Agenda Item No: 5

Annual Health Assessment Audit Report for 2021-22

To:	Corporate Parenting Sub-Committee
Meeting Date:	3rd August 2022
From:	Designated Nurse Children in Care, Cambridgeshire and Peterborough Clinical Commissioning Group
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable
Outcome:	To provide evidence of the quality assurance process in place for health assessments.
Recommendation:	The Sub-Committee is recommended to: a) Note the content of the report; and b) Raise any queries with the lead officers.

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1. Summary

1.1 This report is the annual health assessment audit report for 2021/22. The overall quality of the cases reviewed was found to be good, and in all cases the Health Action Plans and Leaving Care Health Assessment/Passport felt personal to the individual child/young person.

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

1.3 Ongoing partnership work is required to enable improvements around accessing routine dental care and improving the number of SDQs completed by foster carers and returned to the Children in Care Health Team so that they are available at the health assessment. This work is supported by the Children in Care Health Team Lead Nurse, who is pivotal to supporting the recommendations of the audit.

2. Background

2.1 The Designated professionals have a duty to undertake a quality assurance audit of a sample of Initial Health Assessments and Review Health Assessments. The report contains an overview of the sample size and selection and provides detailed information of the tool used, the findings and the recommendations.

3. Audit of Initial and Review Health Assessments by Designated Nurse Children in Care for Cambridgeshire Community Health Services (CCS) Looked After Children Health Team

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

3.2 As such, during this period:

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

- Initial Health Assessments (IHAs) were undertaken by the AA virtual platform until June 2021, when face-to-face appointments were recommenced. Where

appointments were undertaken using a virtual platform, face-to-face follow up arrangements were utilised as required with GP, Health Visitor, Paediatrician, or other relevant health team.

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

3.4 The Designated Professionals have undertaken the audit by being given access to redacted documents including the Health Action Plan (HAP) and the Leaving Care Health Assessment/Passport. Additional information regarding some parameters of the audit is often identified from the SystmOne record, but access was restricted to the printed documents only on this occasion.

3.5 Initial Health Assessment Audit

Issue	Doctor's Assessment	Notes
County where child placed	CCS via Attend Anywhere – 1 (20%) CCS face to face appointment - 2 (40%) Suffolk face to face appointment – 1 (20%) Lincoln face to face appointment – 1 (20%)	0 - 4 years X 2 cases 5 - 9 years X 1 case 10 – 17 X 2 cases
Conducted by	Consultant Paediatrician – 5 (100%)	Evidence of interpreter use was recorded in 1 case.
Paperwork	Yes - 10 (100%) No – 0 (0%)	HAPs were fully completed.
Neonatal blood spot testing	Yes - 4 (80%) No - 0 (0%) N/A – 1 (10%)	N/A answer – 1 case was 16-year-old young person and was born outside the UK so therefore not available.
Family History	Yes - 0 (0%) No - 0 (0%) Limited – 5 (100%) N/A- 0 (0%)	There was evidence that PH forms have been requested in 2 cases, these were included in the HAP. 1 young person came to UK in last year.
Birth History	Yes- 0 (0%) No- 0 (0%) Limited- 4 (80%) N/A – 1 (20%) – born outside the UK	There was evidence that MB forms have been requested in 1 case; this was included in the HAP. N/A answer – 1 young person came to UK in last year.

Outstanding actions from previous HA	N/A – 5 (100%)	All Initial Health Assessments
Other Health professionals identified	Yes- 4 (80%) No- 1 (20%) N/A- 0 (0%)	
Previous Health concerns identified	Yes - 5 (100%) No – 0 (0%) N/A- 0 (0%)	
Dentist appointment date	Yes - 3 (60%) No – 1 (20%) N/A - 1 (20%)	No Answer – 1 case identified that the carer needed to book an appointment, this was identified as an action and captured in the HAP. N/A answer – baby
IHA – Children < 3y Examination of both eyes	Yes - 2 (40%) No - 0 (0%) N/A - 3 (60%)	N/A answer – 3 cases were outside of this age range.
Vision appointment date	Yes - 3 (60%) No - 0 (0%) N/A - 2 (40%)	
Hearing – concerns	Yes - 1 (20%) No - 4 (80%)	No answer – hearing discussed in all 4 cases (100% of no answers). Yes answer – child already referred to audiologist
Hearing date of check (indicated if previous concerns)	Yes- 1 (20%) No- 0 (0%) N/A- 4 (80%)	
Neonatal hearing screen recorded	Yes - 3 (60%) No - 1 (20%) Not Known – 1 (20%)	N/A answer – 1 young person came to UK in last year. No answer – there is no field for this information on the 16 year and over documentation.
Immunisations (Routine and additional immunisations)	Yes - 3 (60%) N - 2 (40%) N/A - 0 (0%)	No answer – in both cases, the foster carer was advised to make an appointment with the Practice Nurse; this action was captured in the HAPs.

Height, weight and BMI recorded	Yes - 4 (80%) No - 1 (20%)	No answer – this child has a learning disability and attends a special school. Not appropriate to undertake growth measurements at the IHA so the School Nurse is to be asked to do this; this action was captured in the HAP.
Head circumference (IHA all and RHA only in <2 years)	Yes - 1 (20%) No - (0%) N/A - 4 (80%)	
Gives picture of development	Yes - 5 (100%) No - 0 (0%) N/A - 0 (0%)	
Educational progress (school age only)	Yes - 3 (60%) No - 0 (0%) N/A - 2 (40%)	
SDQ score available (completed prior to assessment)	Yes - 0 (0%) No - 1 (20%) N/A - 4 (80%)	N/A answer – 3 cases outside the age range and 1 case not appropriate due to learning disability.
If not available, SDQ given to carers /young person	Yes - 0 (0%) No - 1 (20%) N/A - 4 (80%)	
Emotional well-being discussed	Yes - 5 (100%) No - 0 (0%) N/A - 0 (0%)	1 case - UASC young person, there was evidence of very detailed discussions re trauma and impact of not being with family. 1 case – within the Emotional and Behavioural Development Section it is reported that the child has no emotional or behaviour problems, however within other areas of assessment it says that child gets upset after contact and is tearful, and that 6 months previously she was reluctant to attend school, increased behavioural issues at home and commenced attending special project at school. These issues should have been pulled through to give an updated overview.

CRAFFT screening used	Yes - 0 (0%) No - 0 (0%) N/A - 5 (100%)	
Child/young person's view	Yes - 3 (60%) No - 0 (0%) N/A - 2 (40%) Too young to give their view	Yes answer – there was clear evidence of the child / young person/s view being asked, listened and responded to, and captured in the record.
Lifestyle discussed > 10y	Yes - 0 (0%) No - 0 (0%) N/A - 5 (100%)	N/A answer – appropriate in all cases due to age or learning disability.
Health issues documented in Action Plan	Yes - 5 (100%) No - 0 (0%) N/A - 0 (0%)	
Health Action Plan SMART	Y- 5 (100%) N- 0 (0%) N/A – 0 (0%)	
Referral made	Yes - 2 (40%) No - 0 (0%) N/A - 3 (60%)	
Are health professional's details clearly documented and paperwork dated?	Yes - 5 (100%) No - 0 (0%) N/A - 0 (0%)	1 case – the information was minimal and would have benefited from more detail.
Name//NHS Number		
Evidence has been gathered from S1/ Medical Records		

3.6 Findings

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

3.6.2 4 out of 5 (80%) of Health Assessments reviewed and audited were undertaken as a face-to-face appointment.

3.6.3 There is evidence of PH and MB forms being requested in only 1 case; review of these forms was included in the HAP.

3.6.4 There was good exploration of developmental history and achievements.

3.6.5 Emotional well-being was discussed in 100% of cases with the carers, and directly with the older young people.

3.6.6 There were no SDQs completed before the assessment in the 3 cases where this was required. In these 3 cases the SDQ was given for completion, and all 3 had this included in the HAP.

3.6.7 Vison screening, hearing screening and documentation was good.

3.6.8 There was an improvement in Dental Health provision compared to the 2020/21 audit, with 3 of the 4 children this was relevant to, having had a dental check. In the fourth case the child had only been with the carers a short time so had not been seen, but the foster carer was advised to make sure the child was seen by a dentist as soon as possible.

3.7 Recommendations

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

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

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

4. Review Health Assessment Audit

4.1 15 cases were reviewed and audited by Catherine York, Designated Nurse Children in Care

Issue	Nurse's assessments	Notes
County where child placed	Of the cases reviewed, 9 RHAs were undertaken by the Cambridgeshire health team and 6 by out of area health teams. The mode of assessment delivery was: Face to face = 9 (60%) Attend Anywhere (AA) = 3 (20%) Telephone = 3 (20%)	Documented rationale for telephone assessments: 1 case - IT issues so AA mode failed 1 case- the young person was known to have challenging behaviours and is difficult to engage with, and was seen by a Paediatrician two days previously, therefore it was documented that the decision was to utilise the paediatrician consultation information and undertake a telephone assessment to support this, therefore not causing the young person any further stress and challenges. 1 case – no rational was provided.
Age range of cases reviewed	0-4 years = 5 5-10 years = 5 11-17 years = 5	2 cases were assessments of Unaccompanied asylum-seeking children/young people (UASC): 1 case - documented use of an appropriate interpreter. 1 case – documented that English was the second language and the young person was still learning, however there was no evidence that an interpreter was utilised.

		1 case – Leaving Care Health Passport due to this being the young person's final RHA.
Conducted by	Specialist Nurse = 14 (93%) Paediatrician = 1 (7%)	
Paperwork	Completed and detailed = 15 (100%) Not enough detail = 0 (0%)	
Neonatal blood spot testing	For those aged 0-4 years: Yes = 5 (100%) For those aged 6-17years: Yes = 4 (40%) No = 0 (0%) N/A due to age and documentation used = 4 (40%) N/A as UASC = 2 (20%)	100% of children aged 0-4 years had their neonatal blood spot testing result identified and recorded.
Family History	Yes = 9 (60%) Limited =4 (27%) No = 0 (0%) Not available as UASC = 2 (13%)	Limited answer - records identified that in: 1 case - parents had refused the PH forms. 1 case it was identified that only the father's forms were available. 2 cases – information was limited and obtained from the electronic record and previous health assessment. There was evidence in 3 cases that the PH forms had been requested and this was included in the HAP.
Birth History	Yes = 8 (63%) Limited = 5 (27%) Not available as UASC = 2 (10%) No = 0 (0%)	MB forms were identified as being available in 2 cases.

Outstanding actions from previous HA	Yes = 1 (7%) No outstanding actions = 13 (86%) N/A = 1 (7%)	Yes answer – in 1 case an action was identified as outstanding as the young person had declined to attend the dentist. There was evidence that this health promotion activity was discussed again with the young person along with the offer of support as required. Evidence regarding no outstanding actions, was identified in the documents and evidence of the practitioner detailing previous health issues and actions within the document was seen.
Other Health professionals identified	Yes = 14 (93%) No = 0 (0%) N/A = 1 (7%)	
Previous Health concerns identified	Yes = 15 (100%) No = 0 (0%)	Each HAP, contained evidence of discussions regarding ongoing health concerns, such as sleep, nutritional, emotional, vision, heart issues, hearing, toileting, puberty related issues and substance/alcohol use.
Dentist appointment date	Yes = 14 (93%) No = 0 (0%) N/A = 1 (7%)	N/A answer – 1 case was a baby Discussion re dental appointment position for each child/young person was clearly detailed.
Vision appointment date	Yes = 12 (80%) No- 0 (0%) N/A = 3 (20%)	N/A answers – all had evidence of vision being discussed.

Hearing – concerns	Yes = 1 (7%) No = 14 (93%)	There was evidence in each record that hearing had been discussed with carer and young person regardless of their age or previous history of no hearing problems.
Hearing date of check (indicated if previous concerns)	Yes = 1 (7%) No = 0 (0%) N/A = 14 (93%)	
Neonatal hearing screen recorded	Yes = 9 (60%) No = 4 (26%) No as UASC = 2 (14%) N/A = 0 (0%)	No answer – these 4 cases were of older young people.
Immunisations (Routine and additional immunisations)	Yes = 15 (100%) No = 0 (0%) N/A- 0 (0%)	
Height, weight and BMI recorded	Yes = 12 (80%) No = 3 (20%) N/A = 0 (0%)	No answer: 1 case – identified that the Health Visitor would undertake measurement. 1 case – identified that the Paediatrician is monitoring growth and the previous paediatrician measurements were utilised. 1 case – it was documented that there were no concerns re growth and as the young person was not seen in person, it was agreed that growth would be measured at the next RHA or sooner if required.
Head circumference (IHA all and RHA only in <2 years)	Yes = 1 (7%) No = 0 (0%) N/A = 14 (93%)	

Gives picture of development	Yes = 15 (100%) No = 0 (0%)	
Educational progress (school age only)	Yes = 10 (67%) No = 0 (0%) N/A = 5 (33%) – these were all pre-school age children	The HAP captured details of progress within the pre-school settings for those it was relevant to.
SDQ score available (completed prior to assessment)	Yes = 7 (46%) No = 2 (14%) N/A = 6 (40%)	N/A answer: 1 case – not appropriate due to learning disability. 1 case – above the age of SDQ use. 4 cases – too young for SDQ use.
If not available, SDQ given to carers /young person	Yes = 2 (14%) No = 0 (0%) N/A = 13 (86%)	
Emotional well-being discussed	Yes = 15 (100%) No = 0 (0%) N/A = 0 (0%)	There was evidence of consideration and discussions at an age-appropriate level for each child/young person. The detail recorded was personal to each child/young person.
CRAFFT screening used	Yes = 1 (7%) No = 0 (0%) N/A = 14 (93%)	Questions about drugs, alcohol and sex were recorded in 3 cases, showing age-appropriate discussions and health promotion.
Child/young person's view	Yes = 10 (67%) No = 0 (0%) N/A = 5 (33%)	N/A Answer: 4 cases recorded that the child was too you go give their view. 1 case – the record identified that the child was not verbal due to learning difficulties. Evidence of good practice: 5–10-year-old records showed age-appropriate

		questions and responses captured. 1 case – the record identified that the child was busy being a Storm Trooper on the nurse's arrival, and that he thought he was a "healthy Storm Trooper" 1 case - 17-year-old was seen alone and provided their own consent. 1 case – the young person was still in bed when the nurse arrived, so he/she returned 30 minutes later to allow time for the young person to get ready. 1 case – the young person is identified as being Gillick Competent and is offered time without carer. This young person also had an interpreter. 1 case – 13-year-old was seen alone for part of RHA, carer also seen alone for part and then jointly. Area of concern: 15-year-old UASC had RHA via telephone. English was not their first language, and it was recorded that they are still learning, however there was no evidence of an interpreter being utilised. From the record, it is not clear if the young person or the carer, or both were spoken to.

Lifestyle discussed > 10y	Yes = 5 (33%) No = 0 (0%) N/A = 10 (67%)	Yes answer – includes age-appropriate discussions for children who were less than 10 years, thus demonstrating good practice.
Health issues documented in Action Plan	Yes = 15 (100%) No = 0 (0%)	
Health Action Plan SMART	Yes = 15 (97%) No = 0 (0%)	
Referral made	Yes = 2 (14%) No = 0 (0%) N/A = 13 (86%)	Referrals were made in all cases identified as required.
Are health professional's details clearly documented and paperwork dated?	Yes = 15 (100%) No- = 0 (0%)	
Name//NHS Number	All PID redacted	
Evidence has been gathered from S1/ Medical Records	No access to SystmOne to enable checking	

4.2 Findings

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

4.2.2 9 out of the 15 (60%) RHAs were undertaken as a face-to-face assessment. 3 RHAs were completed via a virtual platform thus providing choice to the young person. However, 3 RHAs were also completed by telephone which should not be a mode of choice to its many limitations; in two cases a clear rationale was provider, but in one case there was no explanation as to why this was undertaken by telephone.

4.2.3 Use of an appropriate interpreter was documented in 1 case, however in another case there was no evidence of an interpreter being utilised despite the records showing that the young person had limited English.

4.2.4 In cases where children were younger than 11 years of age, assessments were undertaken with the foster carer with the child present.

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

4.2.6 In the 0–5-year age range, information relating to birth history and family history was available in 9 cases, with limited information being available in a further 4 cases. The two UASC young people had minimal information as would be expected.

4.2.7 Neonatal blood spot testing in the 0 – 5-year age range was 100%. For those aged 6- 17 years this is not a prompt on the HAP but was captured on some records.

4.2.8 Immunisation uptake was found to be 100% across the age ranges.

4.2.9 Growth measurement performance has improved greatly from the previous year's audit where performance was impacted negatively by most health assessments been undertaken using a virtual platform. In this audit period more children and young people were seen face to face, and where they were seen virtually better use of other health professional's growth measurements of the child/young person were utilised.

4.2.10 Head Circumference measurement was undertaken in the 1 case where the child was age appropriate.

4.2.11 There was clear evidence of discussions around dental care, and routine appointments had been attended or were booked in all but one case where the young person did not wish to attend the dentist.

4.2.12 SDQ was completed in only 7 of the 9 cases were the SDQ was applicable. There is recognition that the Children in Care Health Team email the SDQ to the foster carer for each case where it is appropriate, but that there is an issue with the number of returns the team receive from the foster carers. Health and Social Care colleagues are working together to address this issue, and this includes further developing the SDQ Pathway and working with the Fostering Service around training for foster carers. An information leaflet is being developed for foster carers. Where seen face to face, the foster carer is requested to complete the SDQ during the health assessment appointment, however due to the scoring process, the score is not available at the time of the assessment.

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

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

4.2.15 100 % of cases demonstrated that children/carers had been asked about vision and hearing.

4.2.16 Appropriate lifestyle conversations were evidenced in cases where this was age appropriate.

4.2.17 100 % of cases showed health issues documented in the Action Plan.

4.2.18 100 % of cases had a SMART health Action Plan.

4.2.19 Referrals were made in both cases where the need was identified.

4.2.20 100 % of cases showed that the health professional's details were clearly documented, and paperwork dated.

4.3 Recommendations

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

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

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

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

4.3.5 Telephone consultations should be avoided due to their limitations and should only be used if this is at the choice of an older young person; the rationale for this decision must be recorded clearly. If there is a failing of the virtual platform, the appointment should be rescheduled rather than move to a telephone consultation.

4.3.6 An appropriate interpreter should be used in all health assessments where English is not the first language or where English is limited. In cases where the need for an

interpreter is identified at the time of the assessment, the assessment should be rescheduled or if appropriate, the telephone language line should be utilised.

5. Conclusion for IHA and RHA Audits

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

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

5.3 Ongoing partnership working will contribute positively to the required improvements around accessing routine dental care and improving the number of SDQs completed by foster carers and returned to the Children in Care Health Team so that they are available at the health assessment. The Children in Care Team Manager participates in the partnership working, where her expertise informs practice and improves health outcomes for children and young people in care.

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

6. Alignment with corporate priorities

6.1 Environment and Sustainability

There are no significant implications for this priority.

6.2 Health and Care

The report above sets out the implications for this priority.

6.3 Places and Communities

There are no significant implications for this priority.

6.4 Children and Young People

The report above sets out the implications for this priority.

6.5 Transport

There are no significant implications for this priority.

7. Source documents

7.1 None.