradford District Care NHS Foundation Trust.

The number of children under 18 years looked after in Bradford recorded in the Government statistics (Statistics: looked-after children. GOV.UK 2019-2020) was 1,245. This is an equivalent of 87/100,000children, and although this is above the national figure for England of 67/100,000, it was well below the figures for other local authorities (e.g. Blackpool 233/100,000, Middlesbrough 189/100,000, Stoke-on-Trent 159/100,000 and Blackburn with Darwen 106/100,000 children.)

The current figure for children looked after in Bradford in March 2021 was 1348. Many of these children have additional needs, have experienced abuse and neglect and therefore enter care with multiple and complex health and care needs.

There has been a growing need to ensure that these complex health and care needs are understood more globally via a systems approach to how Bradford addresses the needs of children and looked people looked after in their care. The use of a systems approach not only ensures that the child has access to timely services but that there is also clearer understanding of any risks/gaps, overall system capacity and how these can be addressed.

5. GOVERNANCE AND ACCOUNTABILITY FOR LAC HEALTH SERVICES IN BRADFORD.

The CLA team interface closely with safeguarding children and governance arrangements and are therefore aligned.

Provision for the Designated Doctor role has previously been provided by BTHFT and ANHSFT and included in block contract payments for 1.5 and 1 PA respectively. Currently the post is unfilled following the resignation of the two Designated Doctors, and there is interim cover of 3 PAs per week. Funding has been approved to recruit a Designated Dr CLA for 6 sessions a week which is in line with recommendations in the ICD (NMC. 2020)) to lead on development and delivery of the new clinical model. Interviews are set for October 2021.

There is a whole time Designated Nurse with responsibilities for both Safeguarding and Children Looked After. Due to the statutory guidance and the numbers of children looked after in Bradford, part of the coming years priorities will include a review of the need for a full time Designated Nurse for Children looked after

The Designated Professionals CLA, as clinical experts and strategic leaders are a vital source of advice to the CCG and to partners. They are part of the CCG's Safeguarding

team, along with the Designated Professionals for Safeguarding Adults and Children and the Named GPs for Safeguarding Adults and Children.

The Designated Professionals report regularly to the Strategic Director of Quality and Caldecott Guardian of the CCG.

The Designated Doctor and Designated Nurse have accessed safeguarding children and CLA supervision and have also provided formal and ad hoc supervision to members of the wider CLA, care leavers and YOT multi-agency system in respect of health needs, health outcomes signposting to health services and escalating individual cases.

The Designated Nurse attends the following:

- Bradford Safeguarding Partnership Board
- Children in Care and Care Leavers Strategic Group
- Regional Designated Professionals meetings for children in care
- ICS network for Designated Professionals Children in Care
- Corporate Parenting Panel

The interim Designated Doctor currently attends the following:

- Regional Designated Professionals meetings for children in care
- National Network of Designated Healthcare Professionals (NNDHP)
- Bradford Health steering group (multidisciplinary)
- CLA Delivery Group – a task and finish health group to initiate and embed the new system of delivering health care to Children Looked After

The meetings attended by the Designated Professionals will be reviewed once funding for the Designated Doctor post has been appointed to. The Designated Professionals are of the opinion that there should be Designated Professional representation at the Health and Well-being Board.

6. DATA FOR CHILDREN IN CARE BRADFORD APRIL 2020-MARCH 2021

- The number of children starting to be looked after has increased by **7.12%**
- Between April 2020 and March 2021 a total of 509 children became looked after.
- Between April 2020 and March 2021 407 children and young people were discharged from care.
- The total number of children in care in April 2020 was 1252 and in March 2021 there were 1348 children in care in Bradford District.
- This represented an increase of **8.15%**

Date	Admission into Care	Discharge from Care	Total Number of Children in Care
April 2020	29	23	1252
May 2020	35	29	1258
June 2020	68	33	1293
July 2020	78	28	1343
August 2020	44	25	1342

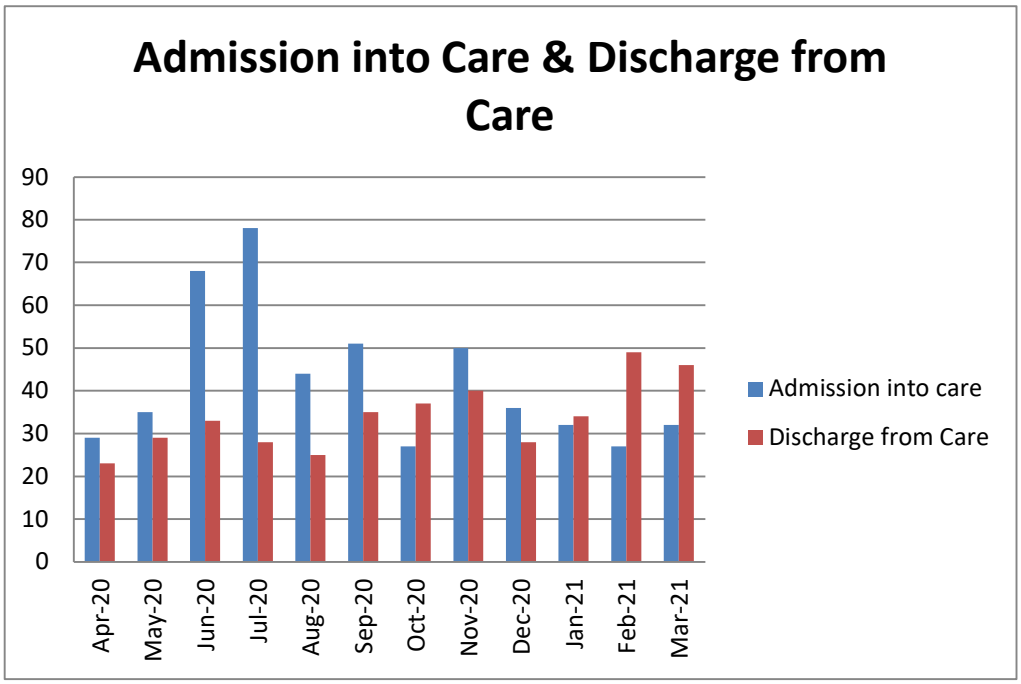
September 2020	51	35	1378
October 2020	27	37	1368
November 2020	50	40	1378
December 2020	36	28	1386
January 2021	32	34	1384
February 2021	27	49	1362
March 2021	32	46	1348

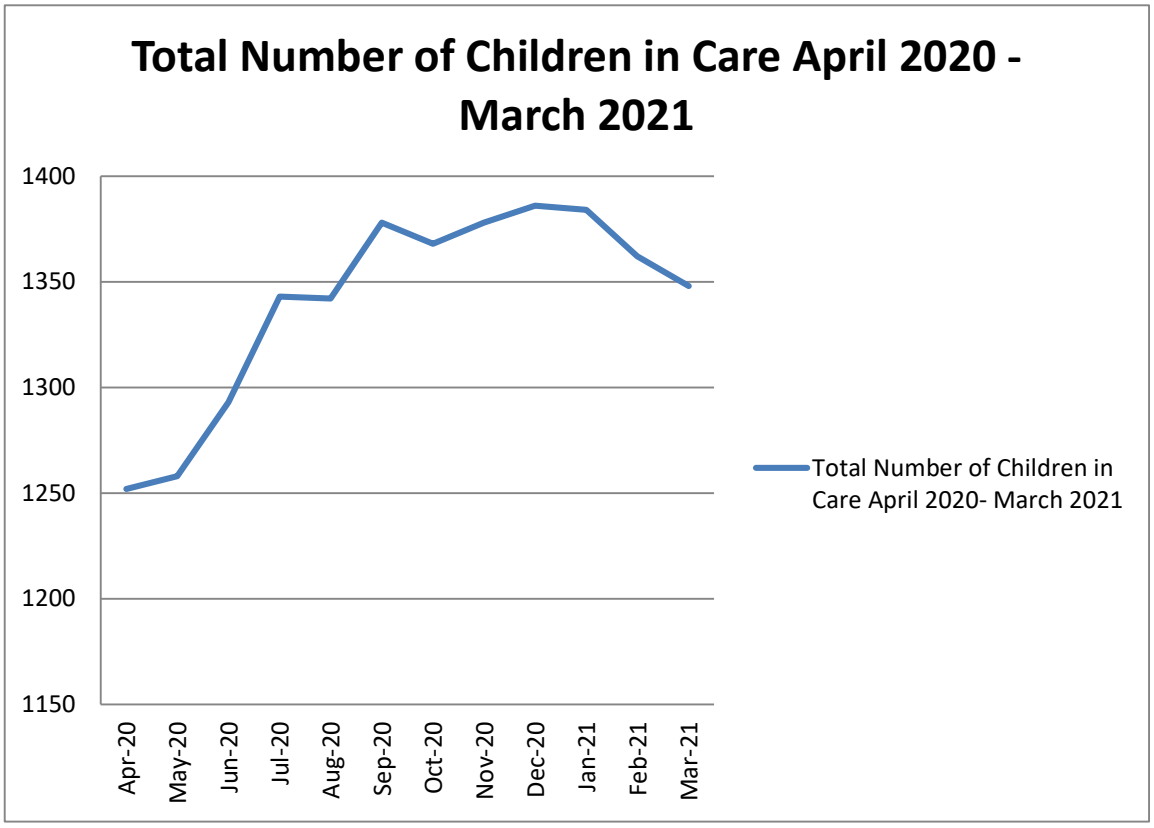
Care Leavers

232 - aged 16-17 years (included in numbers above)
397- aged 18-20 years
75 - aged 21+ years who continued to receive a service

Unaccompanied Asylum Seekers (UASC)

15 - UASC aged 16-17 years
19 - UASC aged 18+





CRAVEN NORTH YORKSHIRE

Limited figures are currently available for children registered as LAC in the Craven Area of North Yorkshire:

There are a total of 42 - 0-18 year old children registered as LAC in the Craven Area.

However, it is important to note that the arrangements for health in the Craven Area are complex as the Bentham GP Practice does not fall within the Bradford District and Craven Clinical Commissioning Group: it falls within the Morecambe Bay CCG. Since provision of health services to children looked after are determined by the Commissioning arrangements of their registered GP, children registered with the Bentham Medical Practice are served by the Morecambe Bay CCG CLA service.

7. NEED FOR CHANGE

The CQC undertook a review of safeguarding children and services for looked after children in Bradford during the week of 25 February 2019; published on 3rd June 2019 it enabled the health system to refocus on ensuring better outcomes for children. It focused on the quality of health services for CLA and evaluated the experiences and outcome for children, young people and their families who received health services within CBMDC and was conducted under Section 48 of the Health and Social Care Act 2008. The inspectors noted the increasing numbers of CLA but at the same time noted the lack of corresponding health resource. Their report concluded that:

- *There are too many looked after children in Bradford who are experiencing lengthy waits to receive medical examinations when they enter care.*
- *There has been significant increases in the numbers of children and young people entering care yet, despite this, there has been no increase in the LAC health nursing service to account for the increasing numbers of looked after children.*

- *LAC specialist nurse team caseloads have significantly increased over the last 12 months, with average caseloads being higher than levels proposed by current intercollegiate guidance.*
- *The capacity of the LAC specialist CAMHS team is under considerable strain and some young people are waiting over a year for specific therapeutic support.*
- *Review of was required of the capacity of the current Designated and Named professional network and address any gaps in the strategic capacity to ensure the sustainability of local arrangements and to drive forward and implement improvements and transformations.*
- *The CQC praised the LAC colleagues by expressing that the voices, wishes and lived experiences of looked after children were consistently captured and documented……..the use of 'signs of safety' is embedded in health review documentation and is helping to provide a balanced, accurate and holistic picture of the child's protective factors and risks……..The child-centred approach promotes and encourages continued engagement with health services*

All of the above were considered as part of the service review and included in the CLAS action plan

8. HEALTH ASSESSMENT CHILDREN LOOKED AFTER APRIL 2020- MARCH 2021

The Initial Health Assessment (IHA) is a holistic health and well-being assessment, to identify these unmet health needs, to agree a health action plan to address them and then to involve the right services to implement the plan. The health assessment needs to happen in a timely way (statutory requirement is 20 working days), to identify these needs and to involve primary and, secondary care, other health therapy services and to advise education. The IHA normally takes 1-2 hours to complete with a further 1-2 hours to write up the mandated paperwork and to prepare the care plan. These children also need 6-12 monthly Review Health Appointments (RHA) to ensure the health recommendations are implemented and to identify any ongoing concerns.

The statutory requirements include:

- All CLA should receive an Initial Health Assessment (IHA) within 20 working days of the child becoming looked after. This includes booking and completing assessment as well as completion of the health action plan (IHA).
- Children under 5 years receive a Review Health Assessment (RHA) every 6 months.
- Children and Young People over 5 years will receive review health assessments (RHA) every 12 months.

The operational protocol (until April 2021) included the following;

The Local Authority will notify new CLA to the CLA Health Team, this should include obtaining parental consent.
Health information should follow the child e.g. immunisation history, birth/medical history, family and social history including information on substance misuse, mental health or physical health issues, school/nursery, dentist and GP summary record.

Initial Health Assessments were undertaken by Consultant Paediatricians in the provider hospitals (Bradford Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust)

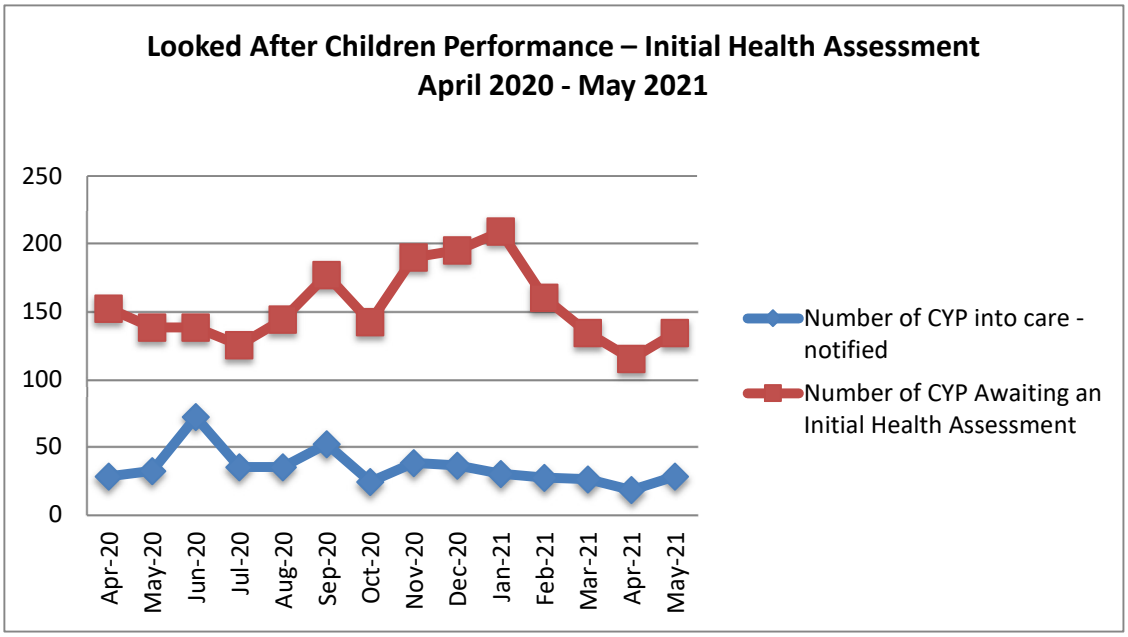
Review Health Assessments (RHAs) are undertaken by the Children Looked After Nursing Team. (BDCFT)

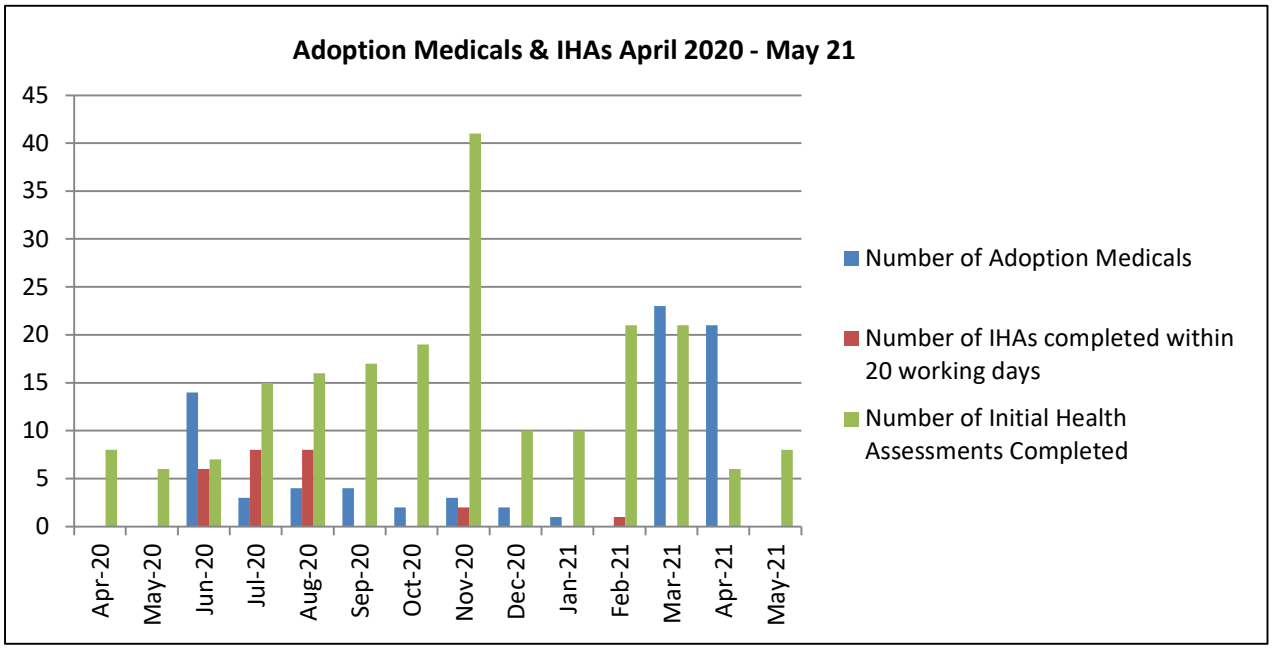
1114 young people had a health assessment between 01.04.20 - 31.03.21.

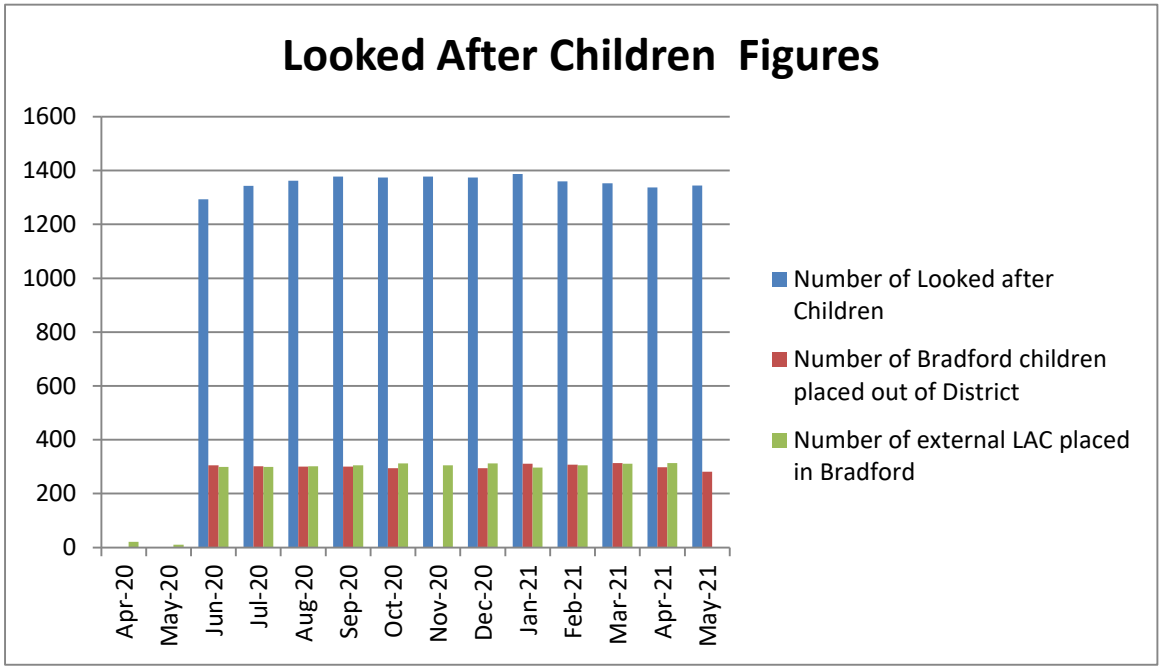
1282 health assessments completed in total:

- **128** Initial Health Assessment
- **349** Review Health Assessment
- **100** Adoption Medicals

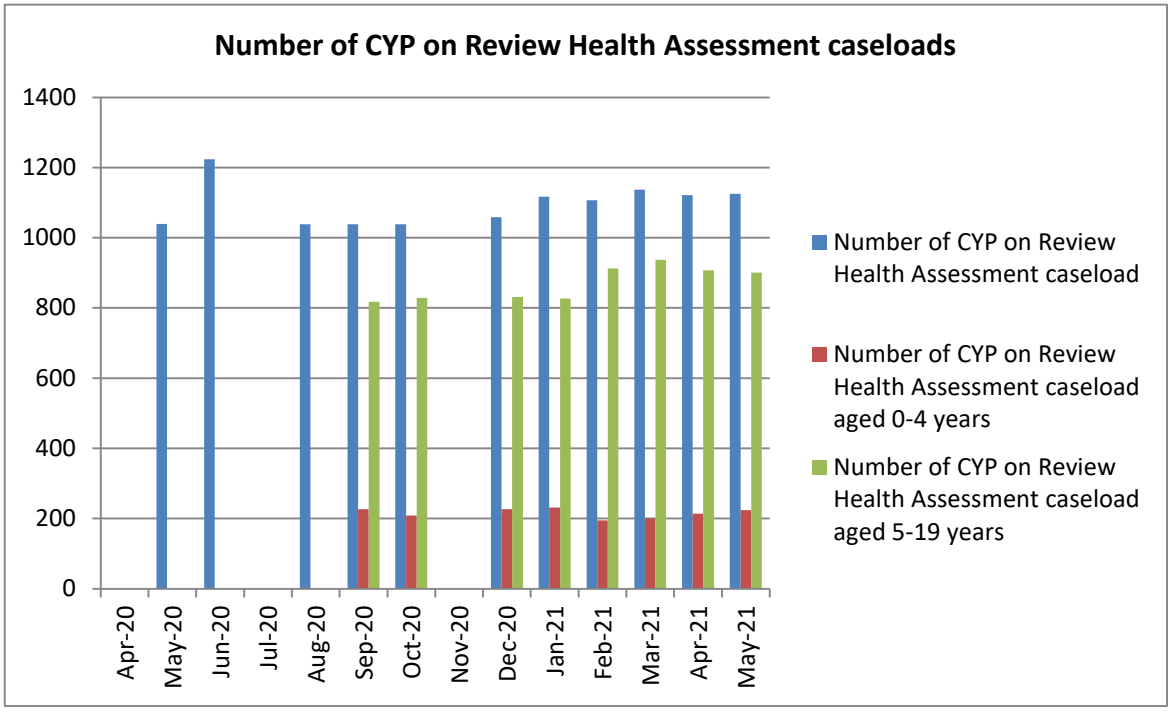
Looked After Children Performance – Initial Health Assessment April 2020

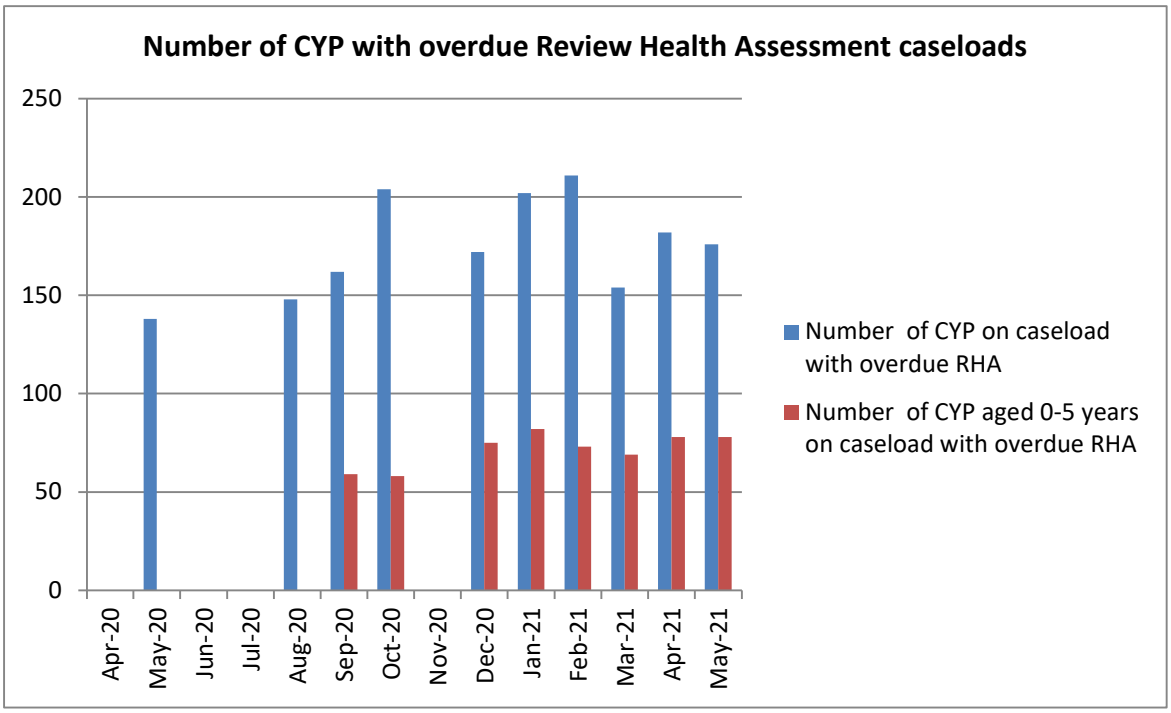






Additional data is included in appendix 2





The performance in terms of timeliness and completion of health assessments requires improvement.

The numbers of new into care continue to increase in 2020/2021 despite Covid 19. Prior to Covid 19 meetings were held with Children's Social Care to look at streamlining the consent process.

IHAs were put on hold at the start of Covid 19, this lead to a spike in April 2020 and virtual clinics were offered.

Throughout the period IHAs were not completed within 20 working days. In May 2020 the average waiting time was 88 days. Paediatricians devised a triage flow chart which nurses used to prioritise new into care.

The figure for children and young people on review health assessment caseload was impacted by the increasing number of CYP being made children looked after and the number of IHAs which were completed 6 or 12 months earlier. The number of children and young people on caseload with overdue RHAs was impacted on by the increasing number of children 'becoming children looked after, long-term sickness and staffing levels.

The average waiting time from a child/young person being made looked after increased steadily throughout 2020-2021 and reached a peak of 147 days in March 2021. This fell to 109 days with the implementation of the new system, though in April 2021 zero IHAs were implemented within the 20 days statutory timetable.

System wide discussions continue in relation to the length of time children and young people are waiting for an initial health assessment

A system waiting list initiative, booking and facilitation of appointments went live on 26 March 2021. 23 appointments were offered and 23 CYP attended. All initial health assessments are now being conducted face to face.

Nurses are undertaking RHAs on all children and young people from the date of their Covid Part 1 IHA as a number of these CYP were not seen face to face. This is to minimise any associated risk.

The number of RHAs continues to be impacted on by the number of CYP becoming looked after, nurses prioritising IHAs, nurse caseload sizes, sickness. There was one WTE vacant caseload in March 2021.

Historically nurses have worked beyond capacity as the data was collected. Despite this there were still 182 (16%) CYP with an overdue RHA. The increasing pressures have been raised with BDCFT, the CCG and the partnership. It is noted that the average caseload for nurses CLA team in Bradford District and Craven CCG is 180, compared with recommended caseload of no more than 100 in the intercollegiate guidelines and caseloads of 80 children in some adjacent CCG. This is coupled with a significant level of complexity in children looked after in Bradford.

9. MEETING STATUTORY GUIDANCE AROUND ACCESS TO INITIAL HEALTH ASSESSMENT AND ADOPTION MEDICALS –

The fact that health agencies have been unable to meet statutory guidance in respect of the timeliness of health assessments for children who are looked after. This has been highlighted as a risk on the CCG risk register, noting the negative impact on health outcomes for CLA, the risk of reputational damage to our district's health organisations in not meeting timescales and resulting in potential missed opportunities in care arrangements for CLA. This has been the result of a number of factors including an increase in the number of CLA by City of Bradford Metropolitan District Council (CBMDC), gaps in NHS service provider provision and CCG commissioning arrangements.

By the end of 2020 some children across Bradford and Craven were waiting over 6 months for an IHA. Statutory guidance advises that LAs and CCGs should cooperate to make adoption agencies and panels secure access to timely medical advice and comprehensive information about a child's health so as to avoid unnecessary delays which impact on permanency and placing of children and young people.

National guidance advises that the organising CCG is responsible for commissioning the child's statutory health assessment(s) and that the NHS has a major role in ensuring the timely and effective delivery of health services to CLA.

The existing CLA Health Service has developed over time and has been influenced by a number of factors:

- In the 2006/2018 budget proposal the council advised that they would reduce the CLA numbers in 2 years through improvements to the Early Help Offer and introduction of the Signs of Safety partnership approach to working with families.
- However, in the 2018/20 budget proposals it was indicated that there was an intention to reduce Early Help Offer and at that time the CCGs advised that this would have a direct impact on the most vulnerable sections of local communities, particularly children and family.

The CCGs have expressed their concern around the reduction in qualified health visitors and school nurse capacity across the district and the potential for negative impact on

access to support for the most vulnerable children and their families in the area; commissioning of 0-19 services is not the responsibility of the CCG

It was acknowledged by the CCG there have been increased pressures on the children looked after team in CAMHS and used Future in Mind funding to support the team; further review of this service is required

An LA decision in early 2018 for co-located CAMHS staff in social care to move to the 'Through Care' team within the LA. Financial reductions in school nursing and subsequent impact on service capacity has affected capacity to deliver timely work with families.

A contract for CAMHS substance misuse ended in November 2019 following Best Practice Guidance and because no individuals were being prescribed opioid substitutes.

The Bridge Project commissioned by Bradford Council provides a comprehensive drug and alcohol service for young people aged up to 21 across the district of Bradford.

CAMHS Self-Harm Policy (2018) proposed a change to the pathway so that young people can be triaged by an appropriate mental health professional in Emergency Departments

Baseline Review of Health Support for CLAs

A system wide baseline review of health services provided to children who are looked after was completed in July 2019 and a number of recommendations for change to existing services were identified including a need to address the gap in respect of the employment of Named Doctors in provider organisations. An action plan for change was developed and a multiagency steering group established to support delivery of the action plan.

As a result of the baseline review of health services a revised and improved pathway for health services for CLA and those awaiting adoption for Bradford and Airedale to reduce duplication of health assessments and releasing capacity for paediatricians was developed.

The CLA health services are commissioned as part of block contracts with ANHSFT, BDCFT and BTHFT. The service specification for the BDCFT CLA nursing team was developed and implemented a number of years ago had not been reviewed to update and align to current provision, measurable performance and quality outcome. There is not a service specification for either of the Acute Trusts for health services to CLA, adoption and foster care.

Historically the service has been supported by a small number of paediatricians who have worked over and above their job plans providing additional clinic slots at weekends and out of hours to meet statutory timescales and to address requests for urgent adoption medicals. As individuals have moved on or changed their working patterns and this additional capacity has been removed from the system there has been a negative impact on the service. It was recommended that the Acute Hospital Community Paediatric services should consider whether the funding available via the block contracts had been fully utilised to provide appropriate levels of clinic slots.

It was determined that the provision available for the undertaking of IHAs required increases to capacity to meet intercollegiate guidance. Interim steps were taken to improve the efficiency of the system included:

- NY and BDMC improve their process for alerting the CLA nursing service of the need for an IHA.
- Additional funding for a Band 4 nursery nurse to support the IHA process, this funding was made recurrent from 2020
- A paediatrician vacancy that had not been filled utilised the funding to appoint a locum to support the IHA process.
- non-recurrent funding was identified to extend support of the IHA process whilst the business case was in development.
- Providers developed processes for recharging for IHAs and adoption medicals undertaken for children placed in Bradford from out of area; it is unclear how far this has been progressed
- BDCFT implemented a system for recharging for review health assessments undertaken for children placed in Bradford from out of area
- The BDCFT CLA nursing team worked with CBMDC Children's Social Care Service to ensure paperwork is fully completed prior to being sent in for an IHA thereby reducing the workload of the nursing team and preventing the delay of assessments due to the lack of parental consent form; challenges persist and are included in monthly data compliance Resource was identified to increase nursing establishment by 4 additional Band 6 CLA nurses
- Funding underspend from a safeguarding children's session was used from 1.11.2019 to increase capacity for IHAs whilst the business case was in development

Initial Health Assessment

Statutory guidance states that IHAs should be undertaken by a registered medical practitioner with appropriate training. In some areas of the country the role had advanced nurse practitioner in the IHA process is being explored. The intercollegiate guidelines suggest that for clinicians completing IHAs the minimum requirement includes:-

- Administration session per clinic up to 4 CLA for health assessment per clinic with 42 clinics schedules per annum

Historically the amount of administration time specifically allocated to paediatricians for completing IHA reports has varied between paediatricians across Airedale and Bradford.

It is recognised that face to face element of IHAs for asylum seekers or non-English speaking children takes twice the time of a routine IHA.

Two options were developed with regard to increasing capacity for completing IHAs. BDCFT had agreed to support two nurses to undertake advanced clinical practitioner training which would allow them to undertake IHAs. However it became apparent that the skills the ACP training provided would not be directly relevant to the CLA clinic setting and once trained the ACPs could not sustain competency and therefore nurses withdrew from the course. There were no current national job descriptions for ACP roles in CLA and no clinical supervision available locally.

A small number of GPs were identified who were willing to undertake training to allow them to undertake IHAs. Work was undertaken with paediatricians to clarify the competences required by GPs undertaking IHAs and the sourcing of relevant training and supervision. It was suggested that GPs could be funded at a sessional rate though

it was noted that payment at GPwSI (GP with special interest) rate is proportionally more expensive than standard GP sessional rates due to the provision of their own indemnity. The action of contracting with one of the provider Trusts was explored.

Adoption Work

One Adoption had coordinated adoption panels on behalf of the Local Authorities against West Yorkshire. Adoption medicals were requested by the Local Authority via the paediatric medical secretaries and carried out by consultant paediatricians. There were concerns about local capacity to deliver adoption medicals within timescales required to meet Court dates. Guidance suggests that this work should be undertaken by paediatricians and locally. Paediatricians who also work with potential adopters and attend panel had seen an increase in their workload. Measures taken to address these:-

- Lack of prioritisation and booking adoption medicals as Court dates were arranged to reduced capacity in the adoption medical process to support requests for an urgent adoption medical where the Court requests an urgent review. Systems discussions commenced around redesigning the pathways for access to adoption medical
- Work also commenced to understand whether the process of carrying out adoption medicals on sibling groups was appropriate where some of the children were unlikely to have a permanency placement plan

There has been no change in paediatrician provision for adoption medical, advice to adoption panel (including completion of adult health forms) and attendance at adoption panel.

However, a new single point of access for all adoption requests has been implemented with a single email address shared by both Acute Trusts. Requests for adoption medicals are no longer received by a phone. The single email address is manned daily on a rotational basis by one of three adoption administrators and the requester is provided with the next available slot for a medical either Bradford or Airedale.

A health assessment will only be arranged on receipt of all completed forms and consent.

Further work needs to be completed to ensure integration with the CLA administration to avoid duplication of health assessments and to ensure no delay in initial health assessment.

Further data and audit is required to assess the adequacy of medical capacity and to address the issue of requests for “urgent” adoption health assessments.

Medical Adviser to Fostering Panel

This role includes responding to queries from members of the foster panel regarding the suitability of applicants to be foster carers or special guardians or the implications of health issues for caring for children. The potential foster carer medical is completed by the applicant’s GP (funded by the CCG) and returned to CBMDC who forward it to provider paediatricians who assess the potential foster carer’s medical. The paediatricians suggested that this is a function that could be undertaken by a GP with appropriate training to free up resources for IHAs. Training has been provided locally by the Designated Doctor has been agreed that completion of adult health forms and advice

to panel regarding the suitability of foster carers, family members and others to provide care for children looked after will be taken over by the Specialist GP.

Appropriate training has been provided and once the necessary administrative arrangements are in place paediatricians will cease completing medical advice to fostering panel and the new arrangements will commence.

Designated Doctor for Children Looked After

The Designated Doctor for children looked after should focus efforts through 4 key commissioning themes:

- To plan and inform – strategic commissioning development
- To design and delivery – preventing and tackling health inequalities
- To facilitate and drive – the development of health and care systems
- To buy and report – effectively managing resources

Review of Designated Doctor provision has acknowledged the challenges placed on previous post-holders to complete initial health assessments on children entering care rather than being able to focus on the necessary strategic component of the role which is key to the success of the new model.
A current lack of time allocated as a Designated Doctor role is negatively affecting the Designated Doctors to effectively contribute to service planning interagency working and training.
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Bradford District is an area of high levels of deprivation; many of the children coming into care have experienced long histories of abuse and neglect presenting with such complex needs often requiring multiple interventions and a large invest of professional time to make any impact. It is with these needs in mind that the options have been revised to reflect the discussion.

The preferred option of recruiting 6 PAs Designated Doctor which would fully meet recommended guidance allowing full discharge of statutory strategic function has been agreed; recruitment expected Oct 2021

Named Doctor for Children Looked After

There are currently no Named Doctors for Children Looked After within provider trusts. It was concluded that the role could be made more attractive if linked with vacant community paediatrician PAs and include:-

- Together with designated professionals support all activities necessary to ensure that the organisation meets its responsibilities for looked after children and young people and care leavers
- Advise colleagues, local children's care, social care and other statutory and voluntary agencies on health matters with regards to children looked after
- Work with and liaise closely with other specialist services such as CAMHS, Specialist GPs, sexual health and services for disabled children

- Support and advise the Board of the Health Care Organisation about looked after children and young people and care leavers
- Contribute to the planning and strategic organisation and provider services for looked after children
- Ensure advice is available to other professionals and services across the organisation on day to day issues about children looked after and their families
- Provide advice and signposting to other professionals about legal processes, key research and policy documents.

With the system in place the previous Designated Doctors were effectively fulfilling both the Designated and Named Doctor roles; this can cause a potential conflict of interest.

It should be noted that the Named and Designated professional are distinct roles and as such should ideally be separate post-holders to avoid potential conflict of interest.

Named Doctor role is the responsibility of provider Trusts; Bradford currently have no provision for these posts. For the new clinical model to be sustainable, to be of the required standard and to full statutory duties it is vital to consider the role of Named Doctor for children in care as a measure to assure and improve quality within the system.

The new clinical model will see increased activity in BDCFT who host GPs acting as medical advisers for children looked after, who are responsible for undertaking initial health assessments and provide advice to fostering panel. Further consideration of these posts will be required once the recruitment for Designated Doctor has been completed.

The recommended job plan time for the Named Doctor role is as follows:

Minimum of 1 programmed activity (equivalent to 4hours/week) for Named Doctor role per 400 children looked after this would include training, audit and supervision.

This would equate to at least 12hours (3 PAs) a week across provider Trusts.

A system wide discussion commenced to agree an approach to implementation of Intercollegiate Guidance.

Children Looked After Nursing Team

The CLA nursing team offer support to the IHA and adoption medical processes and are also responsible for carrying out statutory health reviews of each CLA.

- Once every 6 months before a child's 5th birthday
- At least once every 12 months after the child's 5th birthday

At the Intercollegiate Guidelines for CLA nurses recommend:

- A minimum 1.0 WTE children looked after specialist nurse per 100 children looked after
- Consideration should be given to the complexity of caseload geography, population and size of the catchment areas served when considering the required number of children looked after specialist nurses/children looked after

Due to the increasing numbers of CLA requiring support from the CLA nursing team they are obliged to support the support they have been able to provide across wider CLA

health service, this had resulted in some elements of the CLA nurse role not being completed such as attendance at IRO meetings, work with foster carers and training.

Increasing numbers of CLA also resulted in an increase in the workload of the BDCFT administrative staff supporting the wider CLA team. At the time of the report on 31st March 2021, CLA nursing team staffing was:

- 6.44 WTE nursing staff

Additional CLA nursing team staffing required to meet Intercollegiate Guidelines is WTE nursing staff; 7.56

The Service has requested expansion to 14 WTE to reflect complexity of caseload and to meet predicted CLA increases.

This will include a skill-mix including Band 6 and Band 5 nurses, and Band 4 nurses to work alongside CLA nurses

Recruitment has taken place and capacity continues to be reviewed

In addition additional administrative support was requested to provide support across the provider Trusts.

1.0 E Band 3 Admin
1.0 WTE Band 4 Admin
0.5 WTE Data Analyst

In the meantime CLA Band 6 nurses are no longer needed to support paediatric clinics, releasing them to undertake review health assessments and other specific nursing tasks. The newly introduced Band 4 nursery nurse role, as part of a review of the skill mix within the team is to work alongside the paediatricians. This is deemed to have improved the quality of service provided and positively supports the onward referral to relevant services, saving paediatrician time. This was funded by the CCG.

Improved data collection to enable real time discussion around capacity versus demand has been undertaken but it was acknowledged that this required dedicated time to ensure that data is available in a timely fashion and analysed and reports produced.

10. PROGRESS IN IMPLEMENTATION OF NEW CLINICAL MODEL FOR CLA – APRIL 2021

Issues and Opportunities

The multiagency CLA steering group was established and has met weekly with senior manager level representation from ANHSFT, BDCFT, BTHFT and the CCG. The group has also engaged relevant clinical professionals to informed discussions and the Interim Designated Doctor. The groups developed a model which would address the statutory requirements, reduce the waiting lists and use innovative approaches to meet demand in the district?

A delivery plan and timeline for the implementation to meet the start date of the new system model to meet a start date of 01.04.2021.

Delivery Plan

Theme:

- Implement new clinical model – 31.03.2021
- Recruitment and training of Specialist GP – 31.03.2021
- Increase use of integrated – board to inform service planning – 28.02.2021
- Continuous quality improvement – on-going
- Ensure all consent/data sharing issue regarding children entering care are resolved – 28.02.2021

Achievements:

- Presentation of the potential financial impact of the proposed model to systems finance and performance committee – 21.01.2021 - undertaking to provide a response within 2 weeks
- Secured agreement from BDCFT to employ the Specialist GPs
- Development of a local training plan to support Specialist GPs to undertake IHAs
- Develop a trajectory for addressing the backlog of IHAs

Further to this, following the resignation of the two existing Designated Doctors an interim appointment for 3 months (later extended to 6 months) was made to provide strategic leadership and to help develop the new clinical model and a sustainable system model for Designated Doctor and Named Doctor.

A new integrated clinical model for children looked after was implemented in April 2021.

Four out of five Specialist GPs have joined the team. One GP works with homeless individuals and unaccompanied asylum seekers in every day practice and another is trained in substance misuse. This enhances the skill set of the children looked after team.

A revised trajectory has been produced with the intention of clearing the backlog of Initial Health Assessments by September 2021.

- Four GPs are employed by BDCFTA fifth Specialist GP will be recruited

Training has been provided to Specialist GPs in:

- Legal processes and terminology
- Consent and confidentiality
- Health assessment of children looked after
- Permanency
- Care leavers/unaccompanied asylum seekers
- Adverse childhood experiences, brain development and trauma
- Practical aspects of health assessment and child development

All of the appointed GPs have attended Initial Health Assessments with paediatricians.

Initial health assessments are now carried out by Specialist GPs, CLA and paediatricians with specialist nursery nurse support, following allocation from the triage meeting.

Triage Meeting

A weekly triage meeting has been set-up, currently attended by Designated Doctor CLA, Named Nurse CLA, and admin support from CLA health team and managers from CSC.

- When a child becomes looked after the local authority notifies the CLA health team
- The social worker completes the placement plan form on LCS which includes the health consent within the form. The complete placement plan form complete with signed consent is then scanned and emailed to the LAC health team business support email address
- A list of children received into care is prepared weekly for discussion at the triage meeting
- At the triage meeting background information as to why the child is now in care and past medical history is shared in order to allocate to an appropriate GP or paediatrician for initial health assessment
- Shared information will include any known plans for permanency which should help to plan future adoption medicals. However the plan is that all children who become looked after will receive an initial health assessment within the statutory 20 days
- Children placed out of area, children moving into the area and homeless/unaccompanied asylum seekers and children subject to YOT procedures will also be discussed at triage meeting
- It is agreed that CAMHS managers will attend the triage meeting once monthly to discuss any children looked after with specific or complex mental health needs which cannot be addressed through current pathways
- Triage meetings allow timely discussion between health and social care on operational issues such as provision of health assessment for children and young people placed out of area.

11. PRIORITIES FOR THE YEAR 2021-2022

1a New Clinical Model:

- Embedding the new clinical model for health of children looked after
- Ensuring collection of data to evaluate the system and to assess capacity to meet statutory requirements regarding health of children looked after
- On-going training for professionals providing health care to children looked after
- Ongoing and continued measures to demonstrate improvements to quality, e.g. use of audit.
- To ensure that children and young people remain the focus of improvement and to demonstrate their views and wishes around service development.
- Continued exploration with system colleagues regarding a single point of health access for children looked after.

1. Progression of recruitment and appointment of Designated Doctor CIC and offer support to the progression of appointments of Named Doctor in the provider Trusts.
2. Review and Evaluate the capacity of the Designated Nurse role as currently this is a combined Safeguarding and CIC post which does not afford sufficient oversight of CIC.
3. Evaluation and review of health provision for children placed out of area with system colleagues.
4. To continue to review the processes for adoption medicals and completion and return of adult health forms.
5. To build stronger relationships to gain a system understanding of the needs of Unaccompanied Asylum seeking children and young people.
6. Completion, review and action planning of benchmarking document to provide assurance.
7. To continue to raise discussions across the system regarding the mental health needs, trauma based therapy and CAMHS provision for children looked after.
8. To continue to raise discussions across the system regarding SEND provision of CIC.
9. Continue to highlight blocks that affect the smooth process for children through the system and escalate issues that need system support.

Appendix 1

National Context

At 31st March 2020 the number of children looked after by local authorities in England increased by 2% to 80,080 from 78,140 in 2019. This is an equivalent of 67 per 100,000 children, up from 65 in the last year.

The number of children starting to be looked after decreased to 30,970 in March 2020 from March 2019 – down 3%.

The number of children ceasing to be looked after in the year ending March 2020 was 29,590, similar to the previous year.

The number of children looked after who were adopted in the year ending March 2020 was 3,440 – down 4% on the previous year. This continues to fall since a peak of 5,360 adoptions in 2015.

The broad characteristics of children looked after in the year ending March 2020 remained similar to previous years – 56% male, 44% female.

The largest age group (39%) of looked after children were aged 10-15 years; 24% were aged 16 years and over, 18% were aged 5-9 years, 14% were aged 1-4 years and 5% were aged under one year.

The majority of looked after children are of white ethnicity (74%), 10% were of mixed ethnicity, 4% were of Asian or Asian British ethnicity, and 7% were of Black or Black British ethnicity. Other ethnic groups were 4%.

At 31st March, there were 5,000 unaccompanied asylum seeking children, down 3% on the peak of 5,140 UASC in March 2019. UASC are a distinct group of CLA and currently represent around 6% of all CLA.

UASC are generally male – 90% - and older – 86% are aged 16 and over which is up from 85% in 2019 and 81% in 2018.

UASC are children who have applied for asylum in their own right and are separated from both parents and/or any other responsible adult. Local authorities have a legal duty to provide accommodation for these children.

At 31st March 2020, children looked after:

- **under a care order** – a court order placing a child in the care or supervision of a local authority - 77% - up from 75% in 2019.
- **under a voluntary agreement** – this allows the local authority to provide accommodation for a child where there is parental consent, or when no-one with parental responsibility is in place – 17%, down from 18% in 2019.
- **under a placement order** – a court order allowing a local authority to place a child for adoption – 6% - down from 7% in 2019.

Detained for child protection or under youth justice legal statuses – each less than 0.5%

Appendix 2

	April 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	April 21	May 21
Number of CYP into care – notified	28	32	72	35	35	52	24	38	36	30	27	26	18	28
Number of CYP Awaiting an Initial Health Assessment	152	138	138	125	144	177	142	190	195	209	160	134	115	134
Number of CYP with consent											84	53	57	53
Number of CYP without consent											75	81	58	81
Number of Adoption Medicals			14	3	4	4	2	3	2	1	0	23	21	0
Number of Looked after Children			1293	1343	1362	1378	1374	1378	1374	1387	1360	1352	1337	1344
Number of Bradford children placed out of District			305	302	300	300	295		295	311	307	313	298	282
Number of external LAC placed in Bradford	21	10	299	299	302	305	312	305	312	297	305	311	313	
Number of IHAs due within 20 working days			52	50	51	34	27	21	30	38	28	30	0	22
Number of IHAs completed within 20 working days	0	0	6	8	8	0	0	2	0	0	1	0	0	0
Number of Initial Health Assessments Completed	8	6	7	15	14	15	18	41	11	11	23	21	6	8
Average Time from CYP becoming LAC to IHA completion (working days)	105	88	45		60	151	135		152	170	126	147	109	
Children Looked After and Nursery Nurse Attendance	100 %	100 %	100%	100 %	100%	100%	100%	100%	100%	100%	57%	100%	100%	100%

Review Looked after Children Performance – Review Health Assessments

	April 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	April 21	May 21
Number of CYP on Review Health		1039	1223		1038	1038	1038		1058	1117	1107	1137	1121	1125

Assessment caseload														
Number & % of CYP on caseload with overdue RHA		138/13%			148/14%	162 16%	204 20%		172 16%	202 18%	211 19%	154 14%	182/16%	176/16%
Number of CYP on Review Health Assessment caseload aged 0-4 years						227	209		227	231	195	200	214	224
Number and % of CYP aged 0-4 years on caseload with overdue RHA						59 27%	58 28%		75 33%	82 35%	73 37%	59 30%	78/36%	78/35%
Number of CYP on Review Health Assessment caseload aged 5-19 years						818	829		831	827	912	937	907	901
Number and % of CYP aged 5-19 years on caseload with overdue RHA						123 15%	146 18%		97 12%	120 15%	138 15%	95 10%	104 11%	98/11%
Number of Review Health Assessment due		70			84	99	110		106	122	84	83	66	84
Number and % of RHAs completed within timescales		16/23%			30 36%	19 19%	18 16%		26 25%	27 22%	18 21%	19 23%	16/24%	20/24%
Number of Review Health Assessment Completed						44	72		54	55	46	97	65	52
Number of RHAs with SDQ requested													26	20
Number of RHAs with SDQ returned													10	5
% of RHAs with SDQ returned													38	25%
Review Health Assessment completed – face to face										39	31	81	61	49
Review Health Assessment completed – none face to face (including video)										16	15	16	4	3

Number of children with an EHCP														319
Number of children without an EHCP														1025
Number of children with an EHCP at Initial Assessment														1
Number of children with an EHCP at Review Assessment														

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