CITY OF WOLVERHAMPTON COUNCIL

Corporate Parenting Board Meeting

Thursday, 19 November 2020

Dear Councillor

CORPORATE PARENTING BOARD - THURSDAY, 19TH NOVEMBER, 2020

I am now able to enclose, for consideration at next Thursday, 19th November, 2020 meeting of the Corporate Parenting Board, the following reports that were unavailable when the agenda was printed.

Agenda No	Item
9	**The House Project Wolverhampton (Pages 3 - 20)** [To receive the annual update report on the Wolverhampton Local House Project.]
10	**Wolverhampton Children and Young People in Care Health Annual Report (Pages 21 - 70)** [To receive the Wolverhampton Children and Young People in Care Health Annual Report 2019 – 2020.]

If you have any queries about this meeting, please contact the Democratic Services team:

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Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Corporate Parenting Board
19 November 2020

Report title	The Wolverhampton House Project Annual Report – One year On.	
Cabinet member with lead responsibility	Councillor John Reynolds Children and Young People	
Wards affected	All wards	
Accountable director	Emma Bennett, Director of Children's Services	
Originating service	Children and Young People in Care	
Accountable employee	Julia Tompson Tel Email	Supported Accommodation Manager 01902 555612 Julia.tompson@wolverhampton.gov.uk
Report to be considered by	Corporate Parenting Board	19 November 2020

Recommendation for action:

The Corporate Parenting Board is recommended to:

1. Receive the annual update report on the Wolverhampton Local House Project.

Recommendations for noting:

The Corporate Parenting Board is asked to note:

1. The progress of the Wolverhampton House Project within the first twelve months.

1.0 Purpose

1.1 The purpose of this report is to inform the reader of the progress of the House Project as it reaches the milestone of the 12 months.

2.0 Background

2.1 The City of Wolverhampton Council was approached by the National House Project with a view to delivering a local House Project in Wolverhampton supported by a local funder. In July 2019, cabinet endorsed the recommendation to implement a local House Project for Care Leavers within the City of Wolverhampton. The House Project framework gives greater placement choice for young people to be supported into independence and gives the additionality of peer support contributing to reducing feeling of loneliness and isolation. The theory of change that underpins the project is based upon improving young people's outcomes and wellbeing, supporting positive changes to enable care leavers to live successful healthy adult lives.

2.2 The successful implementation of a local House Project compliments the existing accommodation options available to the care leavers within Wolverhampton. The Wolverhampton House Project was officially launched on 28 October 2019, during National Care Leaver week. Relevant stakeholders, the young people identified, their carers and Social Workers were invited to learn more about the project and to celebrate the launch. Young People from other House Projects also attended to provide encouragement and open discussions with young people from Wolverhampton to inform them of the success of their projects and the benefits from participating. The launch was a huge success and attended by most young people that were invited. Ten young people who applied to be on the project were successful in being offered a place.

3.0 Progress

Young People

3.1 Despite the challenges faced with Covid-19, the young people have progressed extremely well. The ethos of the House Project is around promoting a sense of community and working in a group is instrumental in this. The House Project staff have worked tirelessly to continue to develop this sense of community by holding virtual meetings, and meeting with young people face to face to support them to develop the skills they need to progress.

3.2 At the time of writing this report, we have five young people now moved into their homes, two waiting for their keys, and another is actively sourcing a property in the area of her choice. We have recognised that two of our young people are not ready to progress into independence and still need support to develop their independence skills and their ability to keep safe, so they will be progressed at their own pace and will be invited to be part of the next cohort of young people. It is important to note that this is not seen as a failure but more a commitment to our young people and an acceptance of the diverse needs of our young people, and the support offered from the House Project will continue until they are ready.

Partnership Working

3.3 Partnership working has been instrumental towards the success of the first twelve months of the project:

Wolverhampton Homes (WH)

3.4 Wolverhampton Homes is one of the main partners that have shown their full commitment to the project and are active members of the House Project Steering Group. More recently they participated in virtual meetings with the young people, acknowledged and understood their needs, and sourced properties in the areas that are important to them, which has enabled them to access their support networks.

Reconomy

3.5 Reconomy, as with Wolverhampton Homes, have shown their full commitment to the project and again are active members of the House Project Steering Group. Despite the challenges faced with Covid-19 and key staff members being furloughed, they have continued to support the project. More recently they have committed to offering apprenticeships to all young people participating in the House Project.

The next steps

3.6 The House Project will continue to support the young people whilst they live in the own properties, this support will continue for as long as the young people feel they need it.

3.7 A virtual event was held on 23 September 2020 with young people inviting them to be part of the second cohort of the project. The event was well received and there are already 7 young people interested. The team are currently in the process of supporting the young people to complete their application forms.

The House Project is also already identifying young people for the third cohort.

4.0 Financial implications

4.1 The House Project was funded in its first year by troubled families, due to an underspend during this year, £25,000 was carried forward into year 2.

The financial model of the House Project is based on supporting young people to step down from regulated placements (internal and purchased foster care and residential care) in to House Project (HP) properties. The Covid-19 pandemic has delayed young people from leaving care and move on through the House Project. Finance have projected that the annual savings for the Project up to 31 March 2021 are estimated at approximately £109,000.
[JD/16112020/A]

5.0 Legal implications

5.1 There are no direct legal implications arising from this report.

The contract with the National House Project has been signed and sealed via the City of Wolverhampton's legal services.
[SB/13112020/P]

6.0 Equalities implications

6.1 An equalities analysis has been completed and is regularly reviewed via the House Project Steering Group. This has raised no concerns.

The young people accessing the House Project are already disadvantaged and outcomes for young people in care and leaving are generally poorer than their peers. Traumatic experiences before entry into care can also cause difficulties, which may affect a young person's behaviour, self-esteem or trust in authority figures. The Local House Project supports the ambition to improve opportunities and reduce the disadvantage that care leavers face in society, and the project provides ongoing support via peers and staff for as long the young people require. It is intended that the impact of this support will enable young people to transition into adulthood and independent living successfully.

7.0 Climate change and environmental implications

7.1 There are no direct climate change and environmental implications arising from this report.

8.0 Human resources implications

8.1 There are no direct human resources implications arising from this report.

The recruitment of an additional facilitator has been approved via the necessary processes.

9.0 Corporate Landlord implications

9.1 There are no direct Corporate Landlord implications resulting from this report. A report was presented and approved via Cabinet, Children's Services (2 March 2020), Cabinet, Housing (3 March 2020) and Strategic Executive Board (10 March 2020) to make available properties for letting within the Housing Revenue Account.

10.0 Health and Wellbeing Implications

10.1 The theory of change that underpins this project is based upon improving young people's wellbeing and outcomes, supporting positive changes to enable care leavers to live healthy, successful lives.

11.0 Covid-19 Implications

11.1 There are no Covid-19 implications arising from the recommendation of this report.

12.0 Schedule of background papers

12.1 There are no background papers.

12.0 Appendices

12.1 Appendix 1: The Wolverhampton House Project Annual Report

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THE
HOUSE PROJECT
Wolverhampton

ANNUAL REPORT

OCTOBER 2019 – OCTOBER 2020

Author: Julia Tompson – Supported Accommodation Manager – Children and Young People in Care Service

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Background

The City of Wolverhampton Council were approached by the National House Project with a view to delivering a local House Project in Wolverhampton supported by a local funder. In July 2019, cabinet endorsed the recommendation to implement a local House Project for Care Leavers within the City of Wolverhampton. The House Project framework gives greater placement choice for young people to be supported into independence and gives the additionality of peer support contributing to reducing feeling of loneliness and isolation. The theory of change that underpins the project is based upon improving young people's outcomes and wellbeing, supporting positive changes to enable care leavers to live successful healthy adult lives.

The successful implementation of a local House Project compliments the existing accommodation options available to the care leavers within Wolverhampton.

Launch

The Wolverhampton House Project was officially launched on 28th October 2019, during National Care Leaver week. Relevant stakeholders, the young people identified, their carers and Social Workers were invited to learn more about the project and to celebrate the launch. Young People from other House Projects also attended to provide encouragement and open discussions with young people from Wolverhampton to inform them of the success of their projects and the benefits from participating. The launch was a huge success and attended by most young people that were invited. Ten young people who applied to be on the project were successful in being offered a place.

Twelve months on:

Steering Group

The Steering Group continues to drive the project forward by meeting on a monthly basis. It has been agreed that due to the positive drive of the project, this group will meet bi-monthly moving forward. A member of the Care Leavers Independence Collective attends this meeting representing the young people and is now updating the Steering Group on the views of the young people accessing the project.

Psychological input

A key element of Local House Project provision is psychological support to ensure that projects are run safely', with a particular recognition of the importance of developing a trauma-informed approach to the support of organisations, staff and young people. Ideally this should have been in place at the beginning of the project but due to difficulties with sourcing this facility, there was a delay with the start of this. The National House Project has recognised that this is a generic issue and moving forward are now looking to commission this for local authorities and include this within the partnership contract.

Changing Minds have been contracted for 12 months to provide this to the Project. This service is being delivered by Consultant Clinical Psychologist with experience of working with young people in, or leaving, care and the systems around them. Their role includes:

1)The facilitation of specialist psychological team formulations to create a shared understanding of the young person and their strengths and needs.

2) A monthly psychological consultation day which provides ongoing psychological advice and consultation for the project, supporting staff to feel able to better manage the needs of the young people, with space for staff reflection/self-care and support.

Staffing

Staff members attend a monthly Community of Practice training day with the National House Project and other local House Projects, where good practice ideas and moderation of the learning programme takes place. In addition, staff attended 3 days training with the National House Project in February 2020, where the focus was on trauma informed practice. The National House Project also provides monthly consultations with the House Project staff.

A 12-month secondment for an additional House Project Facilitator has been approved and recruitment to this post is currently in progress. It is important to note that the House Project staff have worked tirelessly throughout the pandemic to promote the ethos of the project and to maintain positive relationships with the young people, and they are commended for this commitment not only by the City of Wolverhampton, but also from the National House Project.

Staff have also been commended by the National House Project AQA lead for their passion and commitment in thinking outside of the box, when working with the young people. Note the commendation:

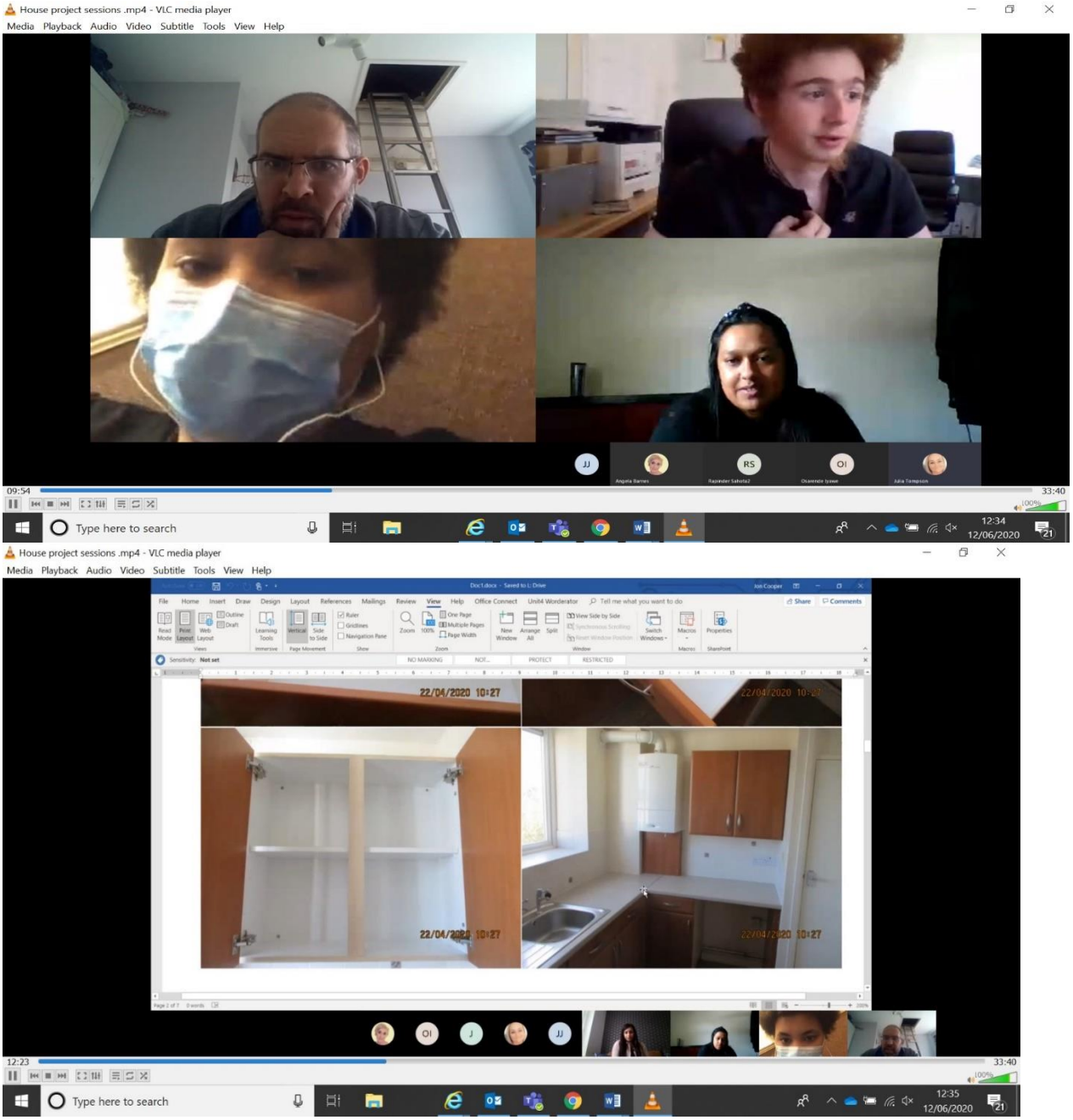
"I have just finished reviewing OI's work on the Decision-Making module.
Wow! I am so impressed with the work that OI has done and the way he has been supported to achieve what was obviously a big step up for him. The evidence is great and particularly the way he has been challenged and supported by you all and by his peers. There is a real sense here of a team working together and supporting each other. The pitch videos are excellent, and I like the way that you as adults have helped the young people to share and develop their ideas. This is exactly what the House Project and ORCHIDS are all about."

In addition, a Supported Accommodation Apprentice post has been approved, which will be ringfenced for Care Leavers. It is ended that the post holder will support the House Project team with the participation sessions.

Partnership working

Partnership working has been instrumental towards the success of the first twelve months of the project:

Wolverhampton Homes – one of the main partners have shown their full commitment to the project and are active members of the House Project Steering Group. More recently they participated in virtual meetings with the young people, acknowledged and understood their needs, and sourced properties in the areas that are important to them, which has enabled them to access their support networks. In addition, they have provided decoration allowances which has enabled the young people to have choice around how they decorate their homes.



Reconomy – as with Wolverhampton Homes, have shown their full commitment to the project and again are active members of the House Project Steering Group. Despite the challenges faced with Covid-19 and key staff members being furloughed, they have continued to support the project. More recently they have committed to offering apprenticeships to all young people participating in the House Project.

Communications

The Wolverhampton House Project now has a microsite, which is linked to the National House Project Website – Wolverhampton was the first House Project to launch their microsite. This site is used to update on local information and celebrate the success of our young people.

In addition to the website, we have a Twitter page and a Facebook page. Within these social media platforms, the team provide:

- Weekly updates - weekly session updates / photos/ activities that they have achieved/ milestones/ portfolios updates
- motivational quotes/ key events – mental health awareness/ festival/ celebrations

The sites are also used to link in with businesses/partnering agencies and external services. The project is followed on Twitter by Mark Riddell, MBE, National Advisor for Care Leavers. It is also receiving positive feedback. Recently, the project posted that they are providing every young person in the project with a starter pack, complete with all the basic essential items needed to set up home. A comment was received from "Out loud and Tune in" stating:

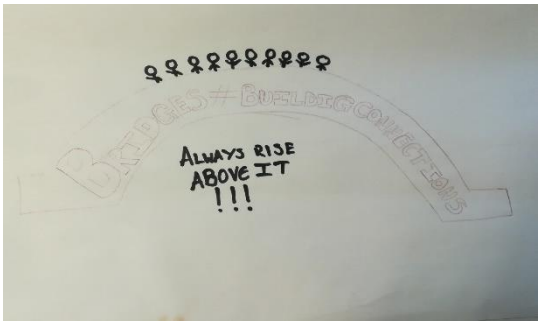
"Imagine if all Care Leavers going onto independence could get a starter pack like this. Maybe it's something we should look at for our young people in Stoke on Trent"

Project Base

The project base was kindly donated and fully decorated by one of our partners, Wolverhampton Homes. Capital assets have recently completed renovation works on modernising the kitchen to enable young people to learn the necessary skills to progress to independence. Reconomy, our partner on the project, kindly purchased white goods: cooker, fridge freezer and washing machine to compliment it. However due to the pandemic, the opening of this office has been delayed, and at present there is no opening date. The House Project Team are working with Corporate Parenting (as part of Co-production)and the Children and Young People in Care Reach Leaving Care Team, to ensure that the base is ready to offer a hub for young people across the City of Wolverhampton as soon as we are able to do so.

Progression of the Young People

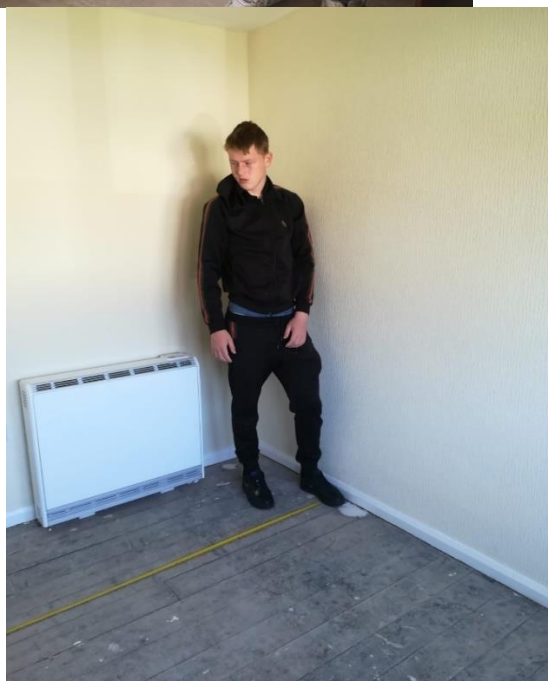
Despite the challenges faced with Covid 19, the young people have progressed extremely well. The ethos of the House Project is around promoting a sense of community and working in a group is instrumental in this. The House Project staff have worked tirelessly to continue to develop this sense of community by holding virtual meetings, and meeting with young people face to face to support them to develop the skills they need to progress.
The young people have created their own group name and logo, "Bridges#, building connections and the project has worked with our design team to develop the logo:

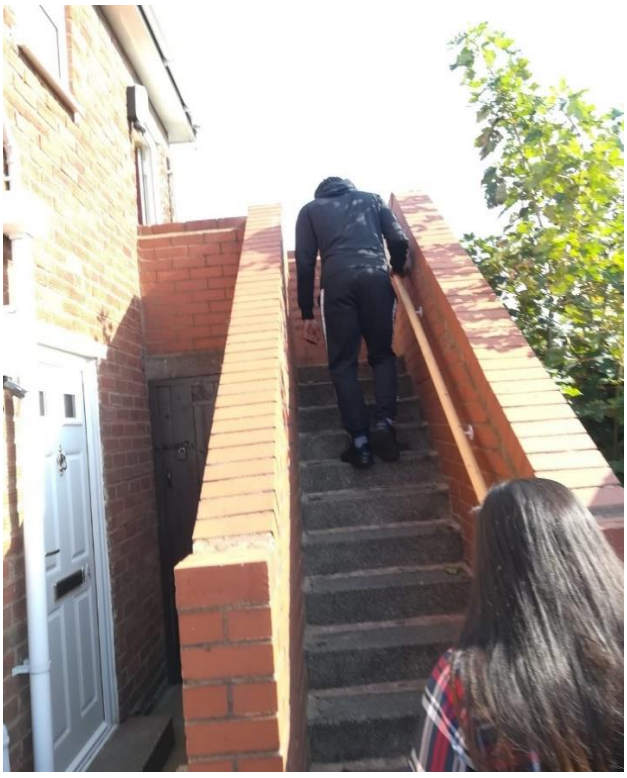


There is also a requirement for the young people to complete a learning programme, which constitutes the completion of 13 modules, all of which will develop the skills needed for them to progress into independence. They focus on an ORCHIDS framework, **Ownership, Responsibility, Community, Homes, Independence, Developmental** and **Sense of wellbeing.** The modules are as follows:

- Application and Interview
- Our rules base and identity
- Learning plan
- Safety plan
- Cook and share
- Residential
- Do something creative
- Independence
- Home
- Decision Making and Care Leavers National Movement
- Power, pitch and purpose
- Network event, Businesses and EET providers
- Benefit my community

All the modules are interlinked, and our young people have completed all those that they are able to complete without Covid restrictions, such as the Residential, Network event and Benefit my community. There are no plans to complete the three modules until restrictions are lifted but this has not prevented the young people from progressing. At the time of writing this report, we have four young people now moved into their homes, two in the process of decorating and furnishing theirs. One young person is waiting for the keys, and another is actively sourcing a property in the area of her choice. We have recognised that two of our young people are not ready to progress into independence and still need support to develop their independence skills and their ability to keep safe, so they will be progressed at their own pace and will be invited to be part of the next cohort of young people. It is important to note that this is not seen as a failure but more a commitment to our young people and an acceptance of the diverse needs of our young people, and the support offered from the House Project will continue until they are ready.





Young People are continuing to invest in the project and there is a sense of community amongst the group. Young people are keeping in contact since moving into their own homes and checking in on each other. There have been noticeable developments in their skills as they transition into adulthood and they have recognised that being part of the House Project has enabled them to progress. One young person recently commented:

"I am so glad that I chose to do the House Project, I'm moving into my flat feeling 100% ready, rather than moving in and struggling. I think every young person in care should be part of it"

We have one young person who has become a member of the Care Leavers National Movement (CLNM). This group is made up of care leavers from Local House Projects across the country. They use their skills as expert advisers to develop House Projects and improve outcomes for all young people leaving care. They are currently promoting the need for the recognition of Digital Poverty amongst young people leaving care.

One Young Person's journey

Reece attended the House Project launch in October 2020 and was reserved and nervous about being on the Project, expressing how he lacked confidence and did not like being part of groups with other young people. Reece felt that he was never good at academic work at school and his tutors always made him feel "dumb". Reece told the staff at The House Project during initial conversations, "If I don't work with you, pick your calls up or come to groups, you will just leave me alone, won't you"- this was his way of building a wall as he felt he had no confidence in his education/ academics and "everyone gave up on him".

Reece initially attended the group sessions; however, he was not always punctual, left early or did not engage fully in the sessions. Having done some one to one sessions with Reece, a relationship was built between Reece and the House Project staff and he was supported to get to the sessions.

Reece started to enjoy the sessions and quickly showed his leadership skills. He encouraged others to be part of the group work and when his peers did not engage or feared doing a particular piece of group work, he was always a positive influence. Reece would sit next to peers that were shy or not as confident to include them in the groupwork and also conversation.

Reece initiated playing interactive board games in the session and this helped the group to bond quickly. The games were something that everyone looked forward to in the sessions and it felt like a real treat to the young people. He quickly made a strong connection with peers in the group and started independently coming to groups.

Reece's personal development has been huge during the last year. He attended sessions in the beginning of the project, sometimes angry, that would result into tears. This was due to a relationship breakdown with his mother. Reece hated being in care, whilst his other siblings were living with his mother. Reece would often attend sessions and ask to speak to staff separately as he had fallen out or had an argument with his mother.

One to one sessions and daily telephone conversations helped Reece deal with his emotions as he did not want external support from agencies. During Christmas, in a quiet session, Reece sang a rap for his mother. This was recorded and then sent to his

mother. This was the point where Reece received a hug and a kiss from his mother, after a long time. From this point, Reece and his mother's relationship started to develop positively. During lockdown Reece moved into his mothers house and went on his first family holiday.

Reece's relationship with his family and mother went from strength to strength. Reece also met a girlfriend which helped with his independence and confidence further.

Reece confidently completed his portfolio for the House Project independently with House Project staff and sought no support from placement. Although Reece felt he was not academically capable, his creative skills overpowered this. He confidently lead and planned a residential for his group, planned for a Pitch to managers to raise money for the Residential and a community/ network event to awareness of the House Project. Reece also had great plans for the House Project base and designed the logo for the Project. Reece was also able to restoratively amend historic issues that he had with peers.

Reece has shown great budgeting skills during his move into independent living. Reece prioritised what he felt was an essential, finding the best deals. The relationship between Reece and his mother is still strong and his mother has been part of Reece's journey to independent living.

During the last year, Reece has grown in patience, maturity, confidence and independence holistically. Reece has a great sense of humour that is infectious, and he can make any bad day/ situation into a positive one. Reece is really caring, helpful, protective of his loved ones- including his leaving care staff and is not afraid to ask for help or admit his failures/ wrong-doings.

Financial Implications

The House Project was funded in its first year by troubled families, due to an underspend during this year, £25,000 was carried forward into year 2.

The financial model of the House Project is based on supporting young people to step down from regulated placements (internal and purchased foster care and residential care) in to House Project (HP) properties. The Covid 19 pandemic has delayed young people from leaving care and move on through the House Project. Finance have projected that the annual savings for the Project up to 31st March 2021 are estimated at approximately £109,000.

The Next Steps

The House Project will continue to support the young people whilst they live in the own properties, this support will continue for as long as the young people feel they need it.

A virtual event was held on 23rd September 2020 with young people inviting them to be part of the second cohort of the project. The event was well received and there are already 7 young people interested. The team are currently in the process of supporting the young people to complete their application forms.

The House Project is also already identifying young people for the third cohort.


THE NATIONAL
HOUSE PROJECT
#NHP
ADVANTAGE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Agenda Item No: 10

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Corporate Parenting Board

Health Services for Children and Young People in Care Annual Report
(Aug 2019 – July 2020)

Date of Meeting: 19/11/20.

TITLE OF REPORT:	Health Services for Looked After Children Annual Report Aug 2019 – July 2020
PURPOSE OF REPORT:	This report aims to summarise the key areas of development and outcomes achieved by local health service providers during the identified time frame.
REPORT WRITTEN BY:	Fiona Brennan, Designated Nurse Children and Young People in Care, Dr Steph Simon, Designated Doctor Children and Young People in Care, **Wolverhampton Clinical Commissioning Group** Dr Wendy Harrison Frazer, Consultant Counselling Psychologist - **CAMHS**
REPORT PRESENTED BY:	Fiona Brennan and Dr Simon Dr Wendy Harrison Frazer - **CAMHS**
EXECUTIVE RESPONSIBLE	Sally Roberts, Chief Nurse and Director of Quality, **Wolverhampton Clinical Commissioning Group**
KEY POINTS:	The report was collated with information provided by Wolverhampton Clinical Commissioning Group. The final copy presented to the Corporate Parenting Board will include Provider information. ***CAMHS report has been formatted and incorporated within this report by WCCG.***
CORPORATE PARENTING BOARD ACTION REQUIRED:	Decision Approval ✓ Assurance

Implications on resources	

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1. Foreword

- This Report outlines how the Wolverhampton Clinical Commissioning Group (WCCG) work with provider and partner agencies in discharging statutory responsibilities to promote the health and wellbeing of Children and Young People in Care (CYPiC), who are the responsibility of Wolverhampton (W-ton) City Council (WCC).

- Challenges and good practice will be highlighted, with recommendations for future development.

- W-ton's revised CYPiC Corporate Parenting Strategy is based upon the NICE Guidance Quality Statements that underpin the recommendations for the health provision for these children.

- The report includes the position at the end of July 2020 and an update of progress relating to the introduction and implementation of revised service specifications and commissioning arrangements for CYPiC health services. Please note the timing varies slightly for Royal Wolverhampton Trust due to reporting structures (July 19 – June 20).

2. Purpose of Report

- To provide assurance to members of the Corporate Parenting Board that action is being taken to deliver on-going improvement to health outcomes for CYPiC and identify areas requiring improvement.

3. Wolverhampton Clinical Commissioning Group (WCCG)

- Working Together to Safeguard Children states that Clinical Commissioning Groups (CCGs), as major commissioners of local health services, should employ or have in place a contractual agreement to secure the expertise of Designated professionals for CYPiC. They take a strategic and professional lead across the health community on all aspects of CYPiC, including provider organisations which are commissioned to undertake this service.

- In line with intercollegiate guidance, the WCCG employ a full time Designated Nurse for CYPiC (DN CYPiC), and a part time (1 day a week) Designated Doctor for CYPiC (DN CYPiC).

- WCCG remain committed to working with stakeholders and commissioned services to ensure the health, safety and well-being of our CYPiC, wherever they are placed. Advocating for this cohort of children is a key part of our approach to commissioning, with a focus on quality.

- There is a national requirement to develop five-year Sustainability and Transformation Plans (STP) covering all areas of NHS spending in England and linking with all national strategic priorities for health, with the aim of bringing local NHS organisations together to ultimately improve the health and wellbeing of local people, and the prosperity of the population through providing standardised, streamlined and more efficient services.

- Wolverhampton CCG forms part of the Black Country and West B/ham (BCWB) STP along with Walsall, Dudley and Sandwell. Designated and Named Professionals work to ensure we fulfil our inter-agency safeguarding responsibilities across the STP footprint as well as ensuring local arrangements remain in place.

- Due to the COVID 19 Pandemic there is an unprecedented demand for health services, with the situation are changing daily. Staff members are required to work under exceptional circumstances with the expectation that they may be redeployed outside of their usual sphere of practice to support the delivery of patient services.

- There is no change to statutory safeguarding functions under COVID 19. The CCG remains legally accountable. We are committed to ensuring that safeguarding remains business critical across the CCGs and partnerships. We are in daily contact with our regional and NHSE national leads monitoring changes in statutory functions as well as identifying gaps in services as non-safeguarding staff are redeployed to other areas. We review guidance as it arrives and ensure that safeguarding partners are informed of changes.

- Interim health guidance for Wolverhampton NHS health providers, Primary Care, Social Workers, and Foster Carers in light of COVID 19 was developed to ensure that as partners we continue to prioritise the physical and mental health of our CYPiC through unprecedented times (Appendices 1, 2, 3 &4)

- Raising the profile of CYPiC within LA and health safeguarding contractual standards has been a key task for the DN CYPiC in ensuring we do not lose sight of this most vulnerable group with the dangerous assumption they are safe by definition of status. This includes CYPiC placed into Wolverhampton by other authorities in unregulated placements. Notification processes and communication of risks by originating to hosting area needs to improve oversight and influence local commissioning arrangements. This has been referred to WST Scrutiny and Assurance group and remains a topic of discussion at both regional and national NHSE forums.

3.1 Core health activities

- The core health activities that require commissioning for CYPiC relating to statutory duties are:

    - **Initial Health Assessments (IHA)** - The initial health assessment should take place in time to inform the child's first CYPiC review within 20 working days of entering care.
    - **Review Health Assessments (RHA) -** The review of the child's health plan must take place once every six months before a child's fifth birthday and once every 12 months after the child's fifth birthday.
    - **Care Leaver Summaries (LCS)** - Care leavers should be equipped to manage their own health needs wherever possible. They should have a summary of all health

records (including genetic background and details of illness and treatments), with guidance on how to access a full copy if required.

- **Adoption Reports** - the collation of reports for adoption and fostering panel.

- When Children and Young People (CYP) are placed in secure accommodation they undergo a Comprehensive Health Assessment Tool (CHAT) undertaken by an independent nurse professional commissioned by Care UK. Often there is no communication in respect of health needs with the placing provider service and there is a delay in sending the health information back to Wolverhampton. There is no national standard pathway to ensure that all CYP placed in secure accommodation undergo a health assessment in a timely manner, and a topic of discussion within NHSE national forums of which the DN CYPiC attends.

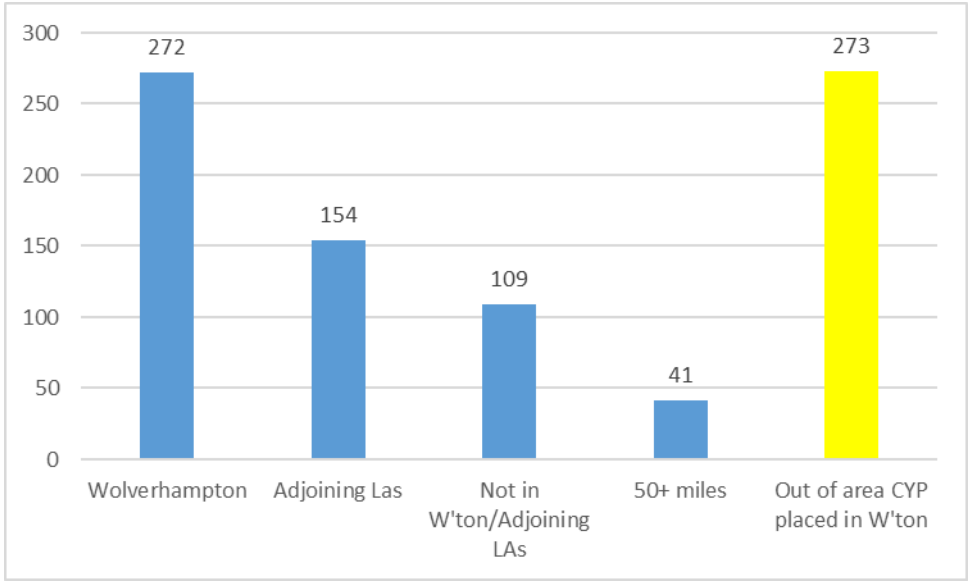
3.2 Demographics and Current Commissioning Arrangements

- Research suggests that the further away CYP are placed from originating authority, the more disadvantaged they are in terms of having their health and social needs met, therefore a revised CYPiC service specification in April 2018 saw the commissioned Provider health service, Royal Wolverhampton NHS Trust (RWT) extend their health care provision to include all children placed outside of Wolverhampton Local Authority, within a 50-mile radius

- Wolverhampton continues to have a relatively high number of CYPiC, standing at 576, with a significant number of our children placed out of City.

- There are 273 CYPiC placed in Wolverhampton by other local authorities (June 2020)

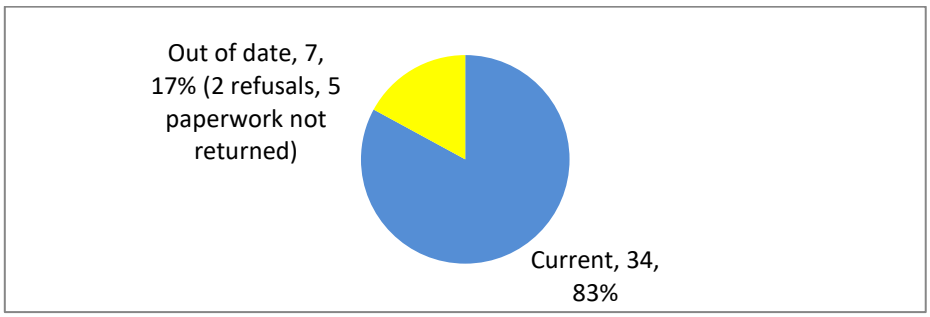
Figure 1



- Only 7% of our children are currently placed further than 50 miles away, a 1% decrease as reported in 2019. The WCCG remain responsible for coordinating the health assessments

for these children, and request hosting area's to complete on our behalf. Payment is made in line with national tariff following robust quality assurance.

Figure 2 RHA's 50 miles plus



- WCCG continues to work to support a more equitable and consistent approach for this most vulnerable cohort, including;

  - Direct contact with Designated Professionals regionally and nationally to ensure timely contact should an issue arise around health care provision.
  - Quality assurance of all statutory health assessments undertaken
  - Presence of DN CYPiC at relevant forums for those placed 50 miles plus, including MASE, and LA strategy /care planning meetings
  - Process in place to escalate concerns to the DN CYPiC and WCCG Children's Commissioner should there be any issues around transition/referrals for universal plus services, in particular CAMHS
  - Monitoring and quality assurance of health provision within specialist placements through the External Placement Panel (EPP).

4 Quality, Governance and Performance

- The Royal Wolverhampton NHS Trust (RWHT) are the current commissioned health Provider for CYPiC including statutory health assessments
- Black Country Partnership Foundation NHS Trust are the commissioned Provider of CAMHS, offering a specialist service to CYPiC.
- During the reporting period there has been a decrease in compliance around Provider timescales for statutory health assessments, and there remains significant progress to be made to achieve 95% target. However the WCCG have had assurance through reporting arrangements that whilst timescales not met, all RHA's are completed and quality assured with exceptions escalated.
- Provider exception reports show that non-compliance is in part due to staffing levels within the CYPiC health team, delays in recruiting staff, and a lack of contingency planning following the extension of service to 50 miles. It has been further impacted by the redeployment of 0-19

service staff due to COVID revised models of working, resulting in them ceasing to support completion of assessments in April 2020.

- There have been added challenges across the system including data accuracy and timeliness of requests by the local authority. Designated and Named professionals are working together with the local authority to address the system issues through the CYPiC Health Steering Group led by the WCCG.

- The 0-19 service will resume the completion of assessments in Sept 2020 as part of the Covid19 restoration and recovery plan, resulting in increased compliance and any backlog being addressed by the end of Sept 2020.

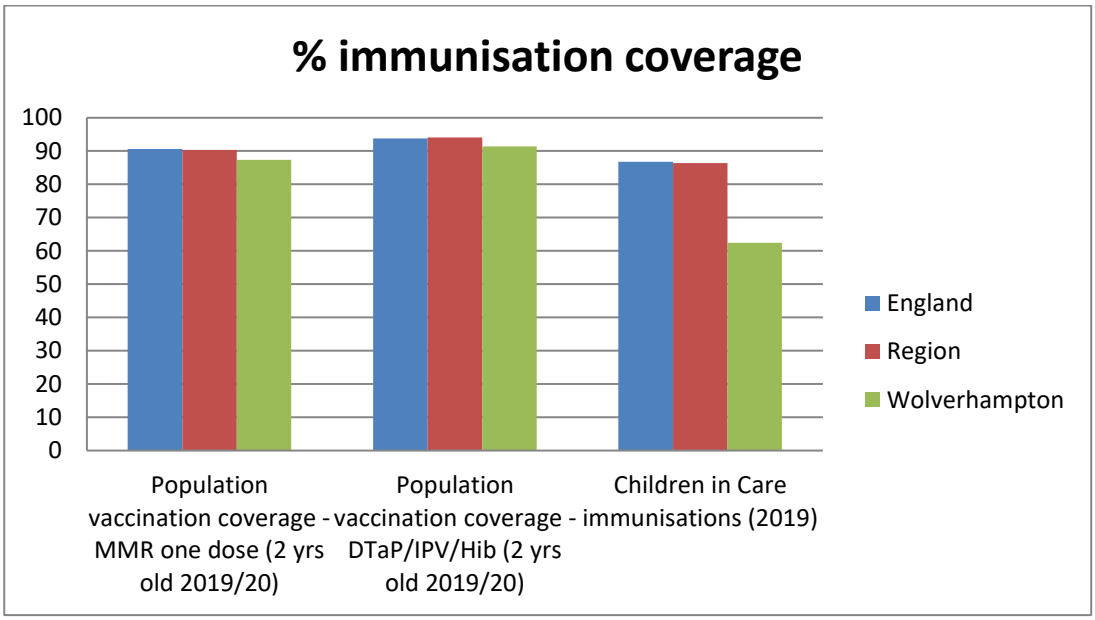
- To ensure that WCCG commission a CYPiC health service that effectively delivers against the agreed service specification, national guidance and legislation, a briefing paper has been submitted by the DN CYPiC to the WCCG Chief Nurse to review future arrangements within the current Provider.

5.0 Public health and wellbeing

5.1 Immunisations

- As recent Public Health data shows, at 2 years of age children in care are less likely than the general paediatric population, both nationally and in Wolverhampton, to be fully immunised. In Wolverhampton immunisation rates have fallen in 2019 across the whole population compared to previous years.

Figure 3



- This difference in the immunisation status of children in care at 2 years old may be due to many children at this age being newly taken into care, often due to neglect which would

include neglect of their medical health, often resulting in many having missed vaccinations whilst in their parents care.

- Our aim is to ensure that once in care, immunisation status is determined, and those with missed immunisations identified. Subsequently, by their next review health assessment they will be up to date.

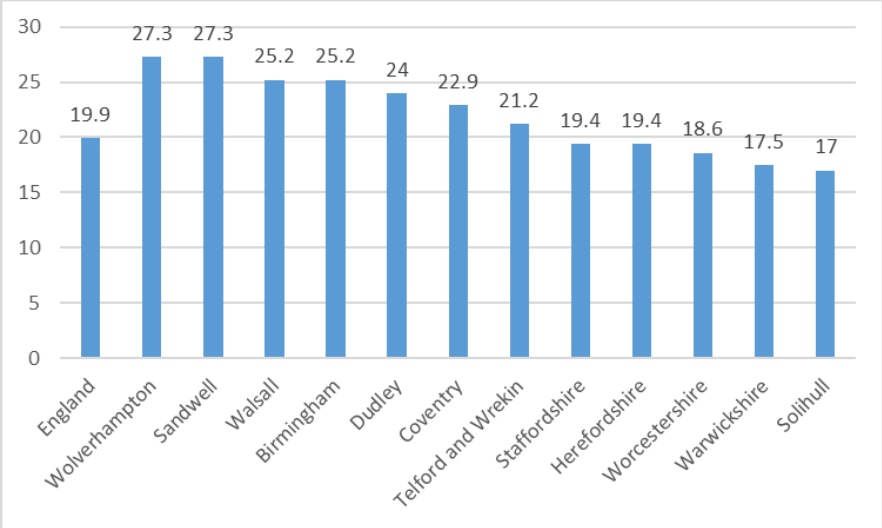
- A recent dip audit of CYPiC Health records showed that:
  - Immunisation status was recorded in **100%** of IHAs
  - In **100%** of IHAs actions were taken to meet identified heath needs including incomplete/uncertain immunisation status
  - In **100%** of RHAs immunisation status was recorded
  - There was evidence in **100% RHAS** included in the audit that actions had been taken to meet health needs which included completing immunisations in those CYP in which they had been missed.

We can be confident that immunisation status is recorded at IHA and action is taken to complete immunisation schedules where these are incomplete. Audit will continue in order to sustain and monitor this area of good practise.

- New guidelines for testing Unaccompanied Asylum Seeking Children (UASC) for blood borne viruses have now been developed, which includes information leaflets for this vulnerable group and their Carers.

5.2 Childhood obesity

Figure 4



- Figure 4 above highlights that W-ton has the joint highest numbers of obese children in the West Midlands in Year 6 (2nd highest in 2018).

- Reassuringly, through the robust quality assurance process, identified issues around BMI in 97% of audited cases were appropriately addressed within the child's health action plan, wherever the child was placed. The remaining 3% were picked up through quality assurance processes.

- Public Health representatives attend the strategic bi-monthly CYPiC health steering group and provide the co-ordination of immunisation services and health screening, including the obesity strategy for all CYP. Recording specific data for our CYPiC is key in identifying and addressing need, and this is a priority action for the health steering group.

5.3 Dental health

- The percentage of up to date dentals checks completed has been declining as a result of the current situation regarding Covid-19 as dentists have been closed. No child however should experience any discomfort and Carers should follow national guidance around when to seek help.

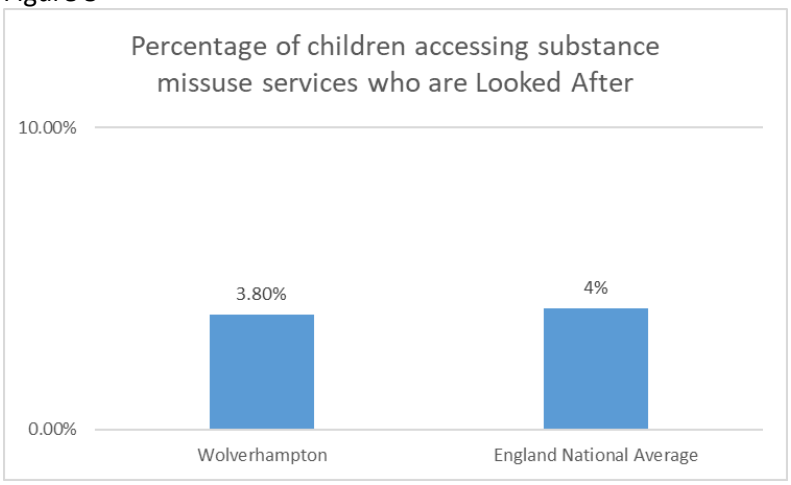
- This is closely monitored through statutory health assessments, and 100% of cases identified where a child needs a dental intervention are addressed and actioned within their health plan.

5.4 Substance Use

- Support for CYP around substance use (up until the age of 18), is provided through Wolverhampton 360 service. Children whose parents use substances also access support from the service

- Covid has hit referrals for the service, reducing by around a third, with approximately 76 open cases. Of these, 5 were CYPiC.

Figure 5



6.0 Provider Service; The Royal Wolverhampton NHS Trust (RWHT)

During the period of time covered by this report the health team consisted of;

- 2 Named Nurses for Children and Young People in Care (CYPiC)
- Named Doctor for CYPiC (who is also one of two Medical Advisors for Adoption and Fostering)
- Medical Advisor for Adoption and Fostering
- Speciality Paediatric Doctor
- GP with a Special Interest in Paediatrics
- Administrative support.

- Statutory initial and review health assessments for our CYPiC are undertaken by practitioners from the following services;
  - Initial (IHA) - Community Paediatricians
  - Review (RHA) - Health Visiting, School Nursing, Partnering Families Team, Named Nurses for CYPiC, and Paediatric Advanced Nurse Practitioners (PANPs).

- During the reporting period, RWT CYPiC Service, were responsible for the completion of statutory health assessments for children living in Wolverhampton and within 50 miles of the city centre.

  (N.B. the CYPiC team also complete assessments for CYP placed in Wolverhampton by other authorities – this report however only looks at assessments completed for CYP looked after by Wolverhampton LA)

6.1 Statutory health activity

Initial Health Assessments (IHA's)

- During the 3 months, July – September '19 (Q2), **23** were completed. There were **28** completed in October – December '19 (Q3), **33** completed in January – March '20 (Q4), and **21** in April – June '20 (Q1).

Figure 6

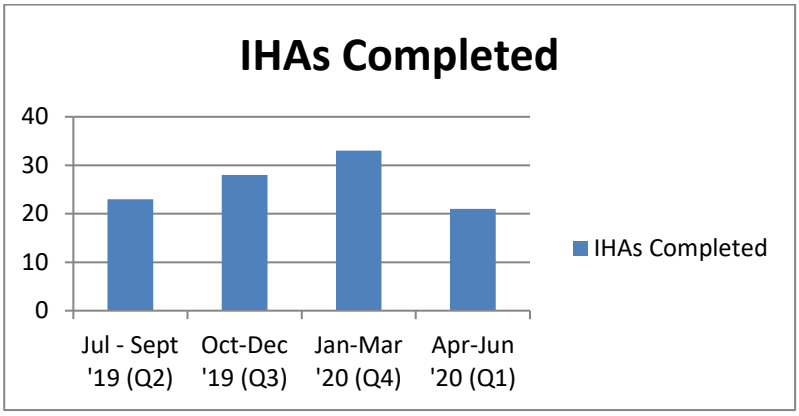
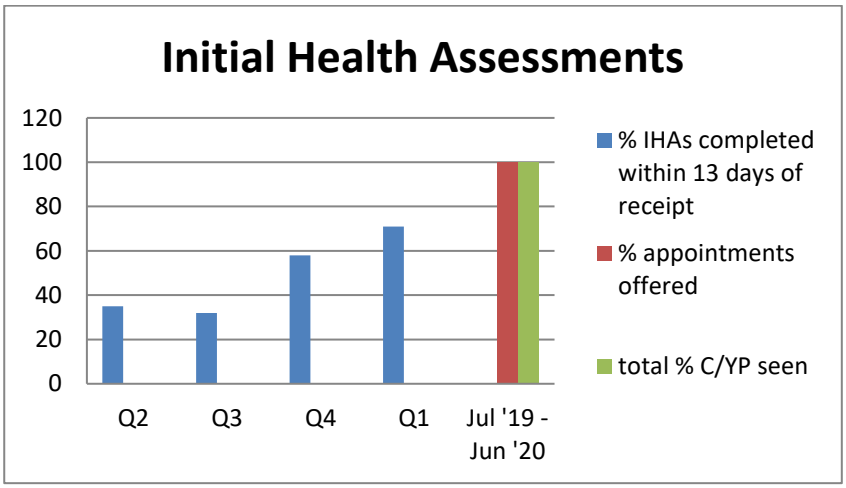


Figure 7



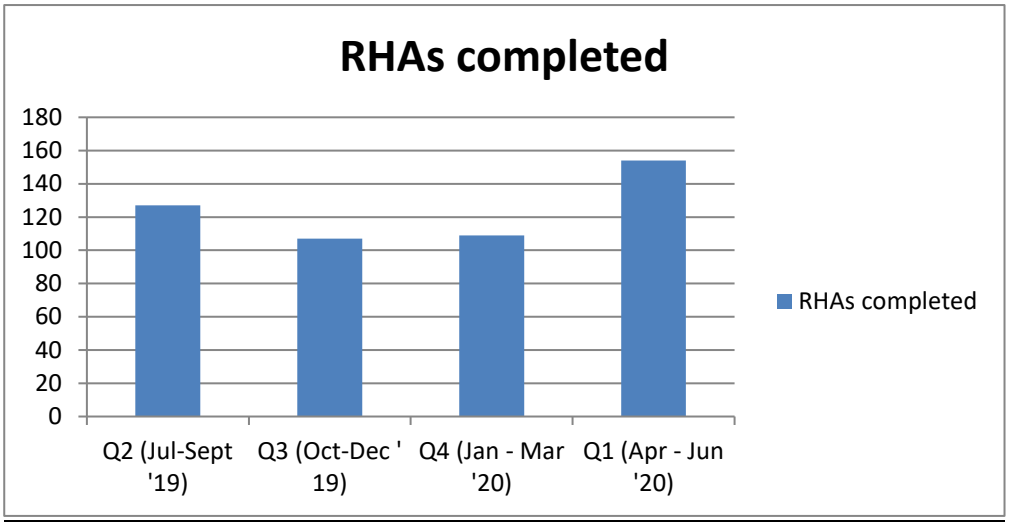
We see a rise to **71%** compliance during April to June, despite additional pressures and redeployment during this time period. This compared favourably with a reported England average of approximately 40-50% (2018).

100% of IHAs were Quality Assured before distribution, and training was delivered regularly to doctors undertaking medicals, by the Named Doctor.

Health Passports are now being issued at every IHA. These are not statutory and should be owned by the CYP throughout their care journey.

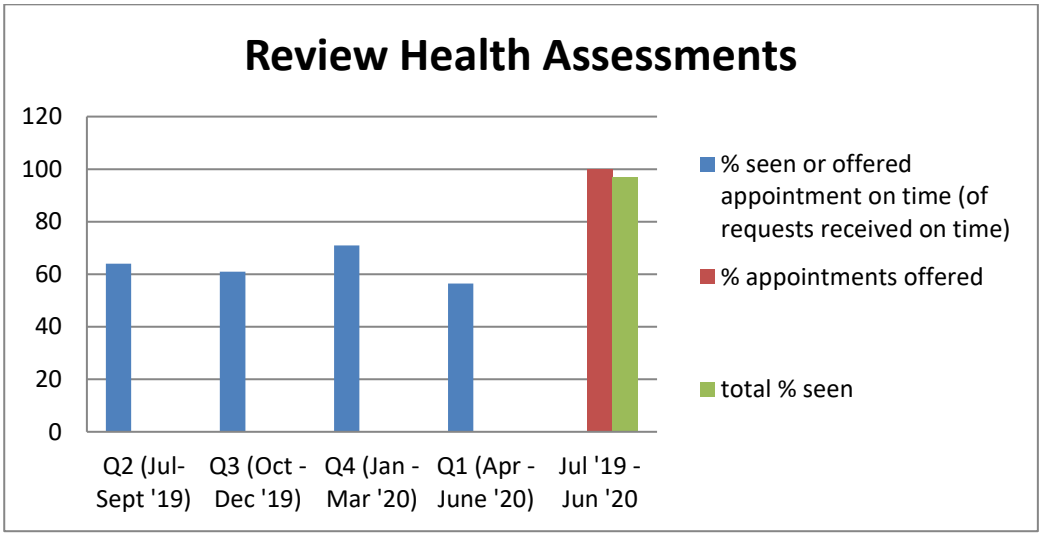
Review Health Assessments (RHAs)

Figure 8



There has been a **29% increase** in the number of RHAs completed during Q1 this year compared to Q4 last year, despite the additional pressure of Covid-19.

Figure 9



- This compares to England average as 88% (2019)
- All of the 497 RHAs completed over the reporting period were Quality Assured with only 25 needing to be returned to practitioners for amendment. Only 4 assessments in total (in Q1) were not QA'd due to capacity of the team and increase in volume.

Leaving care health summary (LCHS)

- It is a statutory requirement that every CYPiC at the age of 17 years is offered a LCHS that details their health history and that of their birth parents (where appropriate).

- An Audit of Leaving Care Health Summaries (LCHS) showed that a total of **55** young people (from a list provided by the LA) required a LCHS between April 2019 and March 2020, of which **36 (65%)** have been completed. Requests were made for consent from the LA for the remaining 19 and the offer of a LCHS made via the young person's Social Worker or Young Persons' Advisor.

- It is the responsibility of the LA to request a LCHS prior to the young person becoming 18. Health services are working closely in partnership to improve compliance in this area, and increase uptake by young people.

6.2 Adoption

- There are two medical advisors in Wolverhampton supported by a specialty paediatric doctor and GP with a Special Interest in Paediatrics. They regularly attend adoption panels as part of the Black Country Regional Adoption Agency, Adoption @ Heart.

- The medical advisors also complete adoption medical reports, providing advice on the health needs of individual looked after children, advise on adult health assessments for prospective adopters and foster carers and discuss the child's health, development, emotional/behavioural presentation, past experiences and in-utero exposure with prospective adoptive parents, to ensure that adoptive parents are aware of any past, current and potential future difficulties the children to be placed with them either have or may develop.

- The medical advisors undertake approximately 40 adoption clinics per year with additional support from two specialty doctors. Between October '19 and August '20 there were:

    - **41** prospective adopters meetings
    - **107** adoption medical reports prepared
    - **179** adult health reports prepared for prospective adopters and foster carers.

- The team are working with Adoption@Heart to improve timeliness of Adult Health reports by strengthening pathways within the CYPiC health team but also by educating GPs on the importance of the health reports to the adoption process.

- The DNCYPiC worked with Adoption at Heart to develop guidance across the STP during lockdown for GP surgeries around responsibilities in completion of adoption and foster carer medicals. Acting as lead clinical contact where issues are identified (across England). This has proved to be very positive with cases decreasing (see Appendix 4).

- Educational and Health Care Plans (EHCP)

There are currently 56 CYPiC in City, and 61 out of City (Reception – Yr. 13) who have a EHCP (24.47%). Health continue to work with partners to streamline statutory assessments with EHCP's to minimise duplication.

6.3 RWT Key Activity and Progress

- A business case has been submitted within the Trust to further expand the team to drive performance and meet statutory timescales. A new Named Nurse (NN) started in post in September 2020. The outgoing NN continues to support the team for two days a week. A 2nd NN post has been recruited to and will be starting in post imminently. The nursing team is to be further expanded with the recruitment of two additional CYPiC nurses over the next few months.

- New guidelines for testing Unaccompanied Asylum Seeking Children (UASC) for blood borne viruses have now been developed, which includes information leaflets for CYPiC and their carers. (Appendix 5)

- Weekly team meetings to enable close monitoring of workload allowing any issues with capacity to be addressed as soon as they arise. This is likely to have led to the increase in ability to meet timescales particularly for IHAs (along with an increase in the medical team overall). There are also monthly meetings with the wider CYPiC health team where action plans are reviewed and any issues escalated to the Directorate or Divisional teams within the Trust.

- CYPiC professionals continue to attend all key Directorate and Trust meetings, and the Trust Safeguarding Operational Group (TSOG). This enables the team to raise the profile of CYPiC within RWT and escalate concerns.

- The RWT team link with other CYPiC/LAC health teams across the region regularly to share areas of good practice and improve local services. This enables the potential to standardise health practices promoting improved services for Wolverhampton C/YP placed in neighbouring boroughs.

- An administration Standard Operating Procedure (SOP) has been agreed and is in use to enable concerns over missing paperwork or administration errors to be addressed and escalated quickly to reduce the effect on timeliness of health assessments.

- The NN team provide supervision to the wider health team on request and on identification of need. As all assessments are Quality Assured this enables the Named Professionals to identify practitioners who may need more focussed training. There is also a rolling level 3 CYPiC Training Programme delivered to the 0-19 team as well as the Emergency Department (ED) and Children's Ward. Training is provided regularly particularly to new members of the team. Teaching by the Named Doctor for CYPiC is incorporated into a regular teaching programme for trainee paediatric doctors and their colleagues at the hospital.

- Named Professionals receive regular supervision from Designated Professionals. There are also regular monthly supervision meetings between them and the medical teams which provides support within the team and where complex cases can be discussed.

- Drop-in sessions are also offered by the NN's where adhoc advice, including sexual health is given, and on-ward referrals made. They also attend Care Planning and Risk meetings, RWT management meetings, CYPiC review meetings, MASE Meetings, and are often key in driving change for individual CYP (Appendix 6).

- Recent changes have also been made to the way in which Learning Disability is recorded for C/YP at their Initial and Review Health Assessments so that the health of this specific group of children can be monitored more closely and to enable identification of children in this group more easily.

- Joint work with Public Health (PH) continues to obtain CYPiC specific data relating to particular health issues such as obesity. As yet this data is available city wide via PH but not isolated for the CYPiC population.

6.4 The Impact and experiences of Covid on our CYPiC

- During the Covid pandemic, as with many services, there has been a move to virtual consultations. The team has worked hard to reduce the impact of redeployment of staff within the trust on delivery of services to vulnerable C/YP.

- All non-acute medical clinic contacts over April and May were virtual, with a move back to Face to Face (F2F) health assessments from the beginning of June.
- During June and July additional clinic slots were used to review all children F2F for IHAs who were not seen due to lockdown in the preceding 3 months as 'catch-up F2F reviews', of which there were **23**.

- Currently all IHA and Adoption examinations are being done in F2F clinics, and it is positive to note that W-ton were one of the first nationally to resume this good practise. Social workers and parents are contacted via telephone and carers and CYPiC are seen at the Gem Centre. This has worked well and is likely to continue post-pandemic.

- RHA appointments are still largely virtual, and the team have found non-attendance rates have dropped with better engagement from those who have previously been hard to reach, with the introduction of video consultations.

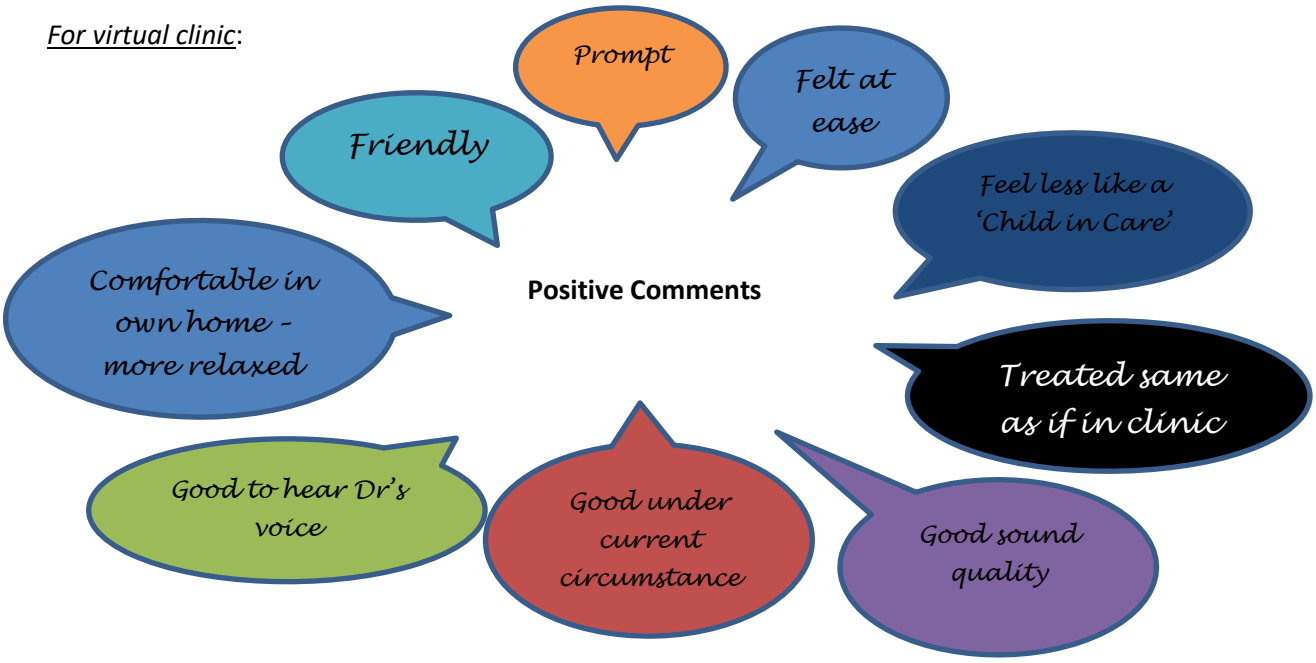
- Feedback was gathered from those who had IHA appointments, both virtual and face to face, between April and July to look at the experiences of children and carers, and gather their feelings.

  16 out of 23 responded to the questionnaires.

  81% 'agreed a lot' that the virtual clinic was a good service. (12.5% - undecided/didn't know)

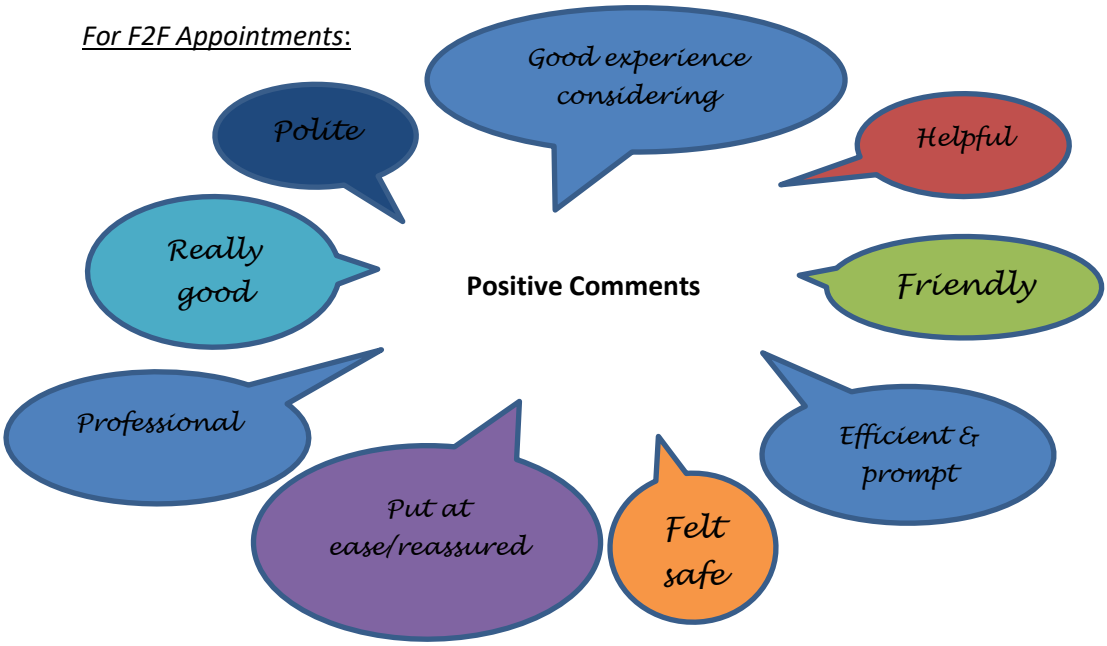
87.5% 'agreed a lot' that the follow-up F2F clinics were helpful (6% - undecided/didn't know)

For virtual clinic:



Negative Comment Technology issues – video link not working

For F2F Appointments:



Negative Comment Uncomfortable to wear a face mask

Case review slide presentation: Adoption in the Time of Covid (written by a speciality doctor)

6.5 Training

- Unfortunately due to the effects of the Covid-19 pandemic training could not be offered in April ’20 to June’20 however this has been re-instated following the easing of restrictions to include;

- A rolling programme of Level 2 and 3 training in order to meet the training requirements (RCPCH 2012) of specific groups of nursing staff.

- “Total respect training delivered by the Local Authority within the Trust.

- The Named Nurses & Paediatric Advanced Nurse Practitioners are compliant with all statutory training requirements in relation to CYPiC.

7. Voice of Children / Young People & Engagement

- CYPiC continue to be key in shaping how we develop and improve health services, including the design of the health passport, the redesign the BAAF statutory health assessment template.

- Members of the CYPiC Council, and Care Leaver Forum are becoming increasingly instrumental in decision making around how we commission services, in particular within mental health and well being services.

- Wolverhampton should be proud of these inspirational CYP who have used their lived experiences to drive change and improve practise.

- A dip sample audit of RHA’s showed that 98% evidenced the wishes and feelings of the CYP for the 2nd year running. This is an excellent outcome, with action plans clearly evidencing their involvement in decision making and health plans moving forward.

- Recruitment processes within health include a CYP panel, with them often having the last word!

8. WCCG Future Key Health Priorities

Health Assessments and Meeting Statutory Duties	During 2010/20, performance regarding provision of health assessments with statutory timescales has reduced. Work with partners and providers is in place to understand the contributing factors and improve performance by Jan 2021. ➢ All care leavers aged 16 and 17 have a high quality, meaningful care leaver's health summary. There is a trajectory to address the shortfall by Jan 2021.
Commissioning and Service Development	Ensure commissioning arrangements are in place for all Provider Services around the provision of integrated CYPiC health care, both locally and across the STP footprint. Ensure robust co-commissioning arrangements are in place with Public Health, to include improved data collection around specific health issues for our CYPiC, to inform the Joint Strategic Needs Assessment (JSNA) and appropriate commissioning decision making locally. Work in partnership with Public health to ensure delivery and partnership working between Public Health and CCG commissioned services including provision of school nursing, health visiting, life style services, immunisation services and health screening for asylum seekers. Raising the profile of CYPiC within LA and health safeguarding contractual standards
Performance and Quality	➢ Ensure that all services commissioned meet the statutory requirements to safeguard and promote the welfare of CYPiC. ➢ Monitor, understand and mitigate Provider performance and quality issues through contractual reporting and key performance indicators. ➢ Ensure more robust oversight and quality assurance of CYPiC placed into W-ton in unregulated placements

Mental Health	➢ Initiated a change in the CAMHS referral pathway to ensure no CYPiC is discharged prior to being seen due to a delay in return of paperwork. This was successfully implemented as a matter of urgency following a number of professionals raising concerns ➢ Where CYPiC have mental health or emotional well-being needs, they are being offered a high quality, timely service that meets their needs, wherever they reside, with minimal disruption when placement changes. ➢ To ensure that CYPiC remain a key priority when commissioning all emotional health and wellbeing services, and that this is guided by what our CYPiC and Care Leavers are telling us.
Education and health care plans (EHCP)	Strengthening the pathways between CYPiC health assessments and EHCP's to provide a coherent and comprehensive story about the child's health needs when accessing education and when in foster care. Health and educational professionals should consider how to co-ordinate assessments and reviews of the child's care plan and EHCP to ensure that taken together, they meet the child's needs without duplicating information unnecessarily.
Training	Develop a virtual CYPiC training package alongside regional colleague's for GP practices as training needs analysis has identified gaps in knowledge and understanding of need. It is hoped that should this be successful, it will be rolled out nationally.

Appendices 1-6

9. Child and Adolescent Mental Health Service CAMHS

Executive Summary for Children and Young People in Care CAMHS Report

The Child and Adolescent Mental Health Service (CAMHS) Children and Young People in Care Team (CYPiC) team provides a therapeutic service to children and young people whom may be either in care and/or adopted and present with mental health difficulties. Typically, these children will have suffered considerable trauma and will present as being insecurely attached. Some of these children will have their own resilience and will find other protective factors in the new systems around them. However, some children and young people in care will require specialist intervention.

In recognition of this requirement Wolverhampton CAMHS in conjunction with the Local Authority, Social Services and Education Department, have resolved to provide a quality service to children and young people in care and adopted children.

The CAMHS service provides an integrated and consistent approach to children and young people in care by placing the child at the centre of care provided. The clinician allocated to work with a child prior to their care placement will continue to support the child following placement rather than allocation to a new clinician.

The service is able to access specialist medical expertise and systemic family psychotherapy and the neurodevelopmental assessment clinic when it is needed. Alongside this service wide support for children and young people in care, there is some limited therapeutic capacity provided by a small number of clinicians, who have some of their time dedicated exclusively to children and young people who are in care and require therapeutic work. These clinicians have received specialist training in approaches that are evidence based for the highly complex needs of children and young people in care. They are therapeutic approaches that are often recommended in court reports and are costly to provide in the private sector. They are not routinely available by many CAMHS services or the core CAMHS team.

Covid-19

This last year was met with the unexpected Covid-19 pandemic which forced us all into unprecedented times and thus changes to our practise to keep each other safe. This report will show figures for pre and during Covid-19 to enable a comparison to be made. This will show whether there were any differences in referral rates, waiting times and discharges during the difficult lockdown and subsequent Covid-19 period. The report cover August 2019 to July 2020 and so figures will be presented as August 2019 – February 2020 (pre-Covid) and March 2020 – July 2020 (during Covid).

1.0) Children and Young People in Care CAMHS Team

The CAMHS Children in Young People in Care team have continued to have a positive staff retention. However some of the clinical hours have been reduced which has had an impact. The full time social worker seconded to CAMHS has had her time in CAMHS reduced to take on more tasks with the local authority. The chid psychotherapist is currently not able to give clinical time to the CYPiC team and the psychology post was not successful in recruitment. However, we were successful in keeping a 0.6 agency art psychotherapist and a clinical psychologist in training 0.4. See Fig. 1.

Fig 1: Children and Young People in Care CAMHS Team

WTE	Professional Title
0.20	Consultant Psychologist - Lead (CYPiC)
0.6	Social Worker (CYPiC)
0.64	Highly Specialist Clinical Psychologist (CYPiC)
1.0	Specialist Nurse Practitioner –EPP (CYPiC)

As seen in Fig 2 we received 95 referrals during the 12 months period compared to 106 referrals recorded last year. We also have an increase in the number of open cases we are working with. The number has been given in two figures; 92 is the number of open cases of children and young people in care seen by the CAMHS CYPiC team and 32 is the number of open cases of children and young people in care seen by other teams in CAMHS. These are the Child and Family Service and Inspire Team. The Crisis Team have worked with 31 of the children and young people during this time period referred into CAMHS.

Following assessment the average length of care episode is 203 days correlating with the highly complex needs and care required suggested by research, clinical experience and knowledge.

Fig 2: Current caseload

Open cases at end of August 2020	92
New referrals between August 2019 – end February 2020 New Referrals between March 2018 – end July 2020	54 + 41 95
Discharges between August 2019 – end February 2020 Discharges between March 2020 – end July 2020	33 + 34 67

2.) Referral and allocation process:

See Appendix I

The referral process for referrals to the CYPiC CAMHS Team remains the same as last year. The changes made last year to the working model for CYPiC team has continued to work well with a better flow through putting the child/young person's voice at the forefront to ensure we understand their position, what they want and if they are ready for therapy. It also helps us make a better informed formulation of their mental health presentation.

Figure 3, 4 and 5 below provides some further breakdown of the information that may be of interest.

Fig 3: CAMHS CYPiC Team Referrals Per Month 2019/2020

2019/20	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
	4	7	15	7	3	12	5	6	7	4	15	9	94

As the data shows there was a significant rise in referrals in October 2019, January 2020 and June 2020. The October and January figures may correlate with the return to school following the summer and Christmas break. Previously we could have interpreted the rise in June as possibly due to the anxiety of the end of term, exams, apprehensions in relation to transitions, losing friends which is a big factor for children experiencing attachment difficulties. However, June also coincides with the changes in lockdown and talk about returning to school and maybe returning to contact with birth families. Given this it would be unfair and unwise to attempt to put meaning on this figure except to notice a significant difference.

Looking across the months at the peaks and flow and comparing the 6 months pre Covid-19 and during Covid-19 there does not appear to be a significant difference in the number of referrals received pre and during Covid.

Fig 4: CAMHS CYPiC Referrals by Age 2019/2020

Age	4	5	6	7	8	9	10	11	12	13	14	15	16	17	21	Total
	1	2	2	4	4	4	4	3	8	6	21	8	15	11	1	94

The table shows that the highest numbers of referrals we receive are for 14 – 17 year olds. This is consistent with previous years. This may be because;

- the young people have not come into care until they are older
- they have received other therapeutic care before coming to CAMHS
- have not needed therapeutic care due to a good package of care around them
- have already been to CAMHS before.

What we do know from research and experience is that the trauma and attachment experienced in earlier childhood becomes entrenched as they get older therefore requiring a higher level of therapeutic skill and significant longer therapeutic input. Children and young people in care are often emotionally dysregulated and the older they are without getting help are at risk of develop a personality disorder if not addressed. This is not always the case for those who are resilient and have a positive experience with a good replacement system around them.

Fig 5: Source of Referrals for 2019/2020

Source of Referrals	Number of Referrals
General Practitioners	11
Social Workers	62
Internal	2
CAMHS Crisis Team	1
Education	3
Paediatricians	8
Other Service/Agency	7
Total	**94**

The highest referring profession is social workers; however we do receive referrals from other professionals. In this instance we always write to the social worker as they hold PR to inform them we have received a referral

The service has also been fortunate to work on a project with the local authority for unaccompanied asylum seekers known as the UASC project. Dr Brigid Duffy and a colleague led on the project to provide therapeutic care to unaccompanied asylum seekers up to the age of 25. Sadly the funding for the project ended in April 2020 but the number of referrals received for unaccompanied asylum seekers between August 2019 and April 2020 was 9 and the number in therapy during that time was 20. This was agreed to be a worthwhile project thanks to a multi-agency approach and demonstrated a need for children and young people who have travelled unaccompanied and experienced dreadful traumas. Since the end of the project it has been agreed that these children and young people will still get a service through the usual referral route into the CYPiC team but only for our commissioned agreement of up to 18 years of age.

As reported last year the new way of working for the team significantly reduced the waiting times and this has continued as the new way has become embedded into our practice. To show how the team have managed during Covid -19 the waiting figures for the first appointment and subsequent appointment is recorded month by month so a comparison can be made between pre and during Coid-19.

Fig 6: Average Waiting Time in Weeks for first appointment – Professionals Meeting following receipt of referral for children and young people in care August 2019 – July 2020

2019/20	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
No of weeks	5.70	5.22	6.20	4.20	5.83	6.60	3.83	5.40	8.00	3.60	3.10	2.86	

Aug 2019 – Feb 2020 Average	5.28 Weeks
Mar 2020 – July 2020 Average	4.25 Weeks

Fig 7: Average Waiting Time in Weeks for second appointment – from Professionals Meeting to Voice of the Child Appointment August 2019 – July 2020

2019/20	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
No of weeks	5.20	4.74	4.22	4.00	3.71	3.67	6.17	3.40	7.50	4.29	4.00	2.71	

Aug 2019 – Feb 2020 Average	4.53 Weeks
Mar 2020 – July 2020 Average	4.39 Weeks

The numbers show that there is little difference between pre and during covid-19 figures except for the average wait for a professionals meeting post Covid-19 reduced by one week. This may have been reduced further if there had not been a wait of 7 weeks recorded in April affecting the average figure. April was the time when the lockdown was really taking a hold and services were having to very quickly change and adapt to a new way of working. The CAMHS CYPiC team were fortunate and grateful that we were given permission to use the local authority MS Teams until we were equipped with what we needed to work differently. Initially it took a little longer to find mobile numbers and email addresses to be able to contact referrers and social workers but this soon settled and as the subsequent months show waiting times were reduced and efficiencies gained due to less travel etc.

A challenging concern that increases the length of stay in CAMHS and increases waiting times is cancellations and non-attendance. These have been captured below with the reasons recorded. See Fig.8

Fig 8: Number of Appointments Cancelled or Not Attended

Reason	**Number of Appointments Aug 2019 – Feb 2020**	**Number of Appointments Mar 2020 –July 2020**
Client Cancelled	82	43
Client Rescheduled	1	6
Did Not Attend	42	24
Clinician Cancelled	15	5

Clinician Rescheduled	1	2
Total	**141**	**80**

When a child or young person in care is not brought to an appointment we make contact to establish why and we inform the social worker. If we are not able to make contact with the carer or residential unit or the non-attendance is repetitive we ask the social worker to intercede to support us. The pre and during Covid-19 data clearly shows a reduction in non-attended appointments. This suggests that the different, creative and flexible ways of working are more welcoming with less barriers. Nevertheless, it is important that the practicalities of attending appointments are balanced with effectiveness and so we are in the process of auditing the outcomes or telephone and video platforms. However, since this report the service has returned to face to face appointments but a blended approach is still offered for those children and young people who found it works better for them.

CYPiC Council and CAMHS Council – Participation

As the team continued to work with the new model that was introduced the previous year and saw the improvement in waiting times and outcomes the CYPiC team decided we needed to check that the young people themselves were happy with the changes we had made and therefore the team lead attended one of the CYPiC council meetings to ask their opinion. The main question was 'were they happy having a Voice of the Child meeting where they had the opportunity to discuss their views, what they wanted and what they needed'. Some young people said no and would rather just be at the professionals meeting to hear what is being said about them but the consensus was it was better for the young person not to attend the professionals meeting because difficult things are discussed which could set them back a long way (words of a young person). In view of this feedback we agreed that we would continue with the model but start the voice of the child meeting by talking about the professionals meeting, who was there and what was discussed so there is transparency and the young person feels fully involved. CAMHS is also very fortunate to have a young person who is in care on the CAMHS council.

Outcomes used by CAMHS for children and young people in care

Wolverhampton CAMHS CYPiC team currently report on a number of key performance indicators to ensure we are meeting commissioner quantitative targets. To ensure we are providing a quality service and providing the right therapeutic models we have available a range of outcome measures. The outcome measure used, the reason for their use, and the outcomes it measures are explained in Appendix II.

3). What CAMHS CYPiC Offer to Children, Young People, Carers and Families and Professional's

- **Direct Therapeutic Work**

Direct therapeutic work involves the following according to the needs of the child:

- Child on their own
- Child and carer together
- Carer on their own
- A worker to see the child and another to see the carer

The clinicians in Wolverhampton CAMHS CYPiC are highly skilled and trained in evidence based approaches for working with looked after children e.g. Theraplay, Dyadic Developmental Psychotherapy, Cognitive Behaviour Therapy, Dialectic Behaviour Therapy, Mindfulness Eye Movement Desensitisation Reprocessing, Trauma Focussed Cognitive Behaviour Therapy and others. This is not the case in all CAMHS teams and in many areas these pieces of specialised work have to be commissioned out.

Clinical interventions aim to integrate attachment, systemic, psychodynamic and psychoanalytic traditions in practice recognising the individual needs of the child or young person. These approaches involve working with others involved in their care (foster carers, residential workers, looked after children's nurses) as an approach to actively engage them within the service. This is because the system around them is vitally important and daily impacts the dynamics within the relationship. Sometimes the work with the foster carer and others is just as or even more important than with the young person, especially if the young person is not ready to engage in therapy.

For the young people who are actively engaged in individual appointments a number of approaches are utilised. The benefits of which for the child or young person include,

- Feeling listened to and understood
- Able to talk or be quiet depending on what feels right for them at the time
- Assistance to make sense of often difficult, painful and confusing feelings
- Exploration of relationships with significant others i.e. carers, with the young person directly or with the carer separately with another worker.

Additional benefits include stabilisation of placements through effective exploration and thus understanding of relationships whilst also achieving improved school attendance and attainment.

Sometimes outcomes can be more limited as therapy is challenging and can prove painful for the child or young person, which may result in a requirement for extended exploration and containment prior to being able to achieve noticeable outcomes following therapeutic consultations. Each child is unique and following a thorough assessment will have an understandable plan which will be developed with colleagues and the child/young person.

Covid-19 has impacted on how we delivered the therapeutic interventions to ensure the safety of everyone. In March 2020 we risk rated our cases for urgency and cases that were not high risk were moved to telephone and video platform deliveries. High risk cases continued to be seen face to face with the use of personal protective equipment (PPE) as advised by infection control. The feedback from children, young people and their carers was positive with the changes in platforms. Lessons were learnt for future practice to maintain a blended approach where different platforms may be desirable or beneficial for the child or young person.

Initially, at the beginning of lockdown, we found that most of the children and young people seen by CAMHS settled possibly due to not attending school. It gave an indication of how stressful some of the children find school, whether that be the education or social side of the system? However, as time progressed, some carers naturally became more stressed.

Towards the end of summer CAMHS gave the opportunity for all cases to be seen face to face with PPE but some children and young people opted to continue using other preferred platforms.

- **Nurturing Attachments and Complex Trauma Training Programme for Foster Carers**

The service has continued to deliver the Nurturing Attachments and Complex Trauma Training programme for foster carers who foster children/young people who meet the criteria for specialist

CAMHS, in order to provide them with the necessary knowledge and skills to provide attachment focused parenting.

The 'Nurturing Attachment Training Programme' is a manualised programme (Golding, 2013) that is designed to provide support and guidance to foster carer and adoptive parents who are parenting children who have experienced maltreatment, trauma or are having attachment related difficulties. The training resources include theoretical content and a range of activities supported by reflective diary sheets, activity sheets, and handouts. The programme is based upon the concepts of attachment theory, an understanding of child and relationship development and the impact of trauma on children's development.

The programme is an 18 week course and each week is 3:5 hours. The course is run by 2 experienced and trained clinicians. Seven groups of carers have so far been trained in the approach within CAMHS. The training has being delivered within the local authority by the CAMHS Social Worker specifically for local authority carers. This has been supported by also training the supervising Social Workers to support the carers within the model.

The recent training programme was paused at the outset of Covid-19 causing a delay in completion. But as practices were adapted and changes made the programme continued remotely and continued to a successful ending. Further programmes will be delivered remotely for the foreseeable future to ensure everyone's safety.

- **Consultation**

The CAMHS service, through the CAMHS Social Worker, offers weekly consultation to Social Workers through bookable appointments, one day per week (8 slots) to support and facilitate attendance.

Consultation is available for all Social Workers across the city who have children and young people in care and/or adopted children on their caseload.

These slots have proved to be useful to allow social workers space to think about the children they work with in a therapeutic way and help them to understand their complex presentations. As previously mentioned, some children are not ready for therapy and other work needs to be done first. A consultation can be useful to think this through in a collaborative way and agree if and when CAMHS is right for a child.

- **CAMHS Clinical Specialist External Placement Panel (EPP)**

The EPP clinical nurse has found this year particularly difficult. The role involves working as a CAMHS clinician within Wolverhampton CAMHS, Wolverhampton CCG and the Children's Local authority; assessing children and young people that have been placed in out of area specialist placements through this panel. EPP is a triparty panel that represents health, education and social care.

The role involves conducting mental health assessments to ensure that the children and young people's mental health needs are assessed and met within placements, and report back to the EPP on findings. The role also involves providing recommendations in regards to therapeutic interventions that may be offered to the children and young people whilst within placement, as well as monitoring progress and ensuring support is 'stepped down' appropriately. The role also liaises with partner agencies and when possible offer joint appointments with social care, education or with the Looked after Health Team. Joint quality assurance visits with the Designated Nurse for Children and Young People in Care at the CCG also take place where an issue around health provision has been identified.

Attendance at multi-agency meetings, children and young people in care reviews is crucial in ensuring the best care is dovetailed to their individual needs and that the residential units are providing what they claim to and commissioners are being good stewards by spending money effectively and wisely. The EPP nurse travels to every child and young person wherever they are placed every three to four months.

At present there are currently 18 young people that are under the External Placement Panel however this has fluctuated at times to 19/20. There is one young person that has recently been removed from the Panel but still has the potential to return.

Since COVID-19 restrictions it hasn't been possible from March 2020 until September 2020 to attend homes to review young people and since the recent tier levels this too is causing restrictions to visit. Most correspondence has been through telephone contact with the child or young person's social worker, residential staff, virtual professional, multi-agency or gathering information from the multi-disciplinary teams such as psychiatry or crisis clinicians within local areas to gain an understanding on the child's needs if presenting in crisis.

Virtual meetings or telephone calls have been offered on occasions however can be declined by the young person with staff reporting that the young person doesn't want to talk over the phone. For newer cases, as the young person has not met the EPP nurse beforehand, contact has been made directly with the social worker to cause less distress.

Reviewing therapeutic work has been varied, as some clinical teams have offered virtual meetings which has been effective however other homes have only been in telephone contact or direct contact with social workers.

In regards to risk there has been five placement breakdowns during the period of March to September 2020 where the young person has had to move either due to difficult behaviours displayed by the child or the home feeling that they cannot meet the child's need. At present, location wise, there are children and young people located in Scotland, Wales, West and East Midlands, North West, Staffordshire and Shropshire area.

4) <u>In Conclusion</u>

<u>Changes and Improvements</u>

Last year's report conveyed that the CAMHS CYPiC team had undergone a number of changes and the figures were starting to show a positive change in waiting times. This report shows that the model continues to be successful in terms of access and waiting times.

<u>Challenges</u>

This year saw unprecedented times with the world forced into a pandemic situation. Covid-19 overwhelmed the nation and forced us into a lockdown situation. Services needed to work very differently and CAMHS developed some creative and flexible alternative practices. This report was divided into 2 six months for reporting purposes so that data could be compared pre Covid and during Covid. Interestingly, comparing the two, there were no significant differences in the number of referrals we received, the number of discharges and the length of waiting times between August 2019 – February 2020 and March 2020 – July 2020. However, there is a difference between the numbers of non-attended appointments with a significant decrease in the second half of the year suggesting new ways of working were favourable and going forward a blended approach needs to be offered.

Therapeutic work with children and young people in care is complex and placement break downs can occur despite the efforts of the various professionals and carers working with the child. This is

particularly heart breaking in the case of adoption breakdowns. Referring a child to CAMHS to prevent a placement breakdown is not always the best course of action. Therapy is not an instant fix and takes a while to work. In most cases, when a child starts to access their difficult memories their behaviour escalates and they become destabilised before they start to settle and emotionally regulate.

Further Challenges

Our major challenge is capacity. As this report has shown the referrals for children and young people in care continue to be high and the complexity and risk increase meaning more time is needed for each referral. However, the national picture is clear for all that there are no more resources and we have to do what we can to work effectively and smart with the resources we have.

In Wolverhampton there has continued to be an increase in the number of out of area children and young people in care cases being placed in private homes. In the last twelve months we have seen out of area children placed with more highly complex needs requiring crisis intervention, hospital stays and psychiatry input. These are taking more and more of our time and resources.

As responsible, ethical clinicians we have a duty of care to continue to find ways of reducing waiting times so that children and young people can access the therapy they need in a timely manner but we also need to ensure we are meeting their needs by providing good therapeutic care until the therapeutic goals have been met. Therapeutic work with children and young people in care is not a 'quick fix' and so balancing the throughput of reducing waiting times and providing the right level of therapeutic involvement is a challenge.

Visions and Plans for the Future

- In April 2020 Black Country Partnership Foundation NHS Trust and Dudley and Walsall Mental Health Trust became one Trust under the name of Black Country Healthcare Foundation NHS Trust. The Trust are getting their structures in place which will lead to the four CAMHS teams across the Black Country becoming closer aligned. This will lead to exciting opportunities to learn from other CYPiC teams to see if there is more we can learn or improve on from each other.

- This November CAMHS will move to a new information system which will allow us to move from paper records to electronic records. This will help us to improve on administration and recording outcome measures.

- Currently an audit is being written up for the CAMHS service which includes CYPiC team on patient's response to the use of telephone and video platforms. We can evidence that these platforms have reduced non-attendance but we have to be sure the children and young people are getting what they need out of the appointments and they are effective, not just convenient. However, it is vitally important that where clinically indicated and needed face to face appointments are encouraged and happen.

- The Midlands Clinical Network have recognised the complexity and inconsistent way children and young people in care are being commissioned around the country. Some CAMHS teams will not accept referrals for out of area children placed in their area, some do. Some teams are commissioned to see children placed in a radius outside if their area some discharge once the child moves over their border. The Midlands Clinical Network, in conjunction with commissioners and CAMHS teams have agreed to engage in a piece of work to agree a rule that all Midlands teams will sign up to. This will provide fairness, clarity and a quicker response for each child when they move. It is hoped, once this is in place, it can be taken to a national level as suggested good practice.

- We are in the process of beginning the next Nurturing Attachment Training Programme cohort and have moved this to a digital platform. We will monitor how this is received and take feedback to see if this is easier and preferential for carers rather than coming into the Gem Centre.

Finally

As stated in last year's report, working with children and young people in care is difficult and heart wrenching but it is a privilege. CAMHS CYPiC clinicians could not have any successes alone and we recognise we are part of the wider professional/agency system that has a part to play in changing and shaping the future of these children and young people. We were especially grateful back in March 2020 when we first encountered lockdown that Sonia Mahay from Social Care gave approval for our team to share the resources or social care and we were given authorisation to share MS Teams that allowed us to keep in touch with each other and social workers until provision was made through the NHS. This was an example of agencies coming together and working together to support the children and young people who need us the most.

Supporting evidence:

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APPENDIX I

LOOKED AFTER CHILDREN WOLVERHAMPTON CAMHS PATHWAY

Black Country Partnership NHS Foundation Trust

Children, Young People & Families

Referral received in to Single Point of Access accepted by any referrer

From Social Worker

Any other professional

Screened by SPA

Meets criteria (see LAC criteria)

NO

Discharge and signpost

Additional information request and consent form send to social worker

When returned

Yes Urgent

Yes Routine

Assessment with Psychiatrist, Crisis Team or Lac Team as required

Voice of the Child Mental Health Assessment

Professional Consultation to the Professional Network to include foster carers, social workers, education, residential staff and carers

No therapeutic need – remain with psychiatry

Therapeutic need identified transfer care to LAC CAMHS

MDT discussion

Is there a tier 3 mental health need?

NO

YES

Signpost, offer consultation at Beldray or Tier 2 service

LAC Intervention identified and offered see list of Specialists interventions

Complete intervention

Discharge

<u>List of Specialist Interventions</u>

- Psychometrics
- Marschak Interaction Method (MIM)
- Theraplay
- Story Stem
- Dyadic developmental psychotherapy (**DDP**)
- Child Psychotherapy Assessment
- Child Psychotherapy
- LAC Family Therapy Clinic
- Nurturing Attachment for Parenting Children with Complex Trauma 18 week Intensive Course for Foster Carers and Adopters
- Cognitive Behaviour Therapy
- Eye movement desensitization and reprocessing (**EMDR**
- Dialectical behaviour therapy (**DBT**)
- Group Work
- Emotional Regulation
- Mindfulness
- Narrative Family Therapy
- Attachment Therapy

<u>Other Services Provided</u>

Weekly Consultation and supervision to Social workers

Consultation and training to residential staff

Training to local authority foster carers

Attachment training

Representation at EPP, Corporate Parenting Board, LAC Health Steering Group etc

Yearly report to Children In Care Council And Corporate Parenting Board of Governors

Appendix II

Outcomes used by CAMHS for children and young people in care

Strength and Difficulty Questionnaire

The SDQ was created by (Goodman et al 1997/2010). The SDQ letters represent the longer title of this outcome measure which is "The Strengths and Difficulties Questionnaire." The SDQ can be used with young people aged 3-17, a SDQ is available for use by the parent, teacher and clinician. When the young person reaches 11 a separate SDQ can also be completed by the young person up to the age of 16. There are also separate questionnaires which are available to measure the level of strengths and difficulties the young people have prior to treatment and following treatment. The SDQ is comprised of 25 questions, rated on a likert scale scored 1-4. The 5 areas the measure explores include: emotional symptoms, conduct problems, hyper activity/inattention, peer relationship problems and pro social behaviour. The SDQ has been indicated when using as a screening tool as has been shown to be able to predict psychiatric disorders due to its "good specificity" and "moderate sensitivity" (Goodman et al, 2000). Hence again this outcome measure does not necessarily always measure the needs of looked after children if their primary presentation is attachment.

Brief Parenting Self-Efficacy Scale

Parenting self-efficacy (PSE) describes a parent's belief in their ability to perform the parenting role successfully. Higher levels of PSE have consistently been shown to be correlated with a wide range of parenting and child outcomes. Consequently, many parenting interventions aim to improve PSE. PSE measurement has typically been via self-report measures.

The Child – Parent Relationship Scale

The Child-Parent Relationship Scale (CPRS) is an instrument developed at University of Virginia's Curry School of Education and Human Development that assesses parents' views of their relationship with their child. Created by Dr. Robert Pianta, Ph.D., the instrument consists of 30 items. There is also a short form with 15 items available.

Goal Based Outcomes

Goal Based Outcomes are designed to be used as part of treatment. For those children/young people considered suitable for therapy, up to three goals should be set collaboratively between children/young people and carers towards the end of assessment. Attainment towards these goals will be monitored throughout treatment. For some children/young people it may take a few sessions to be able to decide on up to three

goals. It is important to support the child/young person to fix three goals as early in treatment as possible.

As can be seen from the information discussed above these outcomes explore a number of areas of the young people's difficulty but do not record the carers outcomes. This is crucial in working with children and young people in care. To ensure placements do not break down and there is continued stability for the young person the carers need to feel able to provide care for the young people. Therefore to capture the carers wellbeing and their relationship with the child, the following outcome measure is used pre and post intervention.

PSI-4

The PSI-4 is the shortened name provided to the Parenting Stress Index (Version 4). The PSI-4 was developed by Abidin (1983). The purpose of the parenting stress index is to measure the amount of stress in the parent and child's system. The three areas of stress measured by this outcome are the: child characteristic, parent characteristic and external situational stress surrounding both the child and carer. There are two forms of the PSI the short and long form. The short PSI- 4 is used by the Wolverhampton CAMHS Looked after children's team and is comprised of 36 questions (Abidin, 2012). The tool has been shown to be both a valid and reliable outcome in the measurement of parent (carer) stress in the three areas discussed (Abidin, 2012).

Appendix 1

Review Health Assessment's (RHA's) for Children and Young People in Care (CYPiC); Interim guidance for Wolverhampton NHS health provider in light of COVID 19.

Introduction: This guidance has been developed by Designated Professionals for Children and Young People in Care (CYPiC) following Governmental and NHSE advice to support the changes in current practise. Consultation has taken place with Wolverhampton provider services and the local authority. This guidance will be regularly reviewed and updated in line with local and national directive.

Changes in local health provision: the 0-19 service will only be completing existing requests for RHA's. This will enable them to prioritise safeguarding contacts with vulnerable families. Future requests will therefore be directed to the Named Nurses for CYPiC. The Designated Nurse CYPiC will cover all assessments for those who are placed 50 miles plus if local area cannot complete.

Guidance:

1. RHAs should continue to be offered as per national requirements (DfE, 2015) and local contractual arrangements. There is a clear expectation that the local authorities will continue send a request for the RHA and accompanying consent.

2. In cases where the child has had a recent developmental assessment, or if the child has recently been seen by the practitioner these consultations could be used to inform the RHA.

3. Following the collation of information, **RHA's should be undertaken remotely in the first instance**. The need to see the child is paramount therefore a video consultation should take place for all cases where possible.

4. Based on this initial remote consultation, a clinical decision will be made regarding whether the CYP requires a more detailed examination. Consideration of age, vulnerability and pre-existing health conditions should all be acknowledged as part of the assessment. If during the assessment the health practitioner has any safeguarding concerns, or concerns regarding the child's health, a referral should be done to appropriate services. This will be in line with the Trusts emergency arrangements to prevent the spread of Covid19.

5. Professional judgement will need to be used to determine if the assessment is conducted via the carer or directly with the CYP or both. However, the voice of the child remains

paramount and will need to be reflected in the health care plan, unless the child is physically unable to do so.

6. Regardless of the method used for the assessment, it is important that the standard RHA format is used and remains a high quality assessment which informs the child's health plan.

7. Information from the child's Social Worker and GP, along with any other professional involved with the child or young person will continue to be collected in line with local process. The Social Worker will need to be informed about the method in which the RHA will be taking place.

8. It is recommended that it is clearly documented within the child's notes what form the RHA has taken and the rationale for adopting this approach. (e.g. 'This RHA was undertaken via a Skype call with the child and foster carer. The reason for this approach is in response to central government and local guidance during the Covid19 pandemic'.) This will ensure a clear audit trail within the records of decision making.

9. It is suggested that a list of all RHAs undertaken via non face-to-face methods are recorded by provider organisations and stored in accordance with organisational record-keeping processes.

10. ***Impact of these changes (timeliness, quality) will be discussed within weekly meetings between CYPiC Named and Designated professionals and LA Head of Service CYPiC to ensure identification and mitigation of risk wherever possible***

11. This guidance will be regularly updated as national guidance becomes available.

Thank you all for your continued support to our Children in Care and their Carers at this difficult time.

Appendix 2

Initial Health Assessments (IHA's) for Children and Young People in Care (CYPiC); Interim guidance for Wolverhampton NHS provider organisations in light of COVID 19

Introduction: This guidance has been developed by Designated Professionals for Children and Young People in Care (CYPiC) following Governmental and NHSE advice, to support the changes in current practise. Consultation has taken place with Wolverhampton health provider services and the local authority. This guidance will be regularly reviewed and updated in line with local and national directive.

Guidance:

1. IHAs should continue to be offered as per national requirements (DfE, 2015) and local contractual arrangements. There is a clear expectation that the local authorities will continue to notify us of children being accommodated, together with a request for the IHA and accompanying consent.

2. In cases where the child has had a recent child protection medical and/or forensic sexual assault assessment, or if the child has a known disability and has recently been seen by a paediatrician, discharged from hospital after birth or 6 Weeks postnatal check information from these consultations could be used as the basis for the IHA.

3. Following the usual collation of information, **IHAs should be undertaken remotely in the first instance**. The need to see the child is paramount therefore a video consultation should take place for all cases where possible.

4. Based on this initial remote consultation, a clinical decision will have to be made regarding whether the child or young person requires a more detailed examination. Consideration of age, vulnerability, pre-existing health conditions, whether children in care of parents or family members, returning into care should all be acknowledged as part of the assessment. If during the consultation the Paediatrician has any safeguarding concerns, or concerns regarding the child's health, the child will be referred to be seen by the appropriate services. This will be in line with local Trust emergency arrangements to prevent the spread of Covid19. The social worker will also be made aware.

5. Given this may be the first medical for some children; video consultation should take place whenever possible so the child is visible. Similarly the voice of the child, and their wishes and feelings should be ascertained and reflected in the health care plan in all cases unless the child is physically unable to do so.

6. Regardless of the method used for the assessment, it is important that the standard IHA format is used, and remains a high quality assessment which informs the child's health plan.

7. In acknowledgement of the service pressures on colleagues from partner agencies, it is suggested that information from the child's Social Worker may need to be collected electronically or via a phone conversation as opposed to them attending an appointment.

8. It is recommended that it is clearly documented within the child's notes what form the IHA has taken and the rationale for adopting this approach. (e.g. 'This IHA was undertaken via a Skype call with the child and foster carer. The reason for this approach is in response to central government and local guidance during the Covid19 pandemic'.) This will ensure a clear audit trail within the records of decision making.

9. It is suggested that a list of all IHAs undertaken via non face-to-face methods are recorded by provider organisations and stored in accordance with organisational record-keeping processes. In the event of the risks being reduced a face to face IHA will be completed.

10. ***Impact of these changes (timeliness, quality) will be discussed within weekly meetings between CYPiC Named and Designated professionals, and LA Head of Service CYPiC in Wolverhampton to ensure identification and mitigation of risk wherever possible.***

11. This guidance will be updated as national guidance becomes available.

Thank you all for your continued support to Children in Care and their Carers at this difficult time.

Health pathway for emergency foster care placements during covid-19 pandemic

NHS Wolverhampton Clinical Commissioning Group

Child at high risk of mental health problems:

•Place with familiar carers e.g. connected person/ family/ teacher and/or with carers who have mental health awareness/ training or can be provided with safety plan and supports

Universal child health needs

•Ensure you are aware of the child's health needs through obtaining GP summary, current medication list and allergies: collect medicines

•Speak to the child about coronavirus using child friendly resources

•Obtain phone number for parents/family

•Universal carer recommendations

•Ideally have space for self-isolation capacity at home

•Written information + videos for foster carers and child

•Foster carers should minimise the child's anxiety about Covid-19 and seek support with their own worries

•Enable remote contact with family/friends

•Foster carers must be able to risk assess whether the child requires medical attention. NB/ Illness OTHER than Covid-19 must not be overlooked.

Key information:

Symptoms of suspected covid-19:

• new continuous cough, or
• high temperature (37.8°C)

Shielding extremely vulnerable persons: Those who have: received an organ transplant and on ongoing immunosuppression medication; cancer and undergoing chemotherapy or radiotherapy; cancers of the blood or bone marrow e.g. leukaemia; severe chest conditions such as cystic fibrosis or severe asthma (requiring hospital admissions or courses of steroid tablets); severe diseases of body systems, such as severe kidney disease (dialysis) https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid- 19

Social distancing:

https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection ***Particularly stringent social distancing for vulnerable persons**: aged > 70 (regardless of medical conditions), < 70 with an underlying health condition listed below (ie anyone instructed to get a flu jab as an adult each year on medical grounds), long-term respiratory diseases, e.g. asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis; chronic heart disease, e.g. heart failure; chronic kidney disease; chronic liver disease, e.g. hepatitis; chronic neurological conditions, e.g. Parkinson's disease, motor neurone disease, multiple sclerosis (MS), a learning disability, cerebral palsy, diabetes, problems with your spleen – e.g. sickle cell disease or if you have had your spleen removed; a weakened immune system from HIV and AIDS, or medicines such as steroid tablets or chemotherapy, being overweight (body mass index (BMI) of 40 or above) or pregnant women

Self-isolation:

https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings

Has this child been living in a household with someone who shows symptoms that may be caused by Covid-19?

Yes

•Child to be placed with foster carer who does not meet the description of an "extremely vulnerable person" – check AH form/ urgent GP advice

•**14 days self isolation** (IF EXTREMELY VULNERABLE FOLLOW ADDITIONAL SHEILDING ADVICE + DO NOT PLACE WITH ANYONE SUPECTED OF COVID-19)

•If becomes unwell SEE RED BOX

•Room essential for self-isolation – separate bathroom good, rigorous cleaning

•Carers should ensure that children are not stigmatised during this time, and advocate within their communities against unhelpful rumours

Is this child extremely vulnerable to Covid-19?

Yes

•Must NOT be placed with anyone with suspected COVID-19

•If well after 14 days follow **shielding advice (see PHE** guidance) for 12 weeks

•If child becomes ill SEE RED BOX

No

•If well after 14 days continue **social distancing** see PHE guidance

***Particularly stringent social distancing for vulnerable persons – see key information**

•Handwashing flagged as paramount

•https://www.nhs.uk/live-well/healthy-body/best-way-to-wash-your-hands/

•f household member becomes ill follow pathway for 2 weeks self-isolation

•If child becomes ill SEE RED BOX

No

Is this child extremely vulnerable to Covid-19?

Yes

•Must NOT be placed with anyone with suspected COVID-19

•Foster carer must follow **shielding** advice (see PHE guidance) for 12 weeks

No

•Social distancing advice ***Particularly stringent social distancing for vulnerable persons – see key information**

•Handwashing flagged as paramount

•https://www.nhs.uk/live-well/healthy-body/best-way-to-wash-your-hands/

•If household member becomes ill follow pathway for 14 days self-isolation

ANY CHILD UNWELL/ BECOMES UNWELL

Consider usual other causes of childhood illness as well as Corona and seek appropriate care/ advice

https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms-and-what-to-do/

•If seriously unwell ring 999

•? mild enough to stay home – seek COVID 111 online if concerned about COVID type symptoms / ring 111

•Provide reassurance to child

•If COVID likely, isolate in household for 7 days from last fever day – 2 m distance if possible, own bedroom, bathroom. Will need flexibility with mask etc if younger child not able to keep 2 m needing a hug??

•Domestic cleaning advice and laundry advice https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings

Process for undertaking Adult Medicals during Covid-19 Restrictions

Prepared by:	Mark Tobin Adoption@Heart Service Head
Date:	6 May 2020
Service:	Adoption@Heart
Distribution list:	Medical Advisors, Designated Nurses, GPs within each Trust, Recruitment & Assessment Team

Given recruiting adoptive parents remains a priority for adoption agencies during the period of Covid-19 restrictions, it is important that solutions are identified for ensuring that we do not experience delays in progressing the medical aspect of the adopter approval process.

Following discussions with Medical Advisors and Designated Nurses across the Adoption@Heart partnership, a process has been agreed. There is now a need for a briefing/directive to be communicated to GP's in each Trust, with oversight from the CCG, informing them of the need for Adult adoption medicals to remain a priority and for applicants contacting surgeries for medical appointments, to be offered these in the normal way, to avoid delay.

The regulatory requirement states that:

"the adoption agency must obtain a written report from a registered medical practitioner about the health of the prospective adopter, following a full examination, which must include the matters specified in Part 2 of Schedule 4, unless the agency has received advice from its Medical Adviser that such an examination and report is unnecessary".

The agreed process in meeting this regulatory requirement during the period of restrictions is as below:

Applicants wishing to adopt, will be advised by A@H to contact their GP's in the normal way following Registration of interest, to book their medical examination.

Applicants will also be required to complete a Coram BAAF self-declaration regarding their medical history.

GP's will be advised by each Trust, that Adopter medical examinations remain a priority, as approving adoptive parents and achieving permanence for children with a plan of adoption, remains a priority, despite the restrictions.

In light of the regulation change enabling applicants to progress to stage 2, prior to the agency obtaining the Medical Advisor report, Adoption@Heart will operate in this way. Applicants will not have access to the Independent Review Mechanism if they are subsequently not approved on the basis of medical information obtained during stage 2. The process will be reviewed at the point where the current restrictions are altered.

CCG Recommendations for Adult Health (AH) medicals

Thank you for your continued efforts to transform your services to support your patients during the COVID-19 pandemic. Adoption services in the Black Country continue to approve adoptive parents and place children without delay despite the current restrictions. GPs have previously completed AH assessments for patients registered with their practice. A statutory requirement, this plays a vital part of the adoption process and should remain a priority for GPs and LAC Health services. There is compelling evidence that delayed or missed opportunities of permanence can significantly affect a child's emotional development.

GPs can use their discretion when deciding whether a face-to-face physical examination is necessary. In many cases this can be undertaken in the normal way, but it will also be acceptable for the GP to have a virtual consultation with the applicant where it is deemed appropriate. The GP can complete part C of the AH form in the usual way and report whether this was a virtual or face-to-face consultation. Any limitations of this type of consultation, along with the rationale, should be clearly documented in the records for audit purposes post pandemic. The AH form will be sent to the medical advisor in the usual way for recommendation to adoption panels.

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Blood Borne Infection screening - Information for Young People and Carers

The doctor you met today has recommended that you have a blood test. The blood test is looking for the following infections: Hepatitis B; Hepatitis C; Human Immunodeficiency Virus (HIV), and Syphilis. It is important for you to understand why we want you to have the test, as it is your decision whether to have the blood test or not.

How might I have caught these infections?

These infections can all be passed from person to person. The infections can be passed on from a mother to her unborn baby. Some children are born with infections that they are not aware of until they are much older.

Your doctor might think that you have been at risk from infection because you are from a part of the world where the infections are more common. During travelling to England some children are harmed or might be put in situations where they catch infections.

Lastly, this can occur during sexual intercourse, or through blood, for example if you share a needle with someone who has an infection, it can be passed on to you.

Why is it useful for me to find out if I have an infection?

Most people with infections, especially if they were born with them will feel fit and healthy for a long time. The infection is causing them damage still though. It is possible to have more than one infection at the same time.

Not all of the infections can be cured, but medication stops the disease getting worse, and keeps people healthy. Without treatment and monitoring, all of these infections can cause people to become severely ill or even die.

HIV treatments have improved so much that it is now possible to lead a normal length life, and for women with HIV to have babies who are not infected with the virus.

It is also important to know if you have an infection, so you can learn how to stop it being passed on to other people.

How will the test be done and who will know whether I have an infection?

You will have blood taken using a needle, usually near your elbow. This is done by a Phlebotomist (a person who does blood tests as their job) the test result is usually back within three weeks.

The doctor you have met today will contact you. If the blood tests show that you have no infection, you will be sent a letter. Otherwise, you will be offered another appointment to discuss the results.

The results of your blood test will be given to you and to your GP, and to other doctors who will look after you to treat infections. Nobody else will be told unless you want them to be. It is important that you have support in looking after your health so you may want to discuss this with an adult that you trust.

What will happen if I have got one of these infections in my blood?

You will be seen by a specialist doctor. They will talk to you about the treatment that you need, and they will organise for you to have your health checked regularly.

Read here for more information about each infection:

What is Hepatitis B virus?
Hepatitis B is a virus that affects the liver. It can damage and scar the liver, and in some people it can lead to liver cancer.

What is Hepatitis C virus?
Hepatitis C is another virus that can damage the liver. In most people the liver damage is mild, but in some people it can cause serious liver damage or cancer in adult life.

What is HIV?
HIV is a virus that attacks the body's defense system that fights infections (immune system). This stops the body fighting off infections that a healthy body would be able to.

What is Syphilis?
Syphilis is a bacterial infection that is either caught from sexual intercourse, or is passed on to a baby from a mother who had the infection whilst she was pregnant. It can cause sores and skin rashes at first, and make people feel unwell. If it isn't treated it then affects different parts of the body, including the brain, and can cause death.

Children who are born with syphilis can get damage to lots of different parts of their body, including the brain, bones and teeth.

Syphilis is usually treated with antibiotics.

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Appendix 6

Case Study - Girl S

Girl S was 14 years of age. She lived with her maternal grandmother who had given notice on the placement due to her inability to keep S safe, and her frustrations that the LA had identified that S needed to be placed in foster care but after 7 months, no placement had been identified.

Girl S was NEET (not in education, employment or training) therefore did not have a school nurse. Health promotion and support remained with the CYPiC Health Team.

The CYPiC Health Team were asked to attend a MASE meeting, as significant concerns were raised in relation to CSE. There needed to be a disruption to the relationship between S and the perpetrator and building a relationship with S was felt to be key.

S had identified health needs including poor sleep, delayed immunisations and back pain – which had not been explored thoroughly. There were also concerns about cannabis use. There were weekly attempts made by professionals to engage with S.

What was noted at the MASE review was that there had been a delay in finding S a placement – the courts had identified the need for a therapeutic placement with access to education. It was escalated via the CYPiC nursing team, to heads of service that there was a significant delay, increasing the risk of further harm to S by the perpetrator. The CYPiC nursing team supported the social worker to arrange a multi-agency meeting to prepare for the External Placement Panel (EPP). CYPiC nurse attended the EPP to share concerns once more – and represented health in the absence of a school nurse.

S was placed in a secure placement out of area within a further month.

It is key to note it was felt that the escalation of concerns to heads of service by the CYPiC nursing team, and by supporting the social workers with the process of EPP and MASE is the reason that S is now in a safe environment. S had not received any consistent education for a number of years.

Since being in placement S has been noted to be only functioning at level 1 academically and is attending education provision 75% of the time. There are now no further concerns regarding the perpetrator and her case has been closed to MASE.

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Appendix 6b

Case Study - Boy M

Boy M is a 17yr old Unaccompanied Asylum Seeking Child (UASC). M arrived in the UK via Kent and through the National Transfer Scheme had come to live locally.

M had a Review Health Assessment in September 2018. At this point, he was living in a flat provided through housing support in preparation for becoming 18yrs of age.

M shared with the CYPiC Nurse that he had some urological concerns. His sexual health was reviewed though M was anxious about doing this as due to cultural issues, he was reluctant to confirm that he was or had been sexually active. The CYPiC nurse had a long supportive discussion with him. Following this M was keen to take LAC nurse details and keep in touch regarding any concerns.

M was also worried that he had a court hearing pending in relation to his request for asylum. His social worker confirmed that a referral to CAMHS UASC service had been made at this point.

It was agreed that due to M being isolated, his access to education being tenuous (dependent upon his asylum status) and a current health issue that the CYPiC Health Team would review him in approximately one month should M wish.

M was offered a follow up appointment which he accepted – he had not visited the GP (as 'I did not want to talk to them'). M confirmed he had been sexually active and that he had concerning symptoms. He was referred to outreach sexual health services and had an urgent review. The Nursing Team kept in contact by telephone and confirmed that after treatment his symptoms had resolved.

M unfortunately had his asylum request refused and remains under the care of CAMHS UASC service at the time of writing.

As a health team we were concerned that without the prompts and the ability to build a relationship with a health worker, M would not have disclosed his personal health issues. He was keen to note that his religion was important to him and it took great reassurance to illicit this information. M continues to be offered monthly contact.

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