LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 19 NOVEMBER 2020

Time: 10:30 am

Location:
VIRTUAL MEETING USING ZOOM

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

For Monitoring Officer

MEMBERS OF THE BOARD

Councillors:

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)

Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport

Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty

Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing

Councillor Rita Patel, Assistant City Mayor, Equalities and Special Projects

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

2 Vacancies

NHS Representatives:

Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Frances Shattock, Director of Strategic Transformation, NHS England and NHS Improvement

Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Healthwatch / Other Representatives:

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Adam Streets, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

Kevan Liles, Chief Executive, Voluntary Action Leicester

Kevin Routledge, Strategic Sports Alliance Group

Mandip Rai, Director, Leicester, Leicestershire Enterprise Partnership

STANDING INVITEES: (Non-Voting Board Members)

Richard Lyne, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust

Professor Bertha Ochieng – Integrated Health and Social Care, DeMontfort University

Professor Andrew Fry – College Director of Research, Leicester University

Information for members of the public

Attending meetings and access to information

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It is important, however, that Councillors can discuss and take decisions without disruption. The only participants in this virtual meeting therefore will be the Board members, the officers advising the Board and any external partners invited to participate.

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information If you have any queries about any of the above or the business to be discussed, please contact Anita James**, Democratic Support on (0116) 454 6358 or email anita.james2@leicester.gov.uk**

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

NOTE: Live Stream of Meeting – Members of the public and press can follow a live stream of the meeting on the following link:
https://www.youtube.com/watch?v=hhGSSFtDGCQ

An archive copy of the webcast recording will normally be available on the council's website within 48 hours of the meeting taking place at the following link:
http://www.leicester.public-i.tv/core/portal/webcasts

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members will be asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 8)**

The Minutes of the previous meeting of the Board held on 24 September 2020 are attached and the Board is asked to confirm them as a correct record.

4. CHILDREN'S SAFEGUARDING REPORT **Appendix B (Pages 9 - 56)**

Members of the Board to receive the Children's Safeguarding Annual report for the purpose of noting the contents.

5. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETING

A verbal update against actions of previous meetings will be given.

6. MENTAL HEALTH FRIENDLY CITY

Paula Vaughan, CCG, to introduce this item and outline concept for a Mental Health Friendly City.

7. ADHD PRESENTATION **Appendix C (Pages 57 - 68)**

Members of the Board will receive a presentation about ADHD and will be invited to discuss the context of ADHD across Leicester including challenges and service provisions.

8. HEALTH INEQUALITIES

Members of the Board will receive a short presentation around Health Inequalities.

9. ANY OTHER URGENT BUSINESS

10. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 28 January 2021 at 10.30am
March date to be confirmed.

At the current time all meetings will be by virtual means until such times as physical meetings can reconvene.

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD
Held: THURSDAY, 24 SEPTEMBER 2020 at 10:00 am as a Virtual meeting using Zoom

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing
Councillor Piara Singh Clair		Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council
Councillor Sarah Russell		Deputy City Mayor, Social Care and Anti-Poverty, Leicester City Council
Ivan Browne		Director of Public Health, Leicester City Council
Martin Samuels	–	Strategic Director Social Care and Education, Leicester City Council.
Professor Azhar Farooqi		Co-Chair, Leicester City Clinical Commissioning Group
Professor Andrew Fry	–	College Director of Research, Leicester University
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Kevan Liles	–	Chief Executive, Voluntary Action Leicester
Dr Avi Prasad	–	Co-Chair, Leicester City Clinical Commissioning Group.
Kevin Routledge	–	Strategic Sports Alliance Group
Frances Shattock	–	Director of Strategic Transformation, NHS England and NHS Improvement
Chief Supt Adam Streets	–	Head of Local Policing Directorate, Leicestershire Police.

Standing Invitees

Richard Lyne	–	General Manager, Leicestershire, East Midlands Ambulance NHS Trust

In Attendance

Gordon King	–	Director Adult Mental Health, LPT

Paula Vaughan	East Leicestershire & Rutland CCG
Hayley Jackson	NHS England
Caroline Trevithick	West Leicestershire CCG
Mark Wheatley	Programme Manager Mental Health, Leicester City Council
Sarah Prema	Leicester City CCG
Simon Pizzey	Head of Strategy & Planning, UHL
Kate Huszar	Health & Wellbeing Lead Officer, Leicester City Council
Anita James	Democratic Services, Leicester City Council.

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Rita Patel, Angela Hillery, Andy Williams, Mandip Rai, Mark Wightman, Tracie Rees, Ruth Lake, Lord Bach and Professor Ochieng.

2. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

3. MENTAL HEALTH AND EMOTIONAL RESILIENCE ISSUES ARISING FROM COVID 19

The Chair welcomed everyone present and thanked all partners for their contributions in the supporting papers to this meeting.

Members of the Board received a presentation on Mental Health and Emotional Resilience issues arising from Covid 19.

Gordon King, Director of Adult Mental Health (LPT) and Paula Vaughan (CCG) introduced themselves and led the presentation and ensuing discussions which were focused around: what the impact of Covid had been on Mental Health of people in Leicester; how Covid driven innovations had made a difference; ensuring innovations and service improvements were working together to have maximum impact on Leicester's communities; and how to support the development of community based Mental Health services that meet the needs of neighbourhoods and people across Leicester.

It was commented that Mental Health services had never faced quite so many challenges as were now being presented in light of the Covid 19 impact and it

was noted that system partners had taken time to look at the impact of Covid 19 upon the Mental Health of people and todays purpose was to consider that and feedback further thoughts.

Attention was drawn to key points of feedback from system partners which included:

LPT

- An increased acuity in those coming forward being more poorly than before with a definite increase in numbers and demand for services and a notable increase in those who were not previously known to services.
- Covid had brought about challenges such as face to face services and to the practicalities of managing in-patients i.e. Bradgate Unit

Police

- There was some indication of a correlation between increasing numbers of missing persons and Covid

OPCC

- Noticed an increase in child sex abuse and abuse relating to internet usage

UHL

- Increase in number of people presenting to A&E with mental health issues as well as increase in people not previously known to mental health services

Universities

- Increase in last few weeks of young people returning to Leicester as students, and seeing an increase on demand for welfare and support services particularly focused on the Hardship Fund and tying in with the economic impacts of Covid

All partners also agreed that Covid has had a significant impact on all staff groups who were their greatest asset but who were also under challenge of Covid with such things as children being at home, isolation and caring for others.

On a positive point, organisations had seen a reduction in overall sickness absence amongst staff and flexible working arrangements and remote working had been positive in allowing people the flexibility to balance their lives better.

The Board discussed the impact of Covid on Mental Health in Leicester's communities which in summary included the following points:

- Raising the concept of investment funding for Mental Health and keeping communities well. System partners were in an adjacent position around funding as it was expected the wider public finances would be under pressure moving forward and there was increased uncertainty about future funding.
- Children, Young People and Parents, although the Board was more focused on adults there is a need to think about impact on children of school age and how that impacts on parents as well as looking at the perspective of new parents and their mental health as Covid had affected maternity, visiting and health services and also to consider people with learning disabilities whose situations were made worse by

added complications in the system.

- Whilst there was a solid offer in place assurances were sought that there was proper sign posting to services and there is a need to think about the robustness of services as well as access to services too.
- Loneliness was recognised as having a big effect on those isolating and their mental health.
- Digital solutions were not always best for everyone and there was raised anxiety in some people around waiting to get GP appointments or access to other health services.
- Important to acknowledge impact on BAME community that perhaps didn't recognise mental health issues in the same way as other groups in society.
- In terms of safeguarding and mental health referrals it was suggested it would be helpful to understand the number of referrals and how that was being managed in terms of access to services and the prioritisation of cases.

Gordon King, Director of Adult Mental Health (LPT) then presented an overview of local innovations to meet demand in mental health services which included progress on projects pre-Covid such as STEP up to GREAT Mental Health; Inpatient Grip and Flow and the agreed plan for reducing dormitories.

In relation to Inpatient Grip and Flow it was noted that there were a substantial number of out of area placements, and the government had set a target to reduce that to zero by March 21, the process to achieve this started in Sept 2019 and by January 2020 had been met. Despite Covid the Trust was one of a few now running at zero out of area placements which was a positive picture and had attracted National attention.

Members of the Board also commented on the redeveloping dormitories plan and were pleased to see this piece of work as patients deserved the right environment to recover in.

Key Challenges in terms of waiting times, caseloads & capacity; Care Planning & documentation and sustaining quality improvement were briefly outlined.

In terms of managing through Covid the key changes introduced were outlined as set out in the presentation slides as follows:

- Central Access point (CAP)
- Mental Health Urgent Care Hub (MHUCH) – this was very innovative and also attracting attention of National Teams for the work done
- Isolation wards and inpatient flow
- Community Rehabilitation
- Maintaining majority of community activity

Quality and infection prevention control (IPC) around workforce and patient safety was set out along with details of the recovery plan and a discussion about service integration and how innovations had made a difference to patients and partners.

The ensuing discussion also included several concerns: that there was a reservoir of mental ill health issues waiting to surface; about the effects of “loss” not just in terms of bereavement but also loss of livelihoods, jobs, business and way of life; about increase in domestic abuse and the impact of that upon mental health of victims and their families; and upon changes to delivery of teaching which raises potential for social isolation, loneliness and unreported mental health issues among the student population.

It was commented that Covid had laid bare more of the inequalities around mental health and it was important to ensure all the services and initiatives operated as a collective system delivered through partnership and transformation of the delivery of these services and to ensure people did not drop out of the system at any point.

It was recognised there was a definite demand for mental health services as well as an unknown demand for mental health services across the city. It was suggested that access to additional resources such as IAPT should be monitored and that equality data should be reviewed to understand the take up of such services by people from BAME communities.

Discussion continued around “meeting the new need” and integrating offers between partners, recognising a need for a broader community early support kind of approach and building on a strength’s based approach with services reaching out to people to support them.

The role of Neighbourhoods and Primary Care Networks was noted and in relation to supporting the development of community based mental health services it was suggested there was a need for a more preventative focus within the community based offer as well as more focus on joined up collaborative partnership working including consultation with voluntary sector and community engagement. The importance of listening and engaging service users, their families and the voluntary sector was noted, as well as ensuring people were being referred to the right services that could help them with the issues that were impacting their mental health such as their poverty.

In terms of financial resource for services, it was recognised that money was an issue with uncertainty about future funding and it would require strategic thinking of what the priorities in the system are and where resources could be reallocated to keep that service flowing.

It was acknowledged that the Board had a central role in constructing and guiding strategy for services and since Covid there had been much more discussion between all partners looking at this as a system with shared objectives and how it should be shaped as well as support work in terms of bringing this down to neighbourhoods.

There was a brief discussion around the issue of PLACE and the importance of configuration noting there was a risk around a single definition of PLACE and recognising the need to be flexible, with services shaped around the needs of

people across the city rather than services structures.

In terms of strategy it was agreed it would be helpful for organisations to share their strategy on what mental health should look like across the city but being mindful of other partners work with other large organisations that impact upon peoples mental health e.g. the Court Service; or the DWP.

It was noted that the Council had a Health and Wellbeing Strategy which included strands for PLACE and mental health, and this would be an opportune time to review that to ensure it was still fit for purpose and together with feedback from the Health & Wellbeing survey those should be used as tools to help inform the Board what they do.

ACTION: Officers to review and revisit key targets in the Health & Wellbeing Strategy

4. FUTURE ITEMS OF BUSINESS AND DATES OF FUTURE MEETINGS

The Chair commented that this had been a very useful meeting focused purely on mental health issues and the conversation about mental health would be continued at the next meeting.

Board members suggested items for inclusion at future meetings as follows:

- Focus and review of “strategy” at the next meeting.
- Explore Primary Care Networks in more detail.
- Consider the effects of Covid and mental health impacts/needs of new parents, parents of school age children, people with learning difficulties and carers.
- Consider long term plans for Ageing Well and supporting people living with frailty.
- Consider the digital divide to those accessing services.
- A discussion on PLACE.
- Return to Health Inequalities e.g. diverse effects of culture and society on mental health.

The Chair concluded the series of issues to be picked up at the next and future meetings and hoped that those would be reflected in the reviewed strategy.

The Chair thanked everyone for their contributions to today’s meeting.

The Board noted that future meetings of the Board would be held on dates to be scheduled.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

None received.

6. ANY OTHER URGENT BUSINESS

None.

There being no further business the meeting closed at 11.58am.

Annual Report Looked after Children (LAC)
Leicester city, Leicestershire and Rutland (LLR)
2019 – 2020

Contents

Abbreviations

ABBREVIATIONS

ACE's Adverse Childhood Experiences

CAMHS Child and Adolescent Mental Health Service

CCG Clinical Commissioning Group

CICC Children in Care Council

CQC Care Quality Commission

DfE Department for Education

DoH Department of Health

EHCP Education and Health Care Plan

HNA Health Needs Assessment

IHA Initial Health Assessment

IT Information technology

JSNA Joint Strategic Needs Assessment

LAC Looked after Children

LCHS Leaving care health summary

LLR Leicester, Leicestershire and Rutland

LPT Leicestershire Partnership Trust

MA's Medical Advisors

MISTLE Multidisciplinary Intervention Support Team Leicestershire

NHSE National Health Service England

NHSI National Health Service Improvement

OLAC Out of area looked after children

RHA Review Health Assessment

SEND Special Educational Needs and Disability

SDQ Strengths and Difficulties Questionnaire

SOG Standard Operating Guidance

YPT Young People's Team

1. Executive Summary

1.1 This Annual Report describes the key developments to improve the health and well- being of LAC over 2019/20 that has been driven by the work of the multiagency Looked after Children and care leavers Strategic Health Group. Hereafter referred to as the Strategic Group. The Strategic Group has shown continued commitment by the three local authorities and health to drive forward better health outcomes for LAC.

1.2 The Strategic Group have worked in effective collaboration to approve administrative processes where health and children's social care partners can access IT systems to check LAC information and increase time efficiency for both initial and review health assessments.

1.3 The LAC Service Specification was signed off in October 2019 between the clinical commissioning group and Leicestershire Partnership Trust. The key performance indicators now fully comply with statutory requirements and are clearly monitored in a multiagency approved dashboard with exception reporting evidence supplied by the Operational LAC Health Group.

1.4 National best practice of using enduring consent has been agreed enabling parents to agree to health assessments for the whole time their child remains in care and this improves access to health services.

1.5 There has been demonstrable increased success in achieving high levels of RHA performance to meet national targets.

1.6 A Leaving Care Health Summary (LCHS) is now fully embedded in practice. Joint working between the LAC nurses and the Personal Advisors for care leavers has improved attendance at pathway planning meetings (when care leaving is first discussed). Utilising the LCHS and health guidance developed alongside this has been shared at regional level.

1.7 The Police national best practice LAC pack has been endorsed and shared by NHS England.

1.8 Annual LAC Health Summits are an opportunity for LAC and care leavers to influence LAC health services. At the 2019 Summit young people expressed a need for further information on access to health services as they transition to adulthood. This resulted in the East Midlands wide health passport guide and adding information for care leavers to the health for teen's website.

1.9 Feedback Children in Care Councils (CICC), Care Leaver Groups and the LAC Health Summit translate to key priorities for the Strategic Group to take forward.

1.10 An annual Health Needs Assessment on LAC by public health is now agreed across LLR and this feeds into the Joint Strategic Needs Assessment (JSNA's) of Leicester city and Leicestershire and Rutland.

1.11 The commissioning of LAC Nurses to support the completion of the Strength and Difficulties Questionnaire (SDQ) at the Review Health Assessment (RHA) will improve holistic and timely health reviews.

1.12 The Care Quality Commission (CQC) Rutland Report of July 2019 endorsed and acknowledged the success of the CAMHS LAC pathway

1.13 Success of the Care Navigation role in LAC health services has resulted in improved administrative processes, managing complex LAC cases and increasing access to health services.

2. Introduction

2.1 During 2019 – 2020 1300 children were in the care of Leicester, Leicestershire and Rutland local authorities who together with local health services have committed to making sure these children are as healthy as possible.

2.2 Across Leicester City, Leicestershire and Rutland the local governance structure and Partnership working between local authorities and health has supported the delivery of the **joint *Department of Health (DoH) and Department of Education (DfE): Statutory guidance: Promoting the health and wellbeing of looked-after children (2015).***

2.3 This statutory guidance is issued under ***section 10&11 of Children Act 2004*** and sets out how local authorities, CCGs and NHS England and Improvement (NHSEI) are required to work together to promote the health and wellbeing of LAC.

2.4 This 2019/20 annual report details the local progress to enact the requirements of the statutory guidance, and how strategic planning is taking forward the commissioning priorities for LAC with Leicester City, Leicestershire and Rutland local authorities and commissioned health services.

2.5 The recent change in legislation; **The Children and Social Work Act 2017 (DfE**), which extends the age that local authorities support care leavers and is reflected in this report describing the increased involvement of LAC health in supporting transitions to adulthood.

3. The Governance Structure

3.1 This Annual Report will be received by the Executive Director of Nursing and Quality representing the three Clinical Commissioning Groups (CCGs) of LLR and the Directors of Children's Social Services for the Local Authorities of Leicester City, Leicestershire and Rutland. They will advise the report be presented to the relevant agency quality assurance group and processes. The report will then be received by the thee Local Authorities Corporate Parenting Boards, the Safeguarding Children's Partnership Boards and the Health and Well-being boards.

4. The Looked after Children and care leavers Strategic Health Group

4.1 The Looked after Children's health agenda is driven by the work of the Strategic Group. Membership includes strategic LAC and care leaver service leads from the three local authorities, the two public health departments, the health provider Leicestershire Partnership Trust, Child and Adolescent Mental Health (CAMHS) and the clinical commissioning groups children and young people's commissioning and safeguarding representatives. Details of the progress made in 2019/20 are set out below:

4.2 **Multiagency effectiveness-** the establishment of the Looked after Children Operational Health Group that delivers monthly assurance to the Strategic Group for example data from the LA's to LPT on new LAC and movement of placements ensures improved knowledge of the LAC caseload across services.

4.3 **Improved administrative processes** - over the last year communication has developed and improved between the LA partners and health providers regarding those children and young people becoming due for their Review Health Assessments. A waiting list is in place ensuring reminders of children due an RHA and timeliness of assessments has greatly improved. Utilising SystmOne to its full potential in regard to Data collation and meeting the Key Performance Indicators. Regular communication from LA regarding admissions, discharges and changes of placement has been more accurate and effective during 2019. Planning for a single electronic patient record for Fostering and Adoption is underway.

4.4 **Care Navigation** - The role of the Care Navigator has been essential to the development of administrative processes to support the LAC service for example: the IHA and RHA decliner pathways and blood borne virus screening pathway. Care navigators track the return of completed IHAs for LAC who originate from LLR living in LLR and those who have been placed outside the area. In addition they also track the return of the RHAs for LAC placed out of area. Care navigators are increasingly obtaining historic medical information for LAC Doctors and Nurses to ensure that the young people have as full a health history as possible. This includes birth details, Bloodspot results and historic genetic, x-ray and scan results. The details of attendances at out of LLR Emergency Departments, Urgent Care Centres and Walk in Centres for LAC originating from LLR but living out of area are obtained where nurses are notified of attendance with no clinical details supplied.

4.5 **Establishing enduring consent** – the format for enduring consent has now been agreed across the 3 local authorities. When this is embedded it will allow health to undertake further health assessments without excess paperwork and delay. The Strategic Group enabled the progression to use the new enduring consent process in 2020 which should commence summer 2020.

4.6 **Improved RHA performance** has been considerable in comparison to 2018/19 figures (shown in the 2018/19 annual report), this has remained consistently high throughout the year as shown in tables later in this report. The combined efforts of both LA and health administrative teams in establishing waiting lists and early notification of RHA requests has ensured that children and young people have their health assessed in line with legislative requirements.

4.7 **Leaving Care Health Summaries embedded in practice** - The number of completed LCHS has increased in the last year and reporting the numbers is now in place in Q1. The LCHS documentation has improved with a virtual version being developed and linking to a QR code which can be scanned by a smart phone. The LCHS has been updated in partnership with service users from the children in care councils (CICC) and care leavers groups. Young people recommended the use of QR code to enable the scanning of the LCHS rather than a paper version as this would be more compatible with their use of technology. A LCHS audit of quality will be reported in July 2020.

4.8 **The LAC Pack** – There has been a positive impact of the use of the LAC pack in Residential Children's Homes and with carers including: improved understanding of their role in keeping children safe and the importance of working with the police to reduce children going missing. There has increased the emphasis on understanding the health and well-being LAC living outside LLR and on LAC from external areas living in LLR. Better mapping of this cohort of children and young people has been enhanced by use of the pack. The Residential Children's Home staff can use the Pack to inform partner agencies of the details of the young people in their care from other local authorities. This provides increased assurance to the police and the CCG about the young people in their area and any specific risk factors.

4.9 **Health Summit May 15th 2019** – This is now an annual event. The 2019 summit was well attended with over 100 multiagency participants from children's social care, health, public health, voluntary organisations, foster carers, residential carers and care leavers. The presentations covered the work done in response to the October 2018 Summit, Health for Teens Website, HNA, CAMHS and the ACEs and MISTLE projects and next steps. The key issues arising from the event were: endorsement to extend the content of the health for teen's website to include health advice and support for care leavers in partnership with the CICC's and local care leavers. The development of an improved LCHS in consultation with young people about to leave care. The development of an East Midlands wide comprehensive care leavers' guide which is also accessible via QR code to smart phone. The work of LAC nurses with personal advisers and 16+ workers to embed the LCHS and promote good transitions between child and adult health services was also approved. The LAC Health Summit which was due in June 2020 has been delayed due to the Covid-19 pandemic.

4.10 **Voice of the child and young person in care** – The details of responding to the views of children and young people are detailed above. In addition the introduction by LPT of a Standard Operating

Guidance (SOG) for the LAC Nurses has a greater emphasis on recording the views of the LAC and screening for their emotional well-being

4.11 **Increasing SDQ completion rate at the time of the RHA** (The SDQ is defined at 9.2 of this report) which is a longstanding issue. LPT have presented the option to commission the LAC Nurses to obtain a current SDQ from carers at the RHA. This has been agreed by all three local authorities but only progressed to service specification by Leicestershire and Rutland. The future plan would be to initiate Nurses collecting the SDQ and triangulation of SDQ data between carer, school and if appropriate the child's own scoring.

5 The Looked after Children Service Specification

5.1 In line with the **Intercollegiate Guidance (2015)** and CQC recommendations the Designated Nurse LAC transferred to the CCG in May 2019. This enabled the role to undertake an increased strategic overview of the health and well-being of LAC across health and local authority services. The Designated Nurse LAC role is located within the CCG Safeguarding Team

5.2 A revised Service Specification was agreed between the commissioner the LCCCG and the provider LPT in October 2019. The 0 – 19 Healthy Together Service provide health visiting/public health nursing services to undertake Review Health Assessments (RHAs) for those LAC under the age of 5 years. LAC Nurses from the LAC Health team complete the RHAs and LCHS (who are eligible) for LAC aged 5-18. The Service Specification includes both the medical and nursing components and Adoption services.

5.3 The service is now monitored against national statutory targets:

- **Initial Health Assessments –** IHA national timescale of Health report available for first LAC review at 20 working days from entering care. The report needs to be sent to the LA by the 19th working day. (Previously this was measured by the return of the health report by 20 working days **from referral** by the LA.)
- **Review Health Assessment –** RHA national timescale 6 months after the IHA for children aged 0 – 4 years and every 6 months until aged 4 years 10 months. Every 12 months after the IHA for children 5 – 18 years and then every 12 months for all their time in care until the age of 18.(previously the RHA was completed within 8 weeks of referral even if the referral was late)
- **Strength and Difficulties Questionnaires –** all Looked after Children (LAC) and young people aged 4 – 16 years who have been in care for 12 months of more have to have an SDQ a minimum of annually to inform their RHA.
- **Leaving Care Health Summaries –** All eligible LAC originating from LLR require a summary of their health history and advice and support when transitioning from child to adult health services between the age of 16 and 18 years. The LCHS cannot currently be commissioned for those LAC living outside the area (NHS England 2019)
- **Annual Health Needs Assessment on LAC.** The service will contribute data to the Annual Health needs assessment and this should inform JSNA and commissioning of service

6 Looked After Health Team

6.1 **Medical:** The CCG has secured the expertise of a Designated Doctor for LAC who is employed by the Provider organisation Leicestershire Partnership Trust (LPT). This is a strategic role across LLR. LPT have combined a Named Doctor for LAC alongside the Designated Doctors strategic responsibilities. This enables LPT to provide LAC clinical expertise to undertake and support the Initial Health Assessments and audits.

6.2 The medical team comprise three paediatricians (including the Designated Doctor) who undertake IHA s as part of a wider job plan and two sessional GPs who have paediatric training, two Medical Advisors for Adoption and one MA for fostering. Trainee paediatricians and GPs also complete IHAs under supervision. There has been a recent increase in medical capacity within the team to improve the timeliness of IHAs in response to the change in KPI.

6.3 **Nursing:** LAC nurses are all qualified nurses at grades 5 and 6 the team comprises of 4 Band 5 Nurses delivering 3 whole time equivalent (WTE) hours per week and 6 Band 6 Nurses delivering 4.2 WTE hours per week. The nurses are split into 4 teams covering specific geographical postcodes with a Band 5 and Band 6 nurse in each area. Included in the Band 6 provision 2 nurses work with specific caseloads one with Unaccompanied Asylum Seeking Children (UASC) and one with LAC aged 16 – 18 in semi-supported living. These nurses have additional skills to support these cohorts of young people who have additional and specific vulnerabilities. The team are line managed by a Band 7 (0.6 WTE) clinical team leader who works closely with the Named Nurse LAC. The Band 7 Named Nurse for LAC (full time) has a specialist role as a clinical expert in LAC as outlined in **The Intercollegiate Role Framework "Looked after children: Knowledge, skills and competencies of health care staff" March 2015 (RCGP, RCN, RCPCH).**

6.4 **Administration:** The looked after children admin team consist of 1 (WTE) Band 4 Admin Team Leader, 3.57 (WTE) Band 3 Senior Admin and 2.6 (WTE) Band 2 admin. The team provide essential support to both the medical and nursing Looked After Children Teams and Fostering and Adoption in an addition to Medical Safeguarding.

6.5 **Care Navigation:** Care navigators are experienced administrative staff who support an efficient LAC administrative service and ensure timely health assessments and comprehensive health details are available to the clinical health staff.

7. <u>Rutland Care Quality Commission (CQC) Inspection July 2019</u>

7.1 The Young Person's Team (CAMHS) received the following positive comments following this inspection: '*'The local area had a 'fast track' care pathway to help promote a timely response to referrals made to the Young Person's Team (CAMHS). The team offered a consultation clinic in Rutland once a month. This helped identify children and young people who would benefit from direct work"*

7.2 The recommendations following the CQC Inspection for improving the health and well-being of LAC have been taken forward by the Strategic Group. Progress includes:

- **Ensuring effective joint arrangements for improving health outcomes for children looked after** – This has been improved by the work of the Operational and Strategic Groups and the development of the dashboard reporting to statutory targets. This enables blocks in the system to be identified and addressed for example aligning access to the IT systems between health and children's social care.
- **Ensuring initial health assessments and care planning for children consistently meets standards outlined in health regulations and clinical guidance** - The Service Specification LAC requires LPT to provide the Key Performance Indicators identical to the statutory requirements. Clear exception reporting is now provided to enable the Strategic Group to target areas of poor performance accurately and quickly. RHA performance has vastly improved in the last year. The improvement in IHA data to meet statutory requirements remains a challenge. The numbers of LCHS has increased over the year.
- **Ensuring children placed out of area benefit from a consistently high standard of health assessments and care planning** – The Designated Nurse LAC audits all of the health assessments undertaken by external providers. The audit is undertaken using the nationally agreed standard Annex H tool. The external provider is notified by the Designated Nurse LAC about any health assessments that do not meet the required national standard. In 2020/21 the IHA and RHA data on the timeliness of health assessments for LAC placed out of area will be reported as detailed in the service specification and dashboard.
- **Ensuring all children looked after benefit from timely access to support in meeting their mental health needs** – In order to improve the accuracy of emotional/mental health assessment of LAC: The 3 local authorities have agreed to commission the LAC Nurses from LPT to ensure the SDQ is completed by the carer at the RHA will commence July 2020. The commissioning of this service was driven by the Strategic Group due to the entrenched problem of SDQ timeliness.

8. Epidemiology and LAC data National and local comparisons

8.1 **Table: Numbers of Looked after Children:**

LAC 1 = population at 31/03/19
LAC 1a = population at 31/03/20
LAC 2 = population taken into care in 2019
LAC 2 a = population taken into care between 01/04/19 and 31/03/20

Area	All	Male	Female	Under 1 year	1-4 years	5-9 years	10-15 years	15+ years	Rate per 10,000 children
England LAC 1	78,150 up 4%	56%	44%	5%	13%	18%	39%	24%	
LAC 2	38,830								65
East Midlands LAC 1	5,820								53
Leicester city LAC 1	654			38 6%	111 17%	140 21%	249 38%	116 18%	66
Leicester city LAC 1a	600			29 5%	94 15.6%	136 22.6%	224 37%	117 19.5%	73
Leicester city LAC 2	206								
Leicestershire LAC 1	584								35
Leicestershire LAC1a	659			36 5.4%	98 15%	134 20%	234 35.5%	157 24%	
Leicestershire LAC 2	121								
Rutland LAC 1	33								44
Rutland LAC 1 a	43			2 4.6%	8 18.6%	15 35%	5 11.6%	13 30%	
Rutland LAC 2 a	26			3	4	4	6	9	

8.1.1 **Analysis:** The LAC population across England has increased significantly up 4% to March 2019 as seen in Table 8.1. In LLR the LAC population has remained similar in the years 2019 to 2020. The Leicester city LAC population has decreased by over 9% and has utilised a number of successful strategies to support families where there was a risk of children becoming LAC. The Leicestershire LAC population has increased by over 12%. Rutland LAC population has increased significantly but actual numbers remain low. LPT has reviewed how LAC nurses are working across LLR with dual qualified nurses working with registered nurses across a geographical patch. RHA clinics have been established to review LAC in stable placements with few health issues and the more complex children are seen by LAC nurses with greater experience and skills. In particular UASC and those LAC in semi-supported or residential care get additional support.

8.2 **Table: Unaccompanied Asylum Seeking Children UASC 2019/2020**

Area	Numbers 2019	Numbers 2020
East Midlands	190	
Leicester city	14	4
Leicestershire	28	27
Rutland	N/A	3

8.2.1 **Analysis:** There have been more Unaccompanied Asylum Seeking Children (UASC) residing in LLR and having a health assessment in LLR although there has been a decrease in the number of UASC who originate with Leicester, Leicestershire or Rutland as their responsible LA. The highest number came from Leicestershire (Table 8.2). Interpreters are used at IHA and RHA for UASC and there is close follow up of any additional blood tests and additional treatments by the UASC nurse. The specialist UASC nurse works with the UASC population, she links with the regional UASC group and has received additional training. The UASC nurse utilises resources developed by the Kent LAC services, for example: sleep hygiene, dietary advice, exercise to manage trauma.

8.3 **Table: Reasons for being in care 2019**

Reason for being in care	Total number England 2019	Percentage England 2019	Leicester City 2020 (7 LAC were not coded)		Leicestershire 2020		Rutland 2020	
Risk of abuse and neglect	49,570	63%	431	72%	416	63%	29	67%
Family dysfunction	11,310	14%	66	11%	80	12%	6	14%
Family in acute stress	6,050	8%	53	9%	53	8%	3	7%
No parents available	5,410	7%	18	3%	35	5%	3	7%
Parent or child illness or disability	4,580	6% (3% parent, 3% child)	21	3.5%	67	11% (5.6% parent 4.5% child)	2	4% (2% parent, 2% child)
Socially unacceptable behaviour	1,230	2%	4	0.6%	8	1%	N/A	N/A

8.3.1 **Analysis:** In LLR there is a higher than the national average number of children who enter care under the category of abuse and neglect. There is a lower than national average number of children who enter care due to family dysfunction. The category of illness or disability in a child or parent is significantly higher in Leicestershire. Where the family were in acute distress the LLR figures are broadly similar to the national average. The Named Nurse has been trained in Signs of Safety the model used by the children's social care workers and all the LAC nurses work closely with social care colleagues to address the impact of neglect on the health of LAC. The SOG for LAC nurses details the care packages required to support LAC and their carers and mitigate against the consequences of neglect. These include managing continence, supporting good hygiene and supporting dietary change.

8.4 **Table: Ethnicity of children in care**

Area	White British	White Other	Mixed Ethnicity	Black British/Black other	Any Asian background	Other
England	74%	-	10%	8%	-	-
Leicester	57%	4%	19.5%	7.5%	9.3%	2.1%
Leicestershire	85.5%	2.4%	8.5%	-	-	3.5%
Rutland	81%	-	8%	2%	-	-

8.4.1 **Analysis:** The ethnic background of LAC in LLR reflects the different populations across the city and two counties. Leicester city is one of the most ethnically diverse populations in England, the ethnicity of the city is somewhat reflected in the LAC population but white children and young people still represent the majority of LAC across LLR.

8.5 **Type of placement - England:**
Foster care = 73% (58% foster carer and 13% family or friend placement)
Secure unit/children's home/semi-independent living = 12%
With parents = 7%
Living independently or residential employment = 4%
Placed for adoption = 3%

8.6 **Table: Type of placement LLR**

Placement Type	Leicester city	%	Leicestershire numbers	%	Rutland numbers	%
Local Foster Care	455 (all types of Foster Care)	76%	476 (all types of Foster Care)	72%	14	33%
Independent Foster Care			As above	As above	8	19%
Residential Care	72 (includes all types)	12%	82	12.4%	8	19%
Connected Person					7	17%
With parent	28	4.6%	-	-	4	9%
Child/Parent placement	2		-	-	1	2%
Supported placements	6	1%	68	10.3%	-	-
Adoption	14	2.3%	17	2.5%	-	-
Unregulated placement	-		25	3.8%	-	-

8.6.1 **Analysis:** Foster care remains the main form of care for LAC from LLR. The placement within a residential setting is broadly similar to national figures. Adoption figures are lower than the national average. Annual training of foster carers is delivered by the LAC nursing team based on topics chosen by cares. These have been well reviewed and have included sessions by Speech and Language Therapists, CSE Nurses and the CAMHS YPT.

8.7 **Table: LAC originating from LLR placed outside LLR (April 2020)**

Local Authority	Number placed out of LLR
Leicester city	113
Leicestershire	145
Rutland	17
Total	275

8.7.1 **Analysis:** A large number of LLR LAC are placed outside LLR, at March 2020 21% of LAC who originated from LLR were placed beyond the LLR boundary. This number remains broadly the same as in previous years at around 270 children and young people. Their numbers and health needs have been monitored more closely since the Designated Nurse LAC moved to the CCG. Every LAC living out of area has their health assessment quality checked by the Designated Nurse LAC which includes checking the timeliness and the detail of a holistic health plan. The three local authorities have been extremely supportive of sharing the LAC reviews on these children as LPT nurses are

unable to attend these reviews. This has resulted in up to date reviews being visible in the Systm0ne record increasing assurance to the CCG.

8.8 **Table: LAC originating from external local authorities (OLAC) (April 2020)**

Local authority where externally placed LAC aged 5 – 18 live	Numbers
Leicester city	10
Leicestershire	132
Rutland	9
Total	151

8.8.1 **Analysis:** The aforementioned **statutory guidance (2015)** makes clear it is a requirement of CCG's that they are able to demonstrate knowledge of the whole of the LAC population, and that they have made provision for meeting their health needs. This includes those children from out of area who are placed in LLR. These children and young people will require access to all health services and must not have their health needs delayed by lack of access to LLR health services due to their LAC status.

8.8.2 LPT LAC nurses are commissioned by originating CCG's to undertake health assessments for OLAC. Currently in March 2020 the nurses have been commissioned for 70 LAC aged 5 – 18 and not commissioned for 81 OLAC. All OLAC are recorded on the Systm0ne LAC caseload whether or not LLR are commissioned to undertake the RHA. The sharing of data between the LA's and health has enabled the CCG's to have full knowledge of OLAC and their originating area details.

8.8.3 All OLAC under the age of 5 years are managed with the health visiting caseload and within the geographical area where they are registered with a GP. Service delivery for OLAC is clearly outlined in the 0 – 19 Healthy Together Standard Operating Guidance.

8.8.4 LPT would only be aware of the OLAC in their area through the information being shared by the local authority. When the LAC moves out of the originating LA that LA and health should also be informed whether or not the LAC health services undertake work with these children. The systems to assure the CCG that health have full knowledge of this cohort has been strengthened in 2019/20 by the use of – The LAC pack, the East Midlands Protocol and monitoring of LAC moving placements which is reported monthly by LPT to the Designated Nurse LAC who will escalate concerns with the appropriate LA.

8.9 **LAC who have a SEND (data source local authorities April 2020):**
Leicester city 240
Leicestershire SEN support 116
Rutland 4

8.10 **LAC who have an EHCP (data source local authorities April 2020):**
Leicester City 58
Leicestershire 167
Rutland 3

8.11 **Analysis:** The Designated Nurse LAC provides specialist advice to the CCG Children's Commissioning Team where issues arise concerning the health and well-being of LAC who have SEND and or an EHCP.

9 Health Assessment Data

9.1 Table: IHA and RHA Data

Date of the change of key performance indicator (Kpi) for IHA and RHA shown in red.

IHA back to LA in 19 days	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
City	14%	40%	25%	39%	38%	50%	60%	6%	8%	0%	25%	14%
County	35%	22%	20%	44%	27%	27%	11%	33%	19%	7%	47%	41%
Rutland	N/A	N/A	100%	0%	0%	N/A	0%	N/A	0%	N/A	N/A	N/A
RHA 0-4 yrs within 6 months of last RHA	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
City	95%	100%	80%	94%	100%	100%	100%	100%	95%	100%	100%	100%
County	80%	88%	58%	82%	71%	90%	95%	84%	86%	90%	58%	100%
Rutland	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A	N/A	100%
RHA 5-18 yrs within 12 months of last RHA	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
City	98%	97%	100%	98%	100%	100%	100%	100%	100%	100%	97%	96%
County	78%	74%	100%	88%	87%	85%	89%	88%	78%	84%	93%	88%
Rutland	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	50%	50%	100%

9.1.2 **Analysis:** The revised Service Specification for LAC signed in October 2019 clarified that the health assessment data needed to be reported in line with the statutory requirements in the legislation **The Statutory Guidance on Promoting the Health and Well-Being of Looked after Children 2015 (DfE and DoH).** The IHA needs to be completed and returned to the requesting local authority (LA) in time for the first review at 28 days since the child came into care. The measure was agreed at 19 working days for the IHA to be returned to the LA. In order to achieve the required timescale the LA and health need to work together to refer a child as they enter care and offer an IHA appointment as soon as possible.

9.1.3 Improving IHA timeliness continues to be a priority for the Strategic Group.
IHA performance has fallen in 2019/20 LPT provides an exception report to the multiagency LAC Operational Meeting which is then shared with the Strategic Group on a monthly basis. There are a number of reasons reported for the failed measure: notification by the requesting LA is later than the agreed 48 working hours limiting the time for an appointment and assessment to be completed and returned, non-attendance at the IHA, cancelled appointments by the young person, the LA or health and delays in finalising the IHA report due to having the content validated by a senior doctor and reduction in the use of Trainees recovery plan has been in place and clinical capacity has been increased by LPT.

9.1.4 The RHA is required to be completed every 6 months from the IHA for a child under the age of 5 years and every 12 months for children and young people aged 5 – 18 years. The performance has improved greatly from 2018/19 figures. Exception reports describing the reasons for failed timeliness can be due to late referral by the LA or late assessment by health. However in 2019/20 performance has only fallen well below expected levels 70% on 2 occasions for LAC from Leicestershire.

9.1.5 The Strategic Group continues to drive forward improvement of IHA and RHA performance.

9.2 Strength and difficulty questionnaires (SDQ)

9.2.1 The strengths and difficulties questionnaire (SDQ) is a clinically validated brief behavioural screening questionnaire to assess the emotional health of the child or young person. The Statutory Guidance (2015) requires that all LAC who have been in care for 12 months or more aged 4 – 16 have the SDQ completed by their carer annually in time for the health assessment.

9.2.2 It has been identified across health and children's social care that the SDQ is often not available at the time of the RHA. However, it needs to be acknowledged that the percentage of all eligible LAC who have had an SDQ in the last 12 months is much improved across the LA's. It is the timely link with the health assessment which enables a holistic review of health and a current, relevant response to emotional well-being.

9.2.3 The Strategic Group have supported the commissioning of health visitors/public health nurses and LAC nurses to ensure the carer completes the SDQ at the time of the RHA and has been agreed by all the LA's. This pilot should start in the summer 2020 as the work has been delayed due to Covid 19. The impact of the SDQ health commissioned pilot will be evaluated by the Strategic Group during 2020/21.

9.3 The Leaving Care Health Summary (LCHS)

9.3.1 The leaving care health summary (LCHS) is required for eligible LAC (there are some exclusions) about to leave care; it should be offered around the time of the last RHA or as the young person approached the age of 18 years. The monitoring of the LCHS has developed over 2019/20 as has the format and quality of the documentation with consultation with Care Leavers and YP in Care regarding this. A LCHS audit is expected in July 2020 to assure the quality of the summary is effective in supporting the transition to adulthood and access to appropriate health services has been planned with the care leaver and supported by personal advisors.

9.3.2 The LAC Health Summit has had an impact on service user involvement with the LCHS review and the input of the opinions of children's social care staff. The numbers of LCHS completed and work done with care leavers and their personal advisors has improved in 2019/20 increasing effective multiagency working.

10 **Adoption and Fostering Tables** 10.1 **and** 10.2 **(LPT medical advisor activity)**

Adoption Activity April 2019 to March 2020	Leicester city	Leicestershire
Face to Face appointments	48	45
Paper write up	31	21
Counselling sessions	25	18
Adult summaries	55	58

Fostering Activity April 2019 to March 2020	Leicester city	Leicestershire
Adult summaries	15	257

10.1 **Analysis:** Medical advisors (MA's) see children at the request of adoption agencies. Work has been undertaken to ensure there is a minimum of 6 weeks notification for this by the LAs. There are no figures from the LA as to how many of the children for whom adoption medical reports are prepared actually move to adoption.

10.2 There are regular liaison meetings with the adoption agencies' leads. Recent discussions have been around the Regional Adoption Agency agenda, consent for electronic patient record and lack of Forms M and B (mother and baby forms from paediatrician/ neonatologist/ midwifery recording the details of antenatal care , delivery, neonatal care from UHL records to support full information recorded in adoption health report for the child.)

10.3 Rutland has moved to the Lincolnshire Adoption Agency which has altered some working practices for the LPT MAs. Fostering MA work is provided by LPT for Leicestershire but not for Leicester city currently.

10.4 Number of Adoptions 2019

10.4.1 The data below shows a comparison of adoption figures for England with local figures. Placed for adoption will not necessarily mean all legal processes are completed and the child is legally adopted. However these children have been placed with the parent/s who it is planned will adopt them.

England = 3,570 down 7%
Leicester city = 27 placed in 2019/20
Leicestershire = 15 placed in 2019/20 (29 Adoption orders granted)
Rutland = 0 placed for adoption

11. Specialist Services for LAC

11.1 Table CAMHS Young People's Team data

Area of work	Leicester	Leicestershire	Rutland	Independent	OLAC	Total
Adoption	11	59		5		75
Connected carer	5	3				12
Out of area LAC(OLAC)					69	69
Statutory Fostering	32	47	4			83
Statutory residential	18	17				35
UASC						24

Total referrals to the team= 379 (this includes Youth Offending, Homeless cases and ACES project)
Total referrals accepted = 330 (87%)
Total referrals rejected = 49 (13%)
Total numbers of LAC = 298 (78% of total referrals)

11.1.2 **Analysis:** LPT have a specialist child and adolescent mental health service (CAMHS) young people's team (YPT) for children and young people who are LAC or who have support from the youth offending service or who are homeless. The table above shows the YPT activity in 2019/20.

11.1.3 This team provides specialist support to both young people and their carers and in addition give advice and guidance to the LA residential homes on complex cases and managing young people.

11.1.4 In addition the YPT team continue to support families where a child has been adopted to assist in management of behaviour and do specialist training for adoptive parents.

11.1.5 Carers and connected carers can access training to increase their knowledge and skills in understanding the impact of abuse and neglect. The LAC Nurses work with the CAMHS YPT in supporting children, young people and their carers with emotional and mental health issues.

11.1.6 Not all LAC emotional health issues will require a CAMHS worker and there are good links to other services which address less complex emotional health issues.

11.1.7 Future work has been identified to develop a 14–25 year mental health pathway for LAC and care leavers and will be a priority for 2020/21.

11.2 Childhood Adversity (ACEs) Team

11.2.1 For more detail see report in Appendix 1. The Childhood Adversity Team is a specialist mental health team that work with young people who are involved with local youth offending services. They work in partnership with these services, providing advice, consultation, liaison and training to other

professionals working these groups of children. In addition, specialist mental health assessment and intervention is provided to those children identified as presenting with or at risk of developing mental health difficulties. The service aims to facilitate the workforce to develop a better understanding of mental health issues in general and specific issues for vulnerable children and young people via training, advice, consultation, and joint working

11.3 Child Criminal Exploitation (CCE) Child Sexual Exploitation (CSE) data

11.3.1 There is a Child Sexual Exploitation, Missing, Trafficked and Modern Slavery Hub in LLR located in Wigston Police Station. This was relaunched as a Child Criminal Exploitation, Missing, Trafficked and Modern Slavery Hub in January 2020.

11.3.2 Table

Quarter	Number of children/young people	Leicester city Numbers who were LAC	Leicestershire Numbers who were LAC	% of CCE cases
1 (2019)	91	12	12	26%
2 (2019)	97	13	18	31%
3 (2019)	111	12	11	20%
4 (2019/20)	98	9	10	19%

11.3.3 **Analysis:** There is a high percentage of LAC amongst the children and young people that the CSE/CCE Hub work with. The data in the table above reflects the additional vulnerability of this group of children. There is a specialist nurse working in the Hub with police and children's social care to support the health element of the work. There is a good relationship between the LAC Nurses and the CCE Nurse and this has developed over the time the Hub has been in place.

11.3.4 During 2019/20 both the Nurses and the Designated Doctor have consulted with the Hub where there have been complex cases where the young person is looked after or suspected of being trafficked or involved in modern slavery. This enhances a joined up approach to cases increases relevant sharing of information and avoids duplication of work.

11.4 Smoking Cessation Project work

11.4.1 A project worker focused on Looked after Young people in Residential Homes and young people in semi-supported living started in April 2020 for 18 months. There are disproportionately higher levels of smoking in the LAC population in comparison to their peer group. As is well documented smoking is associated with many serious health conditions including heart disease, stroke and cancers.

11.4.2 **Expected impact:** The project worker will work across services to determine the most effective approaches to smoking cessation with the LAC cohort. The outcome of this work will not be available until 2020/21.

11.5 Sexual Health

11.5.1 Sexual health clinics are able to offer a range of sexual health services including; emergency contraception, contraception, pregnancy testing, screening for STIs, Psychosexual counselling for 16+ age group, information on sexual violence with links to the sexual violence referral centre (SARC), CSE and CCE services and support for female genital mutilation (FGM).

11.5.2 The clinics will do domiciliary visits in specific circumstances which can include LAC patients. C card is provided at a range of venues including pharmacies and LAC Nurses and School Nurses have C card training. School Nurses offer a free texting service young people Weekdays 9 – 5.

11.5.3 LAC Nurses are C card trained and liaise with the sexual health services when required, teenage pregnancy rates for LAC are three times greater than their peers and the nurse's focus on good sexual and relationship health during the RHA.

11.6 Drug and alcohol services

11.6.1 Across Leicester city and Leicestershire the integrated community drug, alcohol and substance misuse service is delivered by Turning Point Rated Outstanding by the CQC the service provides walk in, community based and online support. There are specific services for young people up to the age of 24 years. This is a third sector organisation and LAC Nurses link closely with Turning Point where a LAC has substance misuse issues.

12 Health Needs Assessment 2019

12.1 A Health Needs Assessment (HNA) on LAC is produced by Public Health partners and has been agreed as an annual document to reflect the health of the LAC population and influence commissioning decisions

12.2 Since 2018 the Public Health teams across Leicester, Leicestershire and Rutland (LLR) have worked together to create a Health needs Assessment (HNA) for Looked After Children (LAC). This is because LAC are at greater risk of poor physical and emotional health outcomes than their peers. The HNA summarises the current local knowledge on the health of LAC and identifies key recommendations to take forward to improve health outcomes for these children and young people. The HNA is a population based review of health needs, rather than the tracking of individual children's health. The HNA uses the most up to date data available and is a snap shot of the health of the LAC population at a specific moment in time so that trends can be identified, examined and acted upon.

12.3 In 2020, the LLR statutory health assessments for LAC form the basis of the data which is analysed. This comprises the initial health assessments (IHA) for the LAC population coming into care in 2019 and the review health assessments (RHA) of the children and young people in care during 2018 and 2019. It includes LAC from LLR living in LLR and externally placed LAC living in LLR (OLAC). It does not include LAC who originated from LLR but were been placed outside the area. The 2020 LAC HNA has been delayed as the Public Health team has been redeployed to focus on the COVID19 response, but it is currently being progressed and should be available in summer 2020

13 Progress on the 2018/19 Annual Report and HNA recommendations:

13.1 **To continue to improve the IHA and RHA data completion and monitoring against the statutory measure**. The agreed Dashboard of data presents clear IHA, RHA, LCHS and record keeping audit data which demonstrates quality improvements. GP, Dental and Optician registration and immunisation data support the LA and the 903 returns

.

13.2 **New Service Specification to meet statutory measures**- signed off October 2019.

13.3 **SDQ available at the RHA** – Not yet achieved but the commissioning pilot for health to ensure the SDQ is completed at RHA will commence July 2020.

13.4 **Better transition from child to adult services** – work across health and children's social care has improved and is reflected in the service development section. Future work is planned.

13.5 **Increased knowledge of the health OLAC and the LLR LAC sent out of area** in 2019/20. There has been improved mapping of both these caseloads and quality checking of all LLR LAC placed out of area. Further work does need to be undertaken as listed in future recommendations for 2020/21.

13.6 **LAC Report to the CCG -** A full report covering the CCG responsibilities to LAC and the current 13 risks to Looked after Children and care leavers was delivered to the CCG Integrated Governance and Quality Committee in May 2020.

13.7 **LCHS embedded in practice and more relevant to care leavers** – Increased data reflects care leavers receive a LCHS. The process and importance has been emphasised to children's social care staff and LAC Nursing is working more collaboratively with care leavers and personal advisors.

13.8 **CAMHS pathway** – The CAMHS pathway is well understood by all services work needs to progress on the 14–25 pathway for mental health transition.

13.9 **Smoke Free Homes Policy, smoking cessation training and smoking cessation offer to Foster Carers** – There is a smoking cessation worker establishing smoking cessation work with a focus on LAC in Children's residential homes. This will be reported in 2021.

13.10 **Monitoring effectiveness of the notifications of LAC moving placement** – The LAC pack, East Midlands Protocol and tracking of notification timeliness has improved the accuracy of knowledge of LAC caseloads. More work is needed on alignment of children's social care and health LAC data and this has been seen as a priority area for 2020-2021.

13.11 **Vulnerability of LAC to CCE reflected in the health response to CCE** – work has been started across health commissioned services to review the key questions to service users and update the CSE information from 2015.

14. Quality Assurance

14.1 **Improved reporting, assurance, audit and quality –** There is a clear audit schedule monitored by the Strategic Group. The quality of IHAs, RHAs is reported annually with a 6 month update on recommendations. Cross agency audits of LAC health and children's social care records are completed twice a year by the Designated Nurse LAC and the Safeguarding/Independent Reviewing Officer Managers in each of the three local authorities. A robust Dashboard which details key health indicators is now in place for the service and is reported on to the Strategic Group. Care Navigators track LAC placed out of the LLR area to ensure their health assessments are undertaken in a timely fashion. Where standards are not met there is an escalation process to the Designated Nurse LAC in the CCG.

14.2 **IHA Audit –** Initial Health Assessments (IHAs) are carried out by a doctor for all children coming into Looked After care as per statutory guidance. A variety of clinicians perform the IHA which leads to a wide variety of styles and of quality. The IHA system seeks to ensure the Local Authority (LA) are informed of the needs of children in their care and as corporate parents, the LA are then tasked to meet their needs. 40 IHAs were picked at random and reviewed for the audit. The aim was to assess the quality of recording of IHAs for LAC within LPT. This offered assurance to the CCG and the Corporate Parenting Boards of the three Local Authorities that LPT LAC Health Team work with. The objectives for the re-audit to:

- Ensure that the recording of the IHAs meets the national standard as laid out in Annex H of the Payment by Results 2013-14 document
- Identify any areas in the clinical recording that can be improved through training or redesign of the IHA proforma.

14.2.1 **Areas of good practice:**

- Consent from Young People, information gathering from records and other professionals, Young People offered confidential slot. These have mainly improved due to a change in the template.
- Improved attendance of SW and timeliness within 20 days. This has occurred due to close partnership working and close scrutiny from operational and strategic groups. There have been process changes to enable this. LPT has also prioritised increasing capacity for IHAs.

14.2.2 **Areas for improvement:**

- Ensuring all issues are included in the Health Plan
- Head circumference and centiles for under 5s
- Young people being seen within 20 days
- Voice of the child

14.2.3 **Areas of risk/ mitigation:**

- Child's Social Worker attending appointment has increased which means information available to aid assessment has improved. This has been due to close partnership working to help SW understand the importance of this for information sharing and quality of health plans.
- The vision and dental screening is often yet to be arranged so no date available – this question remains in the audit tool as it is in the national tool which covers both IHA and RHA - by the time of the RHA the dental etc. visits would have occurred.
- The typed reports are not signed but audit traced through the name of the Doctor on the report and through the SystmOne entry. Decision was made when the IHA and RHA templates were set up that a signature was not necessary. The ones signed here are the paper UASC IHAs.
- The lack of neonatal screening maybe due to the proportion of LAC who are UASC. UASC do not have any health records available prior to coming to the UK. The screening levels improve if the cohort is divided per age – the under 10s are more likely to have a complete electronic record when compared to teenagers or UASC. The Hearing service have changed their practice to record neonatal screening on S1 which shows in the improved figure available.

14.2.4 **Lessons learnt:**

- There is a need for ongoing training regarding writing health care plans to include all issues raised in part b of the health care plan.
- This is a unique tool which most clinicians have no experience of prior to working with LAC and they often bring a very medical model to something which needs to be much broader and more holistic. Part c – the health plan is sent to carers and therefore should summarise all the needs including any from family history which maybe long term issues as well as acute actions to be taken. It needs to be written so that professionals and carers alike have enough information to support their care on a day to day basis. There is also a need for clinicians to ensure they are recording and acting on any findings related to learning / developmental needs and emotional health. This again raises the idea of the IHA being a holistic assessment
- The voice of the child or YP is variably recorded. The clinicians need to capture some of the responses verbatim of the child / YP and to ensure it is recorded when it is the child's response rather than the carers.
- The SystmOne questionnaire needs to remind Doctors to do head circumference and centiles for under 5s.

14.2.5 **Ethical/ professional issues**

There is a constant turnover of GP trainees on 4 month training modules who do some of the IHAs – this makes it difficult to maintain any sort of quality improvement due to having to train new staff every 4 months. However changes to process now mean that permanent staff do the majority of IHAs. There is a plan to run a training session/peer review twice a year to ensure quality of practice is improved and maintained. There have been 3 new staff starting so training will be in place for them initially to ensure they are aware of the quality requirements.

14.3 **RHA Audit** was completed by the Designated Nurse LAC and the Named Nurse LAC in August 2019 reviewing 60 RHAs across LLR for children across the age range 0 – 18 years.

14.3.1 **Why the audit was undertaken**

Review Health Assessments (RHA) are carried out by nurses for all Looked After children (LAC) as per the Statutory Guidance (DoH, DfE 2015). Public Health/ health visitors carry out the RHA every 6 months for LAC aged 0 – 4 and LAC nurses carry out an annual RHA for LAC aged 5 - 18. This can lead to a variety of styles and quality of completion.

14.3.2 **Undertaking the audit should:**

- Improve the quality of RHA and LAC record keeping.
- Increase the accuracy of public health data on LAC.
- Improve the knowledge of the health of the LAC population.
- Allow accurate targeting of health resources to the most vulnerable LAC.

- Determine practice performance and training needs of LAC Nurses.

14.3.3 **Key actions**

- Report audit findings to the LAC Nurses and Health Visitor/ Public Health Nurses disseminating areas of good practice and areas for development
- Focus on training and improving performance in key areas – improved details in health plans and early introduction of the leaving care health summary (LCHS) to LAC from aged 15 years
- Increase work with Sixteen Plus (16+) worker and Personal Advisor (PA) workers in the local authority around the LCHS
- Increase and evidence work on improved strength and difficulties questionnaire (SDQ) performance by the local authority
- Discuss the use of the SDQ by LAC nurses where the SDQ is unavailable and emotional wellbeing is identified as a risk

14.3.4 **Areas of good practice**

- Emotional health assessments are evident in the RHA record
- LAC have their safety needs discussed and appropriate advice given to keep them safe
- LAC have healthy relationships discussed with them (where understanding and age appropriate) to ensure they have an understanding of what makes a healthy relationship and the importance of this to their health
- The voice of the child and whether the child or young person is happy and settled in placement is evidenced. With very small and none verbal children an observation of their attachment needs to be evidenced.
- Recommendations in the health plan are child/ young person focussed

14.3.5 **Areas for improvement**

- The date of completion of the RHA depends on referral being timely from the Local Authority, the recent health needs assessment (HNA) highlighted late referrals as a specific issue and has resulted in a backlog of referrals. The Nurses have limited control over this but clinically should have escalated late referrals to management. This audit was undertaken at the end of the backlog of referrals from the LA. LAC Admin generate a monthly spreadsheet of RHAs which are due, and sent to the 3 LAs in a timely manner so that they can be sent in readiness for the statutory assessment.
- Groups and relationships need to be more accurate including parental responsibility. This should be updated at every contact where there have been any changes as directed in the Standard Operating Guidance. Co-located siblings also need to be updated in groups and relationships.
- There needs to be a greater focus within the RHA of holistic assessment of the developmental progress and physical health of the child/ young person using appropriate developmental assessment tools as needed. For the under 5 cohort, correlating ASQs need to be utilised at each RHA.
- The RHA needs to demonstrate that the health history over the last 6 or 12 months has been reviewed, assessed, chronologically recorded and is then reflected in the RHA health care plan and recommended actions; in both cohorts .
- All LAC however young, need oral and dental health advice given to them and their carers at every RHA and information included in the health care plan.
- Where a weight, height or BMI is not possible (some LAC refuse to be measured) an overview of appearance and whether the weight of the young person appears healthy or if weight and growth has been a health issue in the past or the present should be recorded.
- The LCHS should be discussed at the RHA with all LAC over the age of 16 years. There should be evidence within the record on the young person of a LCHS being initiated from the age of 16 with health information added over time at each RHA.
- SDQ scores should be provided by the local authority, for all LAC there should be evidence of an emotional health assessment within the RHA the Nurse can use the SDQ with the carer and young person to support the assessment where there is a clinical need. LPT need to consider how the nurse could use the SDQ in practice.

14.3.6 **Areas of risk/ mitigation**

- LCHS completion is very low and fails to support the transition to independence of the young person. Poor completion of the LCHS has already been identified within the organisation. The LCHS is on the risk register and there is an action plan in place to address improving completion.
- SDQ scores are a statutory responsibility of the local authority but a lack of measurable emotional health needs to be addressed by the nurse where an SDQ has not been completed. Emotional health is a key issue of risk for this group of children and young people. The SDQ is an ideal tool for the LAC Nurse to use to support a mental and emotional health assessment of the young person. The SDQ for young people would be used where this is appropriate NOT the SDQ tool used for carers.
- Groups and Relationships need 100% accuracy for LAC due to their vulnerability and the increased likelihood of having higher than average health needs and involvement with services. Consideration to sibling groups should be included in a review of groups and relationships and updated at the RHA.
- A holistic assessment is essential to the child or young person. This is the key health information informing the local authority of the present health of the child and their future health needs. This assists the carer to meet the health needs of the child they care for and helps the social worker to ensure they focus on the correct health priorities and how this should be achieved.

14.3.7 **Lessons learnt:**

- Some of the same themes have been present in previous audits – Groups and relationship accuracy, SDQ scores not present, SMART health plans and LCHS.
- The LAC SOG should support the improvement of RHA quality as the SOG has been developed in part from lessons of previous audits and quality issues.
- This detailed audit will support the work of the CTL and Named Nurse is addressing performance with the LAC Nursing Team.
- Monthly record keeping audit to be continued on the over 5 cohort.

14.4 **IRO/Health Audit** – The Designated Nurse LAC and the safeguarding/independent reviewing officer (IRO) managers have completed bi-annual health and IRO audits across both health and children's social care records. The aim of the audits were to:

- Ensure better timeliness of health assessments from the IHA and the subsequent RHAs
- Ensure the SDQ was completed and available in time for the RHA
- Review the quality of the health assessment and that the health plan was outcome focused and actions for the carer and social worker were clear.
- That the impact of the health plan was evidenced in the LAC Review minutes and the future plan for the child/young person.
  In 2019/20 there were 5 audits, 2 in Leicester city but only one with both the IRO/safeguarding lead and the Designated Nurse the other audit was completed by health only. There was 1 audit in Leicestershire but only completed by the Designated Nurse. There were 2 audits in Rutland 1 with the IRO safeguarding lead and the Designated Nurse the other just completed by health.

14.4.1 **Challenges:**

- SDQ completed in time for the RHA
- LAC Nurse attending the LAC review
- LAC Nurse invited to the LAC review
- LAC review minutes sent to health for the health records
- Timeliness of the health assessments are still not in line with the national measure.(Most cases reviewed came into care before improvements had been made and therefore health assessments did not reflect the recent improvements)

14.4.2 **Good practice:**

- Good evidence of emotional health being assessed.
- Health visitors used robust developmental tools to assess LAC under the age of 5 years.

- LAC Nurses gave guidance on management of emotional health difficulties
- The voice of the child was evident in the majority of health assessments

14.4 **LCHS Audit** - the audit system required modification so will not be available in this annual report and will be reported July 2020 to the Strategic Meeting.

14.5 **Staff training and supervision of LAC staff** – The Named Nurse LAC trains health visitors to undertake the RHAs for LAC under the age of 5 years. Student public health nurses are trained at the University by the Designated Nurse. Doctors undertaking IHAs, GP Trainees and Specialist Paediatric Trainees are trained and supervised by the Designated Doctor LAC. The Designated Nurse LAC supervises the Named Nurse LAC and offers advice and guidance to LAC Nurses and health visitors/public health nurses.

14.6 **Work supporting the transition for LAC leaving care** has developed in 2019/20, the Named Nurse LAC attends transition panels and offers a health perspective to more complex care leavers. The LAC Nurses who work with UASC and those LAC in semi supported living attend their pathway planning meetings and support their move to adult health services. The Health for Teens website will be updated with Midlands wide health information useful to any teenager and will be relevant to LLR LAC living in and out of area and OLAC whether being seen by commissioned LPT Nurses or not. Further work on the transition of care leavers from CAMHS to adult mental health services is a priority area for 2020/21.

14.7 **Engaging hard to reach LAC and OLAC** – A Care Navigation service now track LAC from LLR who are sent to live outside the area and ensure their health assessments are undertaken, issues of poor timeliness or lack of services are escalated to the Designated Nurse LAC in the CCG. The LAC Nursing Team has two Band 6 nurses one with a specific caseload of unaccompanied asylum seeking children (UASC), another nurse has a caseload of 16 – 18 year olds in semi supported living. The LLR area has been divided into postcode areas where the remaining Band 6 Nurses work with a Band 5 Nurse. LAC in residential care and complex cases are priority groups for the nurses. Work is being developed by the Named Nurse LAC to work with 16+ and Personal Advisors who support care leavers to understand how to access health services in the transition to adulthood. Local authorities are conducting multiagency meetings including health to discuss vulnerable care leavers; the Named Nurse LAC attends these meetings.

15 Service developments

15.1 **Regional Work** Border issues and responsibilities: the Designated Nurse LAC chairs the East Midlands Group. Over 2019/20 the group has expanded to include the Named Nurses for LAC who meet separately on the same day as the Designated Nurses and then both groups meet for overarching issues to be discussed. Over 2019 an East Midlands Health Advice booklet has been written for use over the East Midlands and across these borders which is where the majority of those placed out of their home LA live. This information is also in a virtual format and has been shared with the LAs across Nottingham/shire, Derby/shire, Northampton/shire, Lincoln/shire and LLR.

15.2 **National Work** – NHS England Clinical Reference Group for LAC - both the Designated Doctor and Designated Nurse for LAC attend this National Group. The group seeks to ensure good communication across the country sharing of good practice and challenging unwarranted variation. The Designate Doctor chairs the Coram BAAF National Health Group. Recent challenges have included GP completion of adult health reports for foster carers and prospective adopters. The Designated Doctor also chairs the NHSE multiagency sub group on NHS numbers, health records and adoption.

15.3 **Mapping of OLAC** and their health has improved during 2019/20. There have been improved links between Residential Homes and LPT and the CCE, Missing, trafficked and modern slavery HUB by sharing the LAC Pack which reinforces the responsibility of residential homes to inform social care, the police and health of the presence of new LAC in their homes.

15.4 **Table: Data from the Police System Compact in May 2020 demonstrates reduced figures since the introduction of the LAC Pack**

	2017 - 2018	2019-2020
Average number of monthly missing reports	345	319
Of those missing number of children under the age of 18	206	179
Of those children under 18 number who were LAC	192	96
% of missing reports relate to under 18s	60%	56%
% of missing reports relate to LAC	93%	53%

15.4.1 The introduction of the LAC pack by the police supported by health, social care and residential placements has reduced the numbers of LAC going missing and improved communication between all of these services. This is a positive outcome and increases mutual understanding of the roles of these services in keeping LAC safeguarded.

15.5 LAC sent out of area - For LAC sent out of area quality checking of all health assessments is in place and monitoring of time lines by Care Navigators. It is expected that in future the exchange of LAC data between the local authorities and health is embedded into practice and measured by the accuracy of the caseloads matching. The HNA 2020/21 should include LAC living outside LLR.

15.6 Blood born viruses (BBV) the process for testing for blood born viruses has been brought into LPT to allow for patient centred working. It prevents 2 blood tests for different conditions. Care navigator tracking improves timeliness.

16 Priorities and key issues for 2020/21:

16.1 **Not meeting the national standard for IHA times** – Fully embed enduring consent in 2020. Demonstrate monthly full reporting of IHA's for LLR LAC in LLR and placed outside LLT using exception reports to determine blocks in the processes.

16.2 **SDQ data is not always available at the time of the RHA** which results in a failure to have a comprehensive understanding of the emotional and mental health needs of LAC. (It is the role of the social worker to ensure an SDQ is completed by the carer annually SDQ data is a statutory requirement). Commissioning LPT to undertake a pilot of SDQ completion at the time of the RHA was due to start April 2020 but was delayed due to Covid-19.

16.3 **The LAC population living outside LLR are at risk of delayed health assessments** and having an inequitable service to their LAC peers who live in LLR. Currently the IHA and RHA national standard data for LAC/CLA placed outside LLR is not reported to the LAC and Care Leavers Strategic Health Group or Corporate Parenting Boards. The reporting of this data is required in the Service Specification October 2019 and this reporting should commence in July 2020/21. This will increase governance of timeliness and indicate specific areas which require improvement.

16.4 **The number of LAC living outside LLR, who have special educational needs (SEND) and LAC who require an Education and Health Care Plan EHCP) having delays to the completion of their EHCP are not recorded**. The LAC and SEND units in Systm0ne do not link in order to identify LAC with SEND. The aim for the future is for both statutory systems to dovetail. During Covid 19 there has been an increased focus on all LA children and young people with an EHCP being identified and shared with health so that ECHP health compliance is prioritised. LAC will be included within this exchange and checking of the caseloads.

16.5 **The extent of the population of OLAC residing in LLR may not be fully known or their health needs fully understood.** The exchange of LAC/CLA caseload data is not fully in place to ensure parity of knowledge of LAC/CLA numbers. Health is not always informed by the external LA.

16.6 **Better understanding of the extent to which LAC and OLAC are living in unregistered and unregulated care settings.** There are proposals to ban the provision of unregulated settings for

young people under the age of 16 and introducing quality standards. Currently the three local authorities are being asked to share if they use such settings and what their local policies are in relation to such settings.

16.7 **Transition from paediatric to adult health services.** Pathways from paediatric health services to adult services need robust mapping in 2020/21**.**

16.8 **Mental health pathway 14-25 for LAC and care leavers.** Mental and emotional health is the most reported issues by care leavers. Improving the pathway to services is a priority.

17 Conclusion and analysis

17.1 This annual report has evaluated health service delivery to LAC across LLR and those placed out of area. There continue to be challenges to meeting the timeframes for IHAs and obtaining SDQs prior to RHA completion. The revised service specification and dashboard commenced October 2019 with improved results expected in 2020/21.

17.2 Governance of the LAC service is driven by the Strategic Group and has improved and progressed with a focus on agreeing enduring consent for health assessments during the time a child or young person remains in the care of the local authorities. Agreement across LLR and embedding of enduring consent is due to be completed in summer 2020.

17.3 SDQ availability at RHA should improve with the health commissioning of nurses supporting carer completion at the RHA in 2020. Covid – 19 has delayed the start of this pilot.

17.4 IHA and RHA audits in 2019 have shown some improvements in quality of health assessments. The introduction of monthly record keeping audits will continue to emphasise the importance of good quality and record keeping to the nursing team. The IRO/Health audit needs to be reviewed to evaluate the usefulness and challenge the reduced involvement of children's social care.

17.5 Service developments have continued throughout 2019/20 the LAC Health Summit has proved to be popular with the multiagency staff and has been a successful way to showcase good practice and developments and discuss and agree future health priorities.

17.6 The voice of the child and young person has been improved and reflected in the care leaver resources now available, the LAC health Summit response to care leaver feedback and the use of the LAC Nursing SOG which sets a high standard of engaging children and young people monitored via monthly record keeping.

17.7 The transition for care leavers to adult health services remains a key area of priority. There has been some progress in linking health into transition work and the LCHS has been improved. However in particular transitions into mental health services and embedding health into work with care leavers requires further development.

Appendices:

1. ACEs project information
2. Helpful Tips for Healthy You

Appendix 1 Childhood Adversity (ACEs) Team 2019-2020 Report

The Childhood Adversity Team is a specialist mental health team that work with young people who are involved with local youth offending services. They work in partnership with these services, providing advice, consultation, liaison and training to other professionals working these groups of children. In addition, specialist mental health assessment and intervention is provided to those children identified as presenting with or at risk of developing mental health difficulties.

The aims and objectives of the service are to provide a specialist mental health consultation, assessment, formulation, and intervention service for children and young people deemed to be at high risk of mental health difficulties due to adverse childhood experiences, difficult social circumstances and/ or social disadvantage. The Childhood Adversity Team aims to provide fast access to a specialist mental health service with expertise in trauma-informed practice.

The service aims to provide a holistic approach to working with young people that does not separate difficulties typically associated with mental health from other aspects of a young person's life. As a result, the service seeks opportunities for identifying and working with other key stakeholders in young people's lives, such as the young people's families or professionals from partner organisations including Social Services, Police Services, and Third Sector organisation.

The service aims to facilitate the workforce to develop a better understanding of mental health issues in general and specific issues for vulnerable children and young people via training, advice, consultation, and joint working.

The service aims to provide an assertive outreach model to some of the more difficult to engage young people and their families to ensure that mental health problems are identified and treated early.

Referrals

	2019			2020
	Apr-Jun	July-Sep	Oct-Dec	Jan-Mar
Referrals received	31	31	22	24
Care plans produced	7	32	13	12

Formulation sessions

Date	Session Length (hrs)	Facilitators	Attendee Service(s)	Number of Attendees
12/03/20	2	Craig	City YOS; Social Care; Care Home staff; CAMHS	4
30/10/19	2	Craig	County YOS; Police; CFWS	5
05/12/19	1	Craig	City YOS; CAMHS; Educational Psychology;	6
11/12/19	2	Craig & Alex	County YOS	4
15/01/20	3	Craig	County YOS	4
23/01/20	1	Craig	City YOS; Police; Educational Psychology	6
29/01/20	2	Craig & Alex	County YOS; CFWS; Police; Education; Children's Rights; Placement	13
12/02/20	2	Craig & Alex	County YOS; Social Care, Education; Police, Turning Point	15
20/02/20	1.5	Craig & Alex	City YOS,	2
12/03/20	2	Craig	City YOS; Social Care; Care Home staff; CAMHS	4

Training Sessions

Date	Session Title	Session Length (hrs)	Attendee Service(s)	Number of Attendees
12/06	Intro to ACEs	2-hrs	L&D custody staff (LPT & Police)	8
18/06	Intro to ACEs	3-hrs	YOS City Volunteers	13
19/06	Intro to ACEs	2-hrs	L&D custody staff (LPT & Police)	10
20/06	ACEs Day 2	1 day	YOS staff	13
28/06	YJB ACEs Project	1hr	YJB, partner agencies	22
03/07	Intro to ACEs	2-hrs	LPT LAC Nurses	10
06/09/19	Police Training	2 hrs	Police Custody Sgts	8
13/09/19	ACEs Day 2	One Day	City & County YOS	6
19/09/19	LAC & ACEs	2 x 1hr	Managers of FYPC, Social Care, Police	~25
20/09/19	Police Training	2 hrs	Police Custody Sgts	8
04/10/19	Police Training	2 hrs	Police Custody Sgts	5
18/10/19	Police Training	2 hrs	Police Custody Sgts	7
01/11/19	Police Training	2.5 hrs	Police	~8
28/11/19	Vicarious Trauma	2.5 hrs	County YOS	13
29/11/19	Vicarious Trauma	2.5 hrs	County YOS	7
29/11/19	Vicarious Trauma	2.5	City YOS	3
14/01/20	Vicarious Trauma	1.5	City YOS	30
16/12	Attachment training	2	Child Sexual Exploitation Team	~15
07/02/20	ACEs	2	Police Custody Sergeants; Police	10

			Commissioner & Chief Executive	
25/02/20	ACEs Day 1	1 day	CYPJS & CFWS	23
26/02/20	ACEs Day 2	1 day	CYPJS & CFWS	23

Training sessions feedback

12th June Intro to ACEs, L&D Custody Staff

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				1	5	0
Presentation				2	4	0
Handout					1	5

18th June Intro to ACEs, YOS City Volunteers

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				3	12	0
Presentation			1	3	11	0
Handout		2	1	2	10	0

19th June Intro to ACEs, L&D Custody Staff

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content					8	0
Presentation				2	6	0
Handout				1	2	5

20th June ACEs Day 2, YOS Staff

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				3	10	0
Presentation				3	10	0
Handout				4	9	0

3rd July Intro to ACEs, LAC Nurses

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				1	9	0
Presentation				1	10	0
Handout				1	4	5

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				3	3	
Presentation			1	2	3	
Handout			1		5	

03/10 Police Training

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				2	3	
Presentation				3	2	
Handout				1	2	2

19/10 Police Training

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored

Content			3	3	1	
Presentation				4	3	
Handout						7

28/11 Vicarious Trauma training

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				6	3	4
Presentation				5	4	4
Handout			1	4	1	7

14/01 Vicarious Trauma

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content		1	3	6	10	2
Presentation		1	2	5	12	2

25/02 ACES Day 1 Training (Mop Up)

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content		1		10	9	1
Presentation		1	2	10	6	1
Handout		1	1	8	10	

26/02 ACES Day 2 Training (Mop Up)

	Unsatisfactory	Satisfactory	Good	Very Good	Excellent	Unscored
Content				8	10	1
Presentation		1	1	9	8	1
Handout		1	1	9	9	

Appendix B

Helpful Tips for a Healthy You

This booklet will hopefully provide you with hints and tips to keep yourself healthy and give information on where and when to seek help.

Content

Top Health Tips

1. It is your responsibility to register with a GP
2. You can request a different doctor if you feel the need
3. Don't feel stupid about asking questions
4. See a dentist every 6 to12 months
5. See an optician every two years - unless you're advised otherwise
6. Recognise your feelings and if you feel low, it's important to talk to someone
7. Speak to your Personal Advisor or health professional about financial help with dental and optician costs
8. If you have any weight/health issues; you may be entitled to a free gym pass. Speak to your GP about this

How to register with a GP

It is important that you register with a GP as soon as possible

You can find your nearest GP practice by visiting NHS Choices www.nhs.uk

To register

- Ring your chosen GP or call into the surgery and speak to a receptionist to find out how to register with them
- You'll be asked to complete a form and will be given an initial appointment

What you will need

- NHS Number: should be found within your Health Summary
- Previous GP's name and address

You may need to take ID with you for example:

- Driving License
- Passport
- National Insurance Letter
- Proof of address; e.g. utility bill
- Birth Certificate

How to register with a Dentist

It is important to keep your teeth and gums healthy. Once registered with a Dentist, they will advise you on how often you need to be seen

You can find your nearest Dentist by visiting NHS Choices www.nhs.uk

To register

- Ring your chosen Dentist or call into the surgery and speak to a receptionist to register
- You may be asked to complete a form and will be given an initial appointment

You can get free NHS dental treatment if, when the treatment start you are:

- Pregnant or have had a baby in the previous 12 months

You do not have to pay, during the course of the treatment if you receive:

- Income support
- Income-based Jobseekers Allowance
- Income-related Employment and support allowance
- Universal Credit
- Disability Living Allowance (DLA)
- Personal Independence Payment (PIP)

To maintain healthy teeth

- Brush your teeth twice a day with a fluoride toothpaste for 2 minutes each time and remember to floss. Buy and use a new toothbrush on a regular basis
- Visit your dentist every 6 months
- Reduce your sugar intake in food and drinks

For more information visit:

www.nhs.uk/live-well/healthy-body/how-to-keep-your-teeth-clean/

How to access the Optician

It is important to keep your eyes healthy and it is easy to have your vision checked.

You can find your nearest Optician by visiting NHS Choices www.nhs.uk

What to do

- Just ring or visit a local opticians
- Most opticians can check your eye health as well as your vision

You can get NHS funded eye sight test if:

- You are partially-sighted (sight impaired) or blind (severely sight impaired)
- You've been diagnosed with diabetes or glaucoma (or at risk of glaucoma)
- You're eligible for an NHS complex lens voucher (your optician can advise about your entitlements)

If you receive:

- Income support
- Income-based Jobseekers Allowance
- Income-related Employment and support allowance
- Universal Credit
- You have a valid NHS certificate for full or partial help with health costs
- You are named on a valid NHS tax exemption certificate

To maintain healthy vision

- Visit your optician every 2 years or as advised
- Visit your optician if you notice your vision has got worse or you are struggling to focus on things or things are blurred
- Limit the length of time using 'screens' (phone, tablets, computers, etc) and take regular breaks
- Protect your eyes from the sun – wear good quality sunglasses

For more information visit:
https://www.nhs.uk/live-well/healthy-body/look-after-your-eyes/

How to deal with Minor Illnesses

You can treat simple minor illnesses such as headaches, diarrhoea yourself but you need to be prepared.

Have a good supply of simple medication in the house.

Tips to remember:

- Follow the directions on the packet or on the leaflet, never exceed the stated dose
- If you have questions about the medicine, ask your pharmacist
- Keep medicines away from children and animals, preferably in a high, lockable cupboard that is cool, dry and not in direct sunlight
- Regularly check the expiry dates. Never use a medicine when it is past the expiry date, take it to your pharmacist who will safely dispose of it for you

Suggested medicines or supplies to keep at home:

- Paracetamol (for pain)
- Ibuprofen (avoid if asthmatic or you have stomach problems - ask your pharmacist)
- Re-hydration medicine (useful if you have diarrhoea/vomiting)
- Anti-histamine tablets (useful for insect bites, hayfever, rashes)
- Indigestion remedy
- Antiseptic solution (useful for cleaning cuts and grazes)
- Plasters - range of sizes (for small cuts)
- An elastic bandage and dressings to support sprains or bruises
- Basic dressing pack
- A thermometer for taking temperatures

For useful information on how to treat minor illnesses visit:
https://www.nhs.uk/live-well/healthy-body/home-remedies-for-common-conditions/?tabname=self-help-tips

Where to get help if I feel ill

You can get help and advice from several places if you are ill. Remember the Emergency Department at the hospital is for REAL emergencies that can not be treated anywhere else.

Self care is the first option to think about with your medicines at home. If you becoming more unwell or you feel you need extra help then consider....

Using your local pharmacy - Pharmacies provide expert advice and medical treatment for a range of common illnesses. They do a lot more than just dispensing medicines, including:

- Treatments for minor ailments (coughs, colds, simple skin problems, head lice, athletes foot) - they may be free if you don't pay a prescription charge via a scheme called 'Pharmacy First' ASK the Pharmacist about the scheme
- Support to stop smoking
- Sexual Health advice and pregnancy testing
- Emergency contraception for up to 72hrs after unprotected sex

Many pharmacies have private rooms available to speak to your pharmacist confidentially about your health concerns.

NHS 111 provides fast and reliable medical advice from professionally trained advisors, supported by nurse and paramedics. It's free to call from landlines and mobiles - available 24hours a day, 365 days a year

Call 111 if:

- Think you need to go to A&E or need another NHS urgent care service
- You don't know who to call or you don't have a GP to call
- You need health information about what to do next

Visit your General Practitioners (GPs)

- Don't wait until you become unwell, register with a GP as soon as you can

REMEMBER: in a life threatening emergency dial 999

Healthy Lifestyles

It is important to maintain a healthy lifestyle even as a young adult, as the health decisions you make now will affect your health in later life. Make your lifestyle and health decisions **WISELY** and with the **CORRECT** information.

You can obtain health information about choices by visiting: https://www.nhs.uk/live-well/

Key Messages for a healthy lifestyles:

- Eat well by having your '5 A Day' of fruit/vegetable
- Drink plenty of water
- Have a healthy weight
- Try to do some form of activity every day, including exercise that gets you breathless and strengthens your muscles
- Have adequate sleep and rest – manage your lifestyle well, don't have too many late nights and keep a good sleep routine
- Maintain your sexual health, visit your local service
- Have a positive mind and self esteem
- If you feel you are drinking too much and can't stop then contact your GP, your PA or your local alcohol NHS support service: **www.nhs.uk**
- Quit smoking by getting NHS support by calling 0300 123 1044 or visiting: www.nhs.uk/smokefree
- Don't use illegal substances / drugs. If you need advice or support then visit: **www.talktofrank.com** or **www.nhs.uk** for local support services
- If you feel you need support in relation to eating disorders contact, 'B-eat' tel: 0808 801 0711 **www.beateatingdisorders.org.uk**

Emotional Health and Wellbeing

Emotional wellbeing or mind health is just as important as physical health.

Evidence suggests that there are 5 steps that we can all take to improve our mental wellbeing. Give them a try:

1 Connect

Connect with people around you; family, friends, colleagues and neighbours. Spend time developing these relationships.

2 Be Active

You do not have to go to the gym. Take a walk, go cycling, or play a game of football. Find the activity that you enjoy and make it a part of your life.

3 Keep Learning

Learning new skills can give you a sense of achievement and a new confidence. So why not sign up for that cooking course, start learning to play a musical instrument, or figure out how to fix a bike?

4 Give to others

Even the smallest act can count whether it's a smile, a thank you or a kind word. Large acts, such as volunteering at your local community centre can improve your mental wellbeing and help you build new social networks.

5 Be mindful

Be more aware of the present moment, including your feelings and thoughts, your body and the world around you. Some people call this awareness "mindfulness" and it can positively change the way you feel about life and how you approach challenges.
(Taken from www.nhs.uk)

If you need support for your emotional health contact:
Kooth online **www.kooth.com** - Free, safe and anonymous online support for young people, Monday - Friday 12pm - 10pm, Saturday - Sunday 6pm – 10pm

Talk to a health professional or someone you trust if you are feeling low, feeling stressed or worried. Don't keep the feelings hidden, remember others can help and support you.

Helpful Websites for Emotional Health and Wellbeing

Issues with Anxiety www.youth.anxietybc.com

The Mix support for under 25s Freephone: 0808 808 4994

Samaritans Telephone counselling 08457 909090

Emotional Health Advice www.YoungMinds.co.uk

Livewell www.nhs.uk/livewell

Mental Health Foundation www.mentalhealth.org.uk

Mind - The mental health charity www.mind.org.uk

Kooth online www.kooth.com free, safe and anonymous online support

Healthy Relationships

Have a look at the checklist below and consider your own relationship...

Healthy	Unhealthy	Abusive
Communication - you talk openly together about your feelings without shouting or swearing	**Not Communicating** - you can talk openly normally but on occasions one of you will shout the other person down	**Communicating abusively** - during disagreements there is often swearing, abusive comments and your partner will 'ignore' you as a punishment
Respectful - you value each other. You are able to keep your own beliefs and opinions and they are respected	**Disrespectful** - you or both of you are inconsiderate. There is occasional disregard of your opinions or values and laugh at what you say or do	**Totally disregards your views**- your partner doesn't care what you think or feel. They may also not consider your safety by making you drink too much or getting you to take drugs when you don't want to
Equal - you are able to make your own decisions on where you go. You are able to see your friends and family when you want to	**Unequal** - one of you makes the majority of decisions about what you do or where you go. Your partner puts pressure on you to do what they want	**Totally controlling** - your partner makes all the decisions for you. Your partner is allowed to go out, see friends and family when they like but you aren't
Compassionate - you feel loved and cared for. You can be open about how you are feeling and your partner supports you emotionally	**Unkind** - your partner is dismissive about your emotions and feelings. They may sometimes laugh or belittle you when you do open up	**Cruel** - your partner seems to take pleasure in making you feel down or actively winds you up or upsets you for no reason

Healthy	Unhealthy	Abusive
Trusting - you trust each other equally and the trust is demonstrated	**Untrusting** - there is often suspicion that your partner is doing things behind your back or your partner suspects you without reason	**Obsessively jealous** - your partner won't allow you to be around other people. They put pressure on you to end friendships. They continually check up your whereabouts and may follow you
Making consensual sexual decisions - you talk openly about your sexual activity, contraception and make decisions together	**Pressuring into sexual activity or ignoring consequences** - one of you is trying to convince the other to have sexual activity, or there is lack of consideration to consequences eg: pregnancy	**Forcing sex or unwanted sexual activities** - your partner dictates when, how and where you have sexual activity. They may threaten you if you don't want to or they pressure you to have sex with someone else
Enjoying personal space - you both enjoy and are able to have your own time alone	**Smothering or trying to stop you spending time with others** - one of you is feeling uncomfortable about the level of time spent together	**Isolating you from friends/family** - your partner controls where and when, who you can see and talk to. Your partner isolates you from other people and can make up lies about friends and family to try and make you not want to see them

If you think your relationship is unhealthy then talk to someone you trust:

- Talk to your GP, nurse or other health professional
- Women can call 0808 2000 247, the free 24-hour National Domestic Violence Helpline run in partnership between Women's Aid and Refuge
- Men can call the Men's Advice Line free on **0808 801 0327** (Monday to Friday 9am to 5pm) or ManKind on **01823 334 244**
- Victim Support - **0333 270 2799** or visit **www.victimsupport.org.uk**

Sexual Health and Identity.

Looking after your sexual health is very important, this includes:

- using contraception and ensuring your partner uses contraception
- regular testing for sexually transmitted infections (STI)
- pregnancy advice
- getting screening for cervical and testicular cancers

Pharmacies may be able to provide free contraception and emergency contraception, otherwise visit your local Sexual Health service.

You can locate your nearest **Sexual Health Service** online: www.nhs.uk and put in 'sexual health service' into the search bar

Have you got your C-card?
The C-Card (condom card) is a small credit card size card which means that you can get free condoms at various places which are part of the scheme. Both young men and women can get a c-card but you must be under 25 years old.

Look out for the C-card stickers or go online to find your local C-card collection point.

Other Services Available:

Family Planning Association (FPA) www.fpa.org.uk
FPA provide sexual health information and advice on contraception, sexually transmitted infections, pregnancy choices, abortion, planning a pregnancy

Brook Sexual Health www.brook.org.uk
Provides free and confidential sexual health advice to young people, pregnancy advice , contraception help and have text & webchat services

East Midlands Children and Young People's Sexual Assault Service www.emcypsas.co.uk or 0800 183 0023

EMCYPSAS can help and support you if you have experienced a sexual assault or rape.

Think you are pregnant and don't know what to do?

It is important to make the right decisions for you and an essential part of this is having all the information you need.

Talk to someone you trust and get health advice from one of the following as soon as possible: GP, Pharmacy, Personal Advisor, Sexual Health Service, Brook Sexual Health, Family Planning Association or Marie Stopes (0345 300 8090 - open for support 24 hrs a day)

Information about relationships

(whether you are straight, gay, bisexual or trans)

Relate can provide helpful advice and support, **www.relate.org.uk**

Sexuality advice is also available for those that consider themselves to be lesbian, gay, bisexual or transgender (or want to talk about their sexuality feelings) - contact:
Stonewall UK, www.stonewall.org.uk
Brook Sexual Health, www.brook.org.uk

Gender Identity is it more common than you think to feel confused about your gender identity but if you need help and advice about how you are feeling, then contact The Gender Identity Development Service (NHS) via telephone: 020 8938 2030/1 or visit: www.gids.nhs.uk

Financial Support

If you find yourself in financial difficulties then ACT, do not ignore letters or reminders. If you need advice/support with managing your finances or debt...

Citizens Advice Bureau - www.citizensadvice.org.uk

National Debt Line - free on 0808 808 4000 or visit: www.nationaldebtline.org

Government Advice online:
www.gov.uk/options-for-paying-off-your-debts

Talk to your Personal Advisor (Care Leaver Service)

Talk to who you owe money to and make a repayment schedule

Benefits:
There are several types of benefits that you may be able to claim (even if you are working), check out the Government website to find out your entitlements: www.gov.uk/browse/benefits

You can access a computer and the internet free at your local library

Am I eligible for free health treatments (such as eye tests, prescriptions, free medicine from your pharmacist)?

You will qualify for help with NHS medical costs if you and/or your partner receive any of the following benefits:

- Income Support
- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance
- Working Tax Credit or Child Tax Credit (in some circumstances)
- Universal Credit
- If you receive any of the benefits listed above, all you need to do to get help with NHS costs, is to show your benefit award letter or HC2 or HC3 certificate to health care staff as proof at point of payment
- If you don't receive any of these benefits, but have a low income, you may still get some help with health costs through the NHS Low Income Scheme – call: **0300 330 1343** to find out more

Learn about managing your money:

- Record your spending every week
- Record your regular payments eg: rent, electric, mobile phone
- Save money for the unpredictable event - even if it's a small amount
- Plan / budget
- Decide on your priorities
- Don't delay bills that need paying

Advocacy for you

A useful service that can support you and act on your behalf if you are struggling to access services contact 'coramVoice' organisation:
www.coramvoice.org.uk
Tel: 0808 800 5792

coram Voice
getting young voices heard

coramVoice can help you if:

- You want some help in saying the things you need to say to those who make decisions about you
- If you are unhappy about the way you are being treated by your Social Worker, Care Leavers Service or Personal Advisor
- If you need information and advice and want to know your rights
- If you need an advocate who can make sure you understand what people are saying and help you say what you want to say and make sure people listen to you
- If you want an advocate to be with you at important meetings

Local Services and Useful Links

NHS 111 For medical advice This helpline is open 24 hours a day. 365 days a year	**Dial 111**
NHS Choices Provides a comprehensive health information service to help you make the best choices about health and lifestyle	**www.nhs.uk**
NHS Patient and Liaison Service (PALS) Contact them if you have issues or need to make a complaint about an NHS service	**To find your nearest office enter:** PALS into the search bar
Refugee Council	020 7346 6700 www.refugeecouncil.org.uk
Health for Teens	www.healthforteens.co.uk
Change for Life	www.nhs.uk/change4life
Live well Health & Fitness	www.nhs.uk/livewell/fitness
Live well Healthy-eating	www.nhs.uk/livewell/healthy-eating
National Bullying Helpline	www.nationalbullyinghelpline.co.uk
Child Exploitation & Online Protection	www.thinkuknow.co.uk
Missing People Runaway Helpline	www.missingpeople.org.uk (116000 –free from mobiles)
Shelter Provides housing advice and those struggling with homelessness	www.england.shelter.org.uk
Victim support Available to give tailored support to help people recover from the effects of crime and traumatic events	0808 168 9111 www.victimsupport.org.uk
Safeguarding support contact your Local Authority to find how to gain support if you are at risk or report a concern about an adult or child	Internet search: 'how to report a concern about an adult/child in....' add in your local area
Your Local Care Leavers Service:	

Poem to describe ADHD - written by Andrea Chesterman-Smith

A.D.H.D

Take my hand and come with me,
I want to teach you about ADHD.
I need you to know, I want to explain,
I have a very different brain.
Sights, sounds and thoughts collide,
What to do first? I can't decide.
Please understand I'm not to blame,
I just can't process things the same.
Take my hand and walk with me,
Let me show you about ADHD.

I try to behave, I want to be good,
But I sometimes forget to do as I should.
Walk with me and wear my shoes,
You'll see it's not the way I'd choose.
I do know what I'm supposed to do,
But my brain is slow getting the message through.
Take my hand and talk with me,
I want to tell you about ADHD.

I rarely think before I talk,
I often run when I should walk.
It's hard to get my work done,
My thoughts are outside having fun.
I never know just where to start,
I think with my feelings and see with my heart.
Take my hand and stand by me,
I need you to know about ADHD.

It's hard to explain but I want you to know,
I can't help letting my feelings show.
Sometimes I'm angry, jealous, or sad,
I feel overwhelmed, frustrated, and mad.
I can't concentrate and I lose all my stuff,
I try really hard but it's never enough.
Take my hand and learn with me,
We need to know more about ADHD.

I worry a lot about getting things wrong,
Everything I do takes twice as long.
Everyday is exhausting for me...
Looking through the fog of ADHD.

I'm often so misunderstood,
I would change in a heartbeat if I could.
Take my hand and listen to me,
I want to share a secret about ADHD.

I want you to know there is more to me,
I'm not defined by it, you see.
I'm sensitive, kind and lots of fun.
I'm blamed for things I haven't done.
I'm the most loyal friend you'll ever know,
I just need a chance to let it show.
Take my hand and look at me,
Just forget about the ADHD.

I have real feelings just like you,
The love in my heart is just as true.
I may have a brain that can never rest,
But please understand I'm trying my best.
I want you to know, I need you to see,
I'm more than the label, I am still me.

A family's struggles and lived experience of ADHD

Hi, my name is 'Anna' and I am a qualified health professional. My husband and I have been together for 30 years and we have 2 sons. This is a family story of how ADHD has severely impacted and affected our family.

My son has never been the classic 'hyperactive' child often portrayed rather unhelpfully by the media. Instead, he had been silently struggling to cope and his schools missed all the subtle signs (messy handwriting, difficulty following instructions, forgetting homework and missing deadlines). They failed to recognise that he was having difficulties and simply told him time and again that he 'was not trying hard enough'. As parents, we noticed some changes which worried us and raised them with his teachers. We were concerned that his educational development was flatlining, he was missing his personal targets set by the school, he was slowly withdrawing himself from his peers and most importantly his self-esteem, self-confidence and self-belief were deteriorating. The school dismissed our anxieties as his performance was still considered 'average', despite the fact that according to their charts and reports, there had not been any improvement in his educational development over several years and that he was on a downward trajectory.

My son is a very private person who finds it difficult to share his thoughts and feelings. He was trying his best to cope by 'masking' his struggles and trying as hard as he could to deliver on the expectations and demands of school life but without appropriate support, his constant frustrations eventually led to extreme overwhelm and utter exhaustion that he could no longer handle attending school. He had become so drained, demoralised and tired of trying, of putting more effort in than his peers but to find himself falling farther and farther behind. We did not have much support from school and as it became clear to us that his mental health was deteriorating, we asked our GP for a CAMHS referral and after what I can only describe as a tortuous process, he eventually received a diagnosis of ADHD.

Experience with CAMHS

Our experience with CAMHS has been one that has been filled with extreme frustration. As I work in the health system, I do have an understanding of the funding issues that are faced but there are some aspects of care that are very poor and cannot be excused by 'lack of funding'. There is a considerable lack of regard to appropriate forms of communication. My son complained that his diagnosis was not well explained, and the clinicians constantly used medical jargon which made it very difficult for him to fully understand and participate in discussions. He also felt that he was not listened to, with clinicians often talking over him and 'telling him what he was feeling' before he had finished what he wanted to say. These issues were brought to their attention on a number of occasions, but nothing changed.

They also took a very 'ableist' attitude concentrating purely on the negative aspects of ADHD. This was particularly unhelpful as he was already incredibly demoralised and yet there was no balancing or supportive information provided to help him understand the many positive attributes that can be celebrated with this condition.

In terms of treatment, CAMHS' main focus has been exclusively the provision of medication, with no regard or understanding of 'Holistic Patient Centred Care'. It did not seem that they felt they had a duty of care to engage in partnership working with other services such as his school or GP as they did not feel that it was their place to:

- provide any advice about reasonable adjustments and environmental modifications which should be considered in school to support him, as recommended in NICE guidance

- consider wider potential causes for his low-mood (despite his history of severe Vitamin D and iron deficiencies). Instead they were focussed only on prescribing anti-depressants and even informed us that they 'are not responsible for his physical health' so we would need to contact the GP if we felt that was a concern!

Fighting for an Education

Attempting to gain coordinated support to help my son re-engage with education has all but broken us. We asked the school to apply for an Education and Health Care Plan, but they refused stating that his educational needs were not severe enough, so we applied for one ourselves. This was turned down by the local authority, on the basis that his needs were purely health related and not educational. We took this to tribunal and the decision was overturned, with the judges being quite scathing about the local authority's refusal to acknowledge that when health needs prevent a child attending school, they have become an educational issue! There was then yet another battle as there was no understanding of how to undertake a comprehensive educational needs assessment for someone with ADHD, nor the value of specialist Speech and Language and Occupational Therapy assessments as part of the process.

Throughout this whole process, services were disjointed and did not communicate with each other, my son remained without an education and nobody seemed to care. We tried a phased return to school but he found it too difficult and overwhelming, mainly because no reasonable adjustments had been made to enable him to participate. It astounds me that nobody from the school or LPT's Healthy Together team seemed to be concerned about my son, especially on a safeguarding perspective as no visits were made to see if he was safe while he remained off school. Instead of proactively finding ways to support my son, the school suggested that we off-rolled him instead.

Had it not been for some excellent support from SENDIASS, I fear that my son would have fallen into a deep depression. With their help, we were able to secure some home tutoring for him to see if he could engage again. This was a life saver for him, and thanks to some really good tutors, his attainment started to rise and he began to recover some confidence. Despite having missed the entire Year 10, he managed to get very good results (7s and 6s) for his GCSEs and has now moved onto A levels.

Constantly Misunderstood

However, as a result of his diagnosis, we faced discrimination from sixth forms which refused him entry (despite him meeting their academic requirements) on the basis that they thought he would be problematic and too disruptive (although there is no history of any major discipline issues in school). I simply cannot find the words to describe the added emotional distress that such actions have caused my son, after all that he'd been and fought through, and just when he felt things were starting to get better, his emotional health declined again.

There is so much prejudice against ADHD as people are misinformed and think of it simply as a behavioural condition. ADHD is a neurodevelopmental condition, it is not a mental health illness nor necessarily a disability (depending on the severity and intensity of the symptoms). However, those affected can be 30% behind their peers in the development of 'executive functioning' skills which are critical for learning. Such impairments can lead to difficulties in processing information, keeping attention, planning, prioritizing, organising, time management, completing tasks (homework) etc.

ADHD is not a choice and executive functioning impairments need to be identified and supported to level the playing field for these children. There is currently little appreciation in the system of how incredibly draining it is for someone with ADHD to stay focused in class,

how classroom noise can be so distracting and frustrating and how being required to write notes while listening is such a complex and cognitively demanding task that exhausts them. Without support, not only is their self-confidence and self-esteem eroded but it also impacts directly upon their ability to engage, learn and thrive. In the face of these challenges, some children externalise their frustrations by becoming disruptive while others internalise them, trying their best to silently compensate, as was the case with our son. If not addressed, this can lead to mental ill health which can increase the severity and intensity of ADHD symptoms to such an extent that it causes great impairment and ADHD then becomes a disability.

A Disjointed and Failing System

We have had to fight our way through the system that should be there to protect our son and help him achieve his potential, but which instead has served to traumatise him. For a child who has an above average IQ, it is so difficult to comprehend that we are in this position because it could and should have been prevented had warning signs been heeded. His school experience has left him lacking confidence and suffering with anxiety and self-esteem issues. Similarly, his experience with CAMHS has left him completely disillusioned with the health service to the extent that he has now started disengaging. My son is a victim of repeated psychological trauma directly caused by a flawed system that has neglected to provide him with appropriate support to grow and flourish and that has unnecessarily subjected him to an Adverse Childhood Experience.

The psychological impact on us as parents has also been significant. The stress, anxiety and emotional distress of fighting for support whilst watching our son struggle and deteriorate cannot be underestimated. We too have become victims of this inadequate system and it has taken a toll on our mental and emotional health over the past two years, leading to unplanned time off work (adding economic cost and burden to the system).

My son has benefited from a stable home and has been sheltered from the effects of socio-economic deprivation. Despite being professionally educated parents, we found the system very difficult and stressful to navigate. It is very easy to see how any parent would struggle with this and that many would simply give up. Who will then fight for these children and support them to reach their full potential? More importantly, why should any parent need to fight for an inclusive education for their child that is non-discriminatory and that proactively recognises, plans for and meets the learning and wellbeing needs of neuro-diverse learners? Why should any child be subjected to such trauma and mental health distress when trying to access an education?

The Value of Prevention

A system that neglects to identify and support the needs of every child with ADHD leaves a trail of extended victims in its wake. As a result, the personal, social and economic costs are incalculable; evidenced by research reporting the disproportionate representation of people with ADHD in respect of broken families, suicides, lost careers, school exclusions, educational under achievement, homelessness, teenage pregnancies, substance misuse, sexually transmitted infections, involvement with the criminal justice system, accidental injuries and eating disorders. Such significant inequalities are unjust, unfair and unacceptable which makes ADHD a public health concern that needs to be addressed.

Prevention is key as early diagnosis with appropriate support and interventions can greatly improve life chances and reduce inequalities. The current deficit approach being taken is causing great harm to our children and requires a fundamental re-think. Instead of purely focusing on weaknesses and seeing ADHD as a challenge, a strength-based model which identifies and harnesses many of the unique strengths that come with ADHD can serve to

empower them to achieve. The ADHD brain has a unique trademark in the ability to hyper focus when interest has been piqued, for the ability to ‘think outside the box’ and in having a hyperactive and high energy brain that never rests. By channelling their unique strengths in the right direction, these can be a huge asset in maximising their learning and enhancing their problem-solving skills, creativity, innovative thinking and productivity.

An Inclusive Education that values and embraces neuro-diversity by seeing ADHD in a positive light and teaches to their strengths can therefore have a powerful positive effect where children are enabled to learn and not traumatised trying to learn.

Appendix C

Explaining ADHD

ADHD is just so difficult to explain to people and therefore so easy for people to misinterpret it. Here are some additional points, just for your information – in trying to explain the 'attention deficit' as the label of ADHD is in itself not what it says on the tin!

The ADHD nervous system is rarely at rest. It wants to be engaged in something interesting and challenging all the time as it needs to be stimulated. Attention is in fact never "deficit." It is actually always excessive, constantly occupied with internal reveries and engagements. They have four or five things rattling around in their minds, all at once and for no obvious reason, like five people talking simultaneously. However, nothing gets sustained or undivided attention, and this impairs their ability to simply focus on one thing, which then appears as an 'attention deficit'. But the flip-side of this is that due to their excessive attention, they are more able to observe a wider perspective by having a 'bird's eye view' – it enables them to see things differently and therefore think differently.

They also have a low threshold for sensory experiences as their senses and their thoughts are on high volume. The ADHD nervous system therefore gets very easily overwhelmed because its intensity is so high, and it can impair their ability to control their emotions.

Due to the Executive Function impairments, they may have difficulties with organization, prioritizing tasks, keeping track of stuff they have to do, time management, finishing tasks, making careless mistakes, thinking about way too many possibilities at once and end up overcomplicating everything which can be so incredibly frustrating for them. Due to impaired ability in regulating emotions, some children become disruptive because they are too overwhelmed with the constant frustrations – and this can happen very suddenly, due to their impulsivity. However, some children who are less impaired, try to hide all this 'chaos' behind the façade by 'masking' all their difficulties – these children usually get missed but their needs are no less greater, but they, too eventually reach their endurance point and can no longer internalise their pain and frustrations by which time they have suffered great emotional and mental health distress. All these impairments can also make it difficult for them to organise their thoughts when in conversation and they can find themselves isolated from their peers.

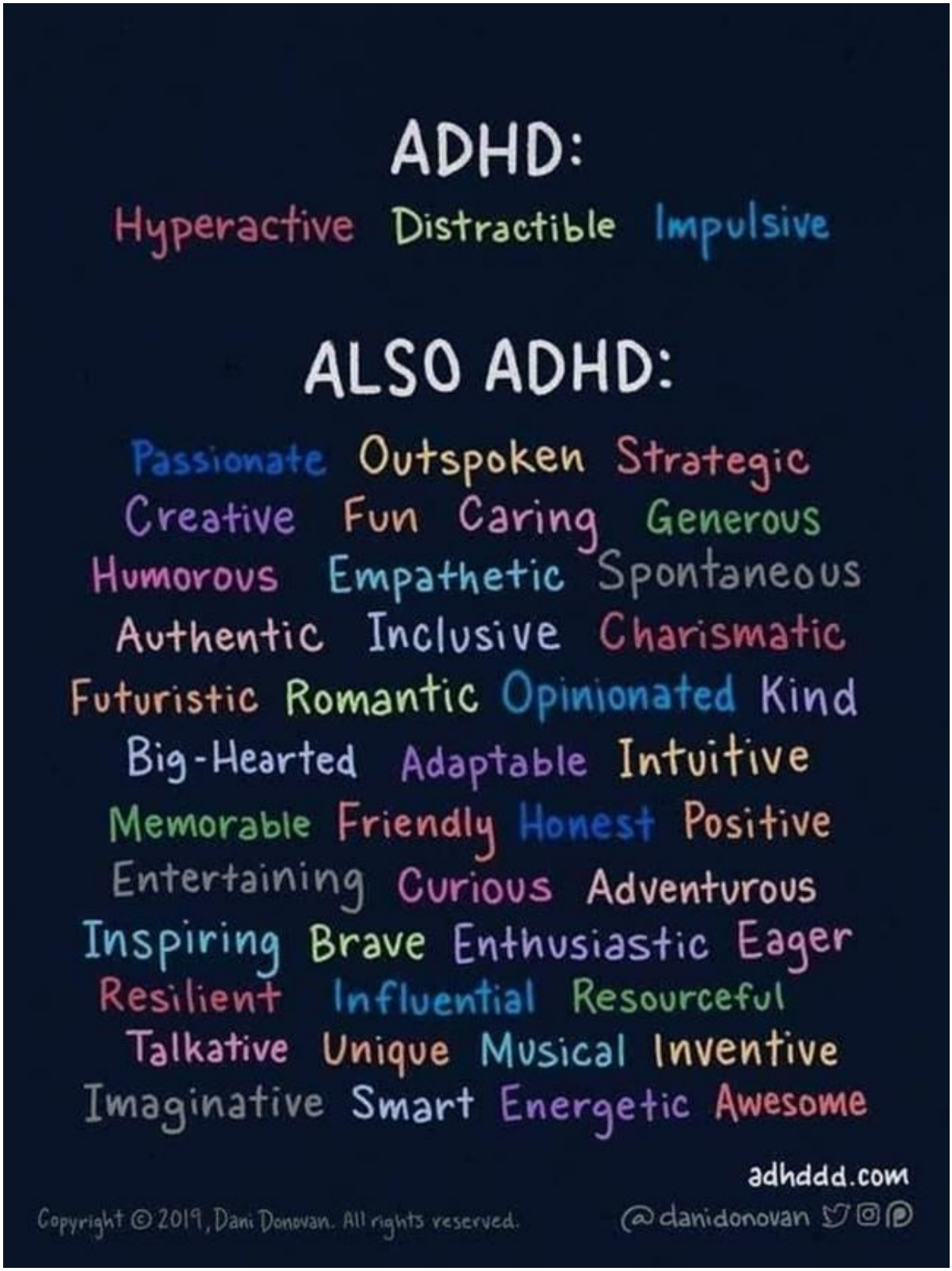
A lack of awareness and understanding of the condition has led to inequitable access to education for these children as the environment as well as teaching processes and practices have ignored these inherent difficulties which has created barriers and made it so difficult for these children to engage and thrive right from the start. It is therefore so important for them to understand the causes behind the behaviour – it is wrong to penalise the children for something that they have no control over. If they are restless, distracted and easily bored, it could mean that the teaching or task is not sufficiently stimulating for their brain and that needs to be adapted (not the child). Also, as they cannot screen out sensory input (e.g. excessive noise, temperature), this can be a great hindrance by distracting them further and therefore the environment needs to be adapted (not the child). Their frustrations in trying to maintain focus would also be compounded if lessons are too long – and that needs to be adapted (not the child). I could go on but I'm sure you can see where I am going with this – it is just not right to blame the child.

King's College London have a free online course on Understanding ADHD, current research and practice: https://www.futurelearn.com/courses/understanding-adhd

ADHD is not a learned behavior.
ADHD is not a discipline problem.
ADHD is not a spoiled child.
ADHD is not a temper tantrum.
ADHD is not a choice.
ADHD is not "the easy way out".

ADHD is a medical condition.
ADHD is a chemical imbalance.
ADHD is a big deal.
ADHD is a battle for self confidence.
ADHD is a fight to maintain focus.
ADHD is a war between brain & body.
ADHD is real.

#TRUTHABOUTADHD


ADHD:
Hyperactive Distractible Impulsive
ALSO ADHD:
Passionate Outspoken Strategic
Creative Fun Caring Generous
Humorous Empathetic Spontaneous
Authentic Inclusive Charismatic
Futuristic Romantic Opinionated Kind
Big-Hearted Adaptable Intuitive
Memorable Friendly Honest Positive
Entertaining Curious Adventurous
Inspiring Brave Enthusiastic Eager
Resilient Influential Resourceful
Talkative Unique Musical Inventive
Imaginative Smart Energetic Awesome
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Appendix C

A.D.H.D

Links to several articles:

1. The Adverse Health Outcomes, Economic Burden and Public Health Implications of Unmanaged Attention Deficit Hyperactivity Disorder (ADHD): *A Call to Action to Improve the Quality of Life and Life Expectancy of People with ADHD*

http://www.russellbarkley.org/factsheets/Final%20ADHD%20Summit%20White%20Paper%20revised%2012-10-19.pdf

2. Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/ hyperactivity disorder in girls and women

https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-02707-9

3. Identification and treatment of offenders with attention-deficit/hyperactivity disorder in the prison population: a practical approach based upon expert consensus

https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1858-9

(To activate the links please hover over then press Ctrl on your keyboard and click with your mouse)