# Children looked after

## Health Needs Assessment

May 2021

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# Table of Contents

## Executive summary

The purpose of the Health Needs Assessment (HNA) was to improve the local understanding of the health needs of Children Looked After (CLA) in Croydon and to inform the future direction, priorities, and commissioning of the services to improve the health and wellbeing of CLA in Croydon.

The HNA was carried out between December 2019 and April 2021. It focuses on Children who are currently Looked After aged 0-17 years, including Unaccompanied Asylum Seeking Children (UASC); it does not cover Care Leavers.

It is important to note that while this is called a Health Needs Assessment, this should not be interpreted as an assessment of the NHS CLA health services. CLA Health is a responsibility of any professional supporting a child and therefore the assessment accounted for the whole CLA system. As a result, the findings and recommendations will be relevant to all stakeholders involved in looking after children in Croydon, whether working in health social or education settings.

The COVID-19 pandemic will have exacerbated children and young people's existing health and wellbeing concerns and may also have impacted negatively on the wellbeing of their carers. Services need to be aware of additional vulnerabilities and identify and support needs. (1)

### Methodology

The HNA used four key processes for gathering information and insights;

1. **A literature and evidence review**: to understand, from published evidence, the burden of physical and mental health problems and health risk-taking behaviours among CLA.
2. **Stakeholder engagement**: interviews and meetings with CLA and the professionals who work with them in Croydon (See appendix A for detail).
3. **National and local data**: to identify high level needs and health service use across Croydon.
4. **Audit**: Of 130 randomly selected Initial (IHAs) and Review Health assessments (RHAs).

## Limitations

Pandemic regulations, and movement to virtual services and staff movement led to a delay in completing the health needs assessment. Due to the variation in data sources and data quality, caution must be noted in comparing national and local data. Where local data was not available, data from the literature or national data sets is applied to the Croydon CLA population to generate estimates of level of need.

## Main findings and recommendations

The main findings and recommendations are set out in Table A below. Croydon's situation is discussed in relation to key areas of national guidance.

**Table A. Croydon situation and Recommendations**

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 1: Planning, responsibilities, governance and voice of the child** | Key responsibilities for planning and commissioning health services. This includes the role of the Designated Doctor and Nurse [1]<br>Quality Statement 2. Looked-after children and young people receive care from services and professionals that work collaboratively. [1]<br>Ensure services are developed taking account of the views of looked-after children and young people. [2] | There is good evidence of partners working collaboratively to improve services for CLA health, through for example the CLA Operational group, the Quality Assurance meetings, and attendance by the designated nurse and doctor at corporate parenting panels.<br><br>Partnership development has been one of the main priorities over the last year with, for example, the development of CLA health champion role in the social care workforce.<br><br>The audit of the health assessments showed that the full range of health issues and needs as identified by the wider range of professionals (e.g. GPs, SEN team) were not being recorded in this one shared document.<br><br>It was unclear whether there is an ongoing and systematic approach | **Rec 1** Ensure that each member of the wider CLA team understands theirs and others roles with respect to CLA health and ensure that they input to the health assessment process.<br>**Rec 2** Use the governance processes to ensure that the roles and responsibilities for implementing DOH guidance and NICE recommendations for CLA health are understood and implemented by all stakeholders working with CLA.<br>**Rec 3** Assess the extent to which the Croydon system is adhering to the NICE 'Looked-after children and young people [PH28]' guidelines, to identify gaps in service provision.<br>**Rec 4** Improve access to training courses to support social workers and other non-health staff and carers for identifying managing and underlying health needs and promoting healthy behaviours.<br>**Rec 5** Develop a systematic way to capture children's views and experiences and use this to develop, plan and improve CLA health services and is used to inform the design of tailored and culturally appropriate services.<br>**Rec 6** Use estimated data on health risk factors and numbers with different physical, educational and emotional health needs to identify possible gaps in service provision. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| | | to capturing the voice of the child in CLA health. | |
| **Theme 2: Information sharing** | Ensure there are effective arrangements in place to share information about a child's health.<br>- Ensure that healthcare professionals share health information with social workers and other professionals. (1)<br>- Ensure health information is incorporated into relevant assessments and shared with healthcare professionals, as appropriate. (1) | A memorandum of understanding between health services and the council has enabled improved information sharing over the last year.<br><br>The CHS CLA health team now has link nurses for other key services such as sexual health, drugs and alcohol, CAMHS and YOS to strengthen sharing information sharing. A due diligence check has been added to the RHAs where the team records who they have been contact with in preparing the health assessment.<br><br>In the audit of records from 2019/2020 it had been unclear how and to what extent health information was being shared effectively by all professionals involved with children's care or what mechanisms there are in place to do this. | **Rec 7** Continue to develop ways to understand and capture the full range of contributions to CLA health.<br>**Rec 8** Continue the routine monitoring of health assessments to ensure these are completed in full and shared with relevant professionals. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 3: Health assessments and planning** | A health assessment of physical, emotional and mental health needs take place on entry to care and at regular intervals to support effective health planning<br>Social care, education and healthcare staff refer looked-after children and young people to specialist and dedicated services within agreed timescales, and monitor and update health plans to ensure their needs are continuously met. | The low number of health professionals recorded as being involved with children's care on the audit of the health assessments could suggest that referrals were not being made, however it is more likely they were not being recorded.<br>The low number of SDQs attached to the health assessments suggested that this process needs improvement and considerable work is underway to improve this. There was evidence from the audit of the health assessments and workshop feedback that action plans were not being routinely followed up.<br>The audit identified that some of the information was focused on process as opposed to actual health status e.g. seen a dentist, seen an optician. | **Rec 9** All professionals to take responsibility for ensuring that all health needs identified are captured in the IHAs and RHAs.<br>**Rec 10** Review the process for updating, and recording health assessment actions.<br>**Rec 11** Establish processes to ensure that all CLA have 100% of the 0 to 5 mandated health checks.<br>**Rec 12** Review the SDQ processes to ensure they are available at the health assessments and to other mental health and wellbeing services.<br>**Rec 13** Provide opportunities for children to talk about their worries and fears, through direct work, an advocate / mentor / befriender or trusted adult. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 4: Support for mental health and emotional health and wellbeing** | Flexible and accessible emotional health and wellbeing and mental health services are needed that offer skilled interventions to looked-after children and young people and their carers.<br>Providers of health services and key partners should provide services for looked-after children and young people that: meet the full range of their needs including emotional health and wellbeing. | While there are CAMHS services for the highest need and Council clinical mental health and wellbeing support has been established, (three clinical staff) it is unclear whether there is sufficient capacity to support the high numbers of CLA who may require emotional wellbeing and mental health support.<br>The health assessment audit showed much lower numbers being recorded as receiving CAMHS and other therapist support than would be expected.<br>Children have reported that many of the CAMHS services are too generic in their approach, and would prefer tailored services (e.g. the child with anger issues, who would prefer to do boxing classes rather than getting referred to CAMHS). | **Rec 14** Develop a holistic, child-centred pathway for the emotional wellbeing and mental health of CLA.<br>**Rec 15** Review the level of commissioned support for CLA emotional wellbeing and mental health in comparison with estimated need in the CLA population. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 5: Diversity** | Providers of health services and key partners should provide services for looked-after children and young people that are sensitive to the needs of black and minority ethnic children and young people and can provide appropriate interventions for emotional and mental health problems associated with racism and cultural identify. | The health assessment forms do not appear to allow for the in depth explorations of health issues relating to the diversity of the CLA in Croydon.<br>See appendix B for the requirements for different ages. (2) | **Rec 16** Ensure that the needs of vulnerable cohorts e.g. children with disabilities are captured and known by all professionals interacting with a child.<br>**Rec 17** Ensure mental health services are sensitive to the needs of BAME, different cultural and religious groups and UASC, and can provide appropriate interventions for emotional and mental health problems associated with racism and cultural identity and PTSD.<br>**Rec 18** Ensure health assessment content reflects the diversity (e.g. sexual, religious, ethnic, cultural, language) of CLA in Croydon. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 6: SEND** | Special Educational Needs (SEN): acknowledging that around two-thirds of looked-after-children have SEN there is a responsibility to ensure needs are identified and met. | It is not clear how SEND status and input from the early years team is routinely incorporated into the IHAs and RHAs. | **Rec 19** Use the IHA and RHA processes and liaison with health visiting and the early years' teams, early years providers and schools to support the early identification of SEND.<br>**Rec 20** Review systems for information sharing, learning and intelligence between the Virtual School and health services to improve understanding of health needs in the CLA SEND population. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 7: Promoting Health** | Role of health and non-health professionals in promoting and supporting health: including the role of social workers, primary care teams, Virtual School Heads and Independent Reviewing Officers (IROs)<br>Provide services that promote and support healthy lifestyles. | The risks from overweight and obesity rates, dental caries, low levels of physical activity mean that anyone working with CLA needs the skills to have informed conversations about healthy lifestyles including immunisations<br>The assessment found that informed conversation about healthy lifestyles (e.g. weight, physical activity, oral health, etc.) are not routinely recorded in the IHAs and RHAs.<br>The numbers of children with up to date immunisations is lower than national average, in particular MMR2; although this is not solely a CLA issue in Croydon. | **Rec 21** Ensure all professionals are skilled to promote health and the conversations about healthy lifestyles are recorded in the IHA and RHAs.<br>**Rec 22** Work with primary care and the school immunisation team to ensure that CLA immunisation rates increase and ensure up to date immunisation status is included as part of the IHAs / RHAs and other records.<br>**Rec 23** Finish and implement the draft CLA immunisations action plan 2020 produced by the CLA immunisations task and finish group. |

| Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 8: UASC** | Ensure that unaccompanied asylum-seeking children and young people have access to specialist psychological services (including CAMHS) with the necessary capacity, skills and expertise to address their particular and exceptional health and wellbeing needs. | The specific health and wellbeing needs of UASC did not appear from the audit to be systematically addressed in the IHAs, RHAs.<br>A pathway for UASC was cited as a gap in a staff workshop. | **Rec 24** Consider the development of a UASC specific health pathway.<br>**Rec 25** Review the health assessment content to ensure it addresses the specific needs of UASC e.g. PTSD, FGM. For reference, review Kent's specific UASC form (see appendix H). |

**Next steps**

- Present the main findings and recommendation to the CLA parenting panel, the CLA Clinical Governance group, Social care heads of service and any other relevant board (e.g. Health and Wellbeing Board).
- The HNA will sit with the Director of Children, Families and Education.
- Use the recommendations to inform the CLA Health action plan.

# 1. Introduction

## 1.1 Purpose of the Health Needs Assessment

In 2019 the Children Looked After (CLA) strategic partnership committed to improve the health and wellbeing outcomes of CLA in Croydon. This Health Needs Assessment (HNA) was commissioned to:

- provide a clearer understanding of the health needs of Children Looked After in Croydon,
- identify any gaps in services required to meet their needs,
- identify potential inequalities affecting CLA, and
- provide recommendations to stakeholders with the aim of supporting them to develop an evidence-based CLA action plan.

The health and wellbeing of children in care encompasses their physical, social and emotional wellbeing, all of which are influenced by multifactorial factors including the care they receive. [1] The health and wellbeing needs of children and young people vary with age, gender, ethnic group, cultural background, reason for being in care and the services in place need to reflect this. Children in care are at a higher risk of poor physical health, education and social outcomes than their peers who are not in care and these poor outcomes persist into adulthood. [1] Children in care are also more likely to have more mental health problems compared to their peers. [1]

Delays in identifying and meeting the health and wellbeing needs of CLA can have far reaching effects on all aspects of their lives, including their chances of reaching their full potential and leading healthy lives as adults.

Looking after and protecting children and young people from harm is one of the most important roles of a Local Authority. As a corporate parent, it is therefore important to understand the key health needs of CLA and assess how those needs are currently being met by services.

## 1.2 Scope of the Needs Assessment

This needs assessment relates to the health and wellbeing needs of children in care aged 0- 17 years, including Croydon Unaccompanied Asylum Seeker Children (UASC); it does not cover transitions or those leaving care.

## 1.3 Methodology

The HNA used four key processes for gathering information and insights:

1. **A literature and evidence review**: to understand, from published evidence, the burden of physical and mental health problems and health risk-taking behaviours among CLA.
2. **Stakeholder engagement**: interviews and group meetings with Children Looked After and the professionals who work with them in Croydon.
3. **National and local data**: to identify high level needs and health service use across Croydon.
4. **Audit**: of 130 randomly selected Initial and Review Health assessments.

The HNA commenced in December 2019, produced draft recommendations in December 2020 and was completed in April 2021.

### 1.4 Limitations

Pandemic regulations the move movement to virtual services and staff redeployment led to a delay in completing the needs assessment.

Due to the variation in data sources and data quality, caution must be noted in comparing national and local data. Where local data was not available, data from the literature or national data sets is applied to Croydon CLA population to generate estimates of level of need.

## 2. The context

### 2.1 National policy and guidance

Local authorities have a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

In March 2015, Department of Education (DfE) and the Department for Health (DHSC) published the statutory guidance "Promoting the health and wellbeing of looked-after-children" [2]. The guidance outlines joint responsibilities for local authorities, clinical commissioning groups (CCGs) and NHS England. Key areas of the guidance are highlighted in Table 1.

**Table 1.** Key areas of "Promoting the health and wellbeing of looked-after children" [2]

| **Key areas of "Promoting the health and wellbeing of looked-after children"** |
|---|
| • **Responsibilities**: the guidance outlines key responsibilities for planning and commissioning health services<br>• **Information sharing**: ensure there are effective arrangements in place to share information about a child's health.<br>• **Health assessments and planning**: local authorities are responsible for ensuring that a health assessment of physical, emotional and mental health needs take place on entry to care and at regular intervals to support effective health planning<br>• **Mental health services**: including targeted and dedicated support for mental health (e.g. through Child and Adolescent Mental Health Services (CAMHS) should be commissioned to support this well-established area of need)<br>• **Special Educational Needs (SEN)**: acknowledging that around two-thirds of looked- after-children have SEN there is a responsibility to ensure needs are identified and met<br>• **Role of health and non-health professionals in promoting and supporting health:** including the role of social workers, named health professionals, primary care teams, Virtual School Heads and Independent Reviewing Officers (IROs). See appendix B.<br>• **Engagement:** ensuring the voice of looked-after-children is taken into account in the commissioning and delivery of services<br>• **Transitions:** ensuring transition arrangements are in place for children who cease to be looked after so that their health need continues to be met whether they are returning home, being adopted or making the transition to adulthood |

There is also NICE guidance, guidelines and quality statements governing the health of CLA. A small selection of these are set out in Table 2. The NICE quality statements can be found in appendix C.

**Table 2.** Some requirements from NICE guidance, guidelines and quality statements

| |
|---|
| • Quality Statement 2. Looked-after children and young people receive care from services and professionals that work collaboratively.<br>• Quality statement 5. Support from specialist and dedicated services: Evidence of local arrangements for health plans to be monitored and updated by independent reviewing officers, social workers and the lead health professional to ensure that the child or young person's continuing needs are being met.<br>• Social care, education and healthcare staff refer looked-after children and young people to specialist and dedicated services within agreed timescales, and monitor and update health plans to ensure their needs are continuously met.<br>• Ensure that healthcare professionals share health information with social workers and other professionals.<br>• Ensure health information is incorporated into relevant assessments and shared with healthcare professionals, as appropriate.<br>• Ensure that physical and emotional health information follows the child or young person. |

- Flexible and accessible mental health services are needed that offer skilled interventions to looked-after children and young people and their carers.
- Providers of health services and key partners should ensure that local strategic partnerships (including children's services and their partners) provide services for looked-after children and young people that:
    - meet the full range of their needs (including needs relating to physical, social, educational and emotional health and wellbeing)
    - promote and support healthy lifestyles
    - Develop services that address health and wellbeing and promote high-quality care.
- Ensure that child and adolescent mental health services (CAMHS) are sensitive to the needs of black and minority ethnic children and young people and can provide appropriate interventions for emotional and mental health problems associated with racism and cultural identify
- Early intervention to promote mental health and wellbeing can prevent the escalation of challenging behaviours and reduce the risk of placement breakdown.
- Ensure that unaccompanied asylum-seeking children and young people have access to specialist psychological services (including CAMHS) with the necessary capacity, skills and expertise to address their particular and exceptional health and wellbeing needs

## 3. Demographic profile of Children Looked After in Croydon compared to the national picture

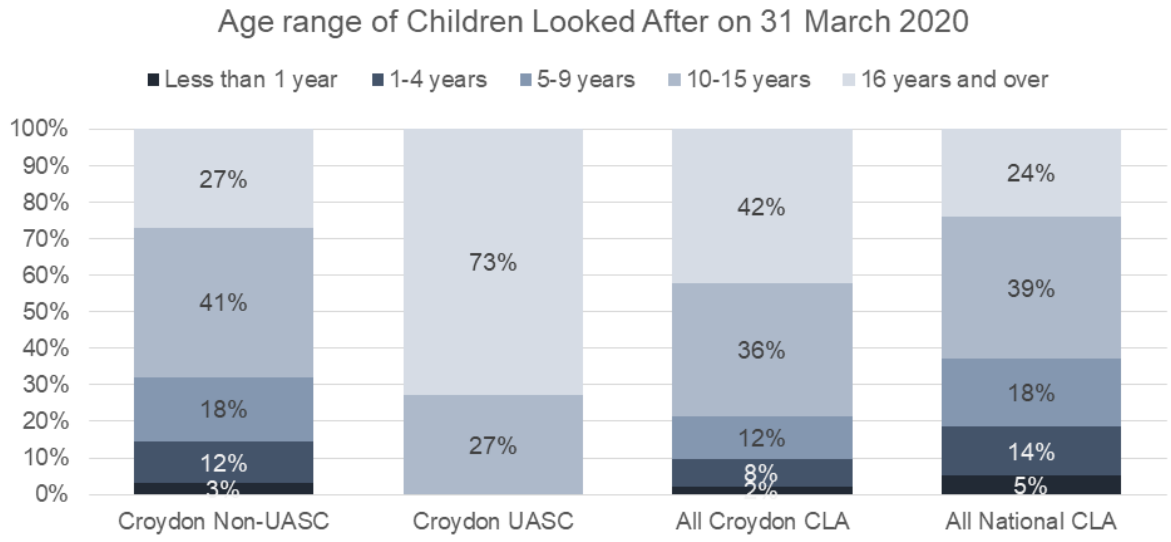
The demographic profile including age, sex, ethnic group, UASC or not, reason for being in care, placement stability provides an indication of the range of health needs the CLA population in Croydon may present with, and need support for.

Latest published figures (31st March 2020) show Croydon has consistently higher rates of CLA compared with the England average (83 vs. 67 per 10,000 children aged under 18 years in 2020) [12]. A key factor in Croydon which contributes to the high number of children in care is the number of UASC. As at 31 March 2020 there were 791 CLA in Croydon of which 34% (270) of the 791 CLA were UASC compared to the national average of 6%. [12] The number of UASC is steadily reducing; in 2012 UASC accounted for over half of Croydon CLA.

### 3.1 Age of Children Looked After in Croydon

The age range of Croydon's non UASC CLA population is broad with a third of children being under the age of ten. This follows a similar pattern to the age groups of CLA nationally. In comparison, the UASC in Croydon are much older, all aged 11 or above and the majority aged 16 or more (Figure 1). [12] [13]

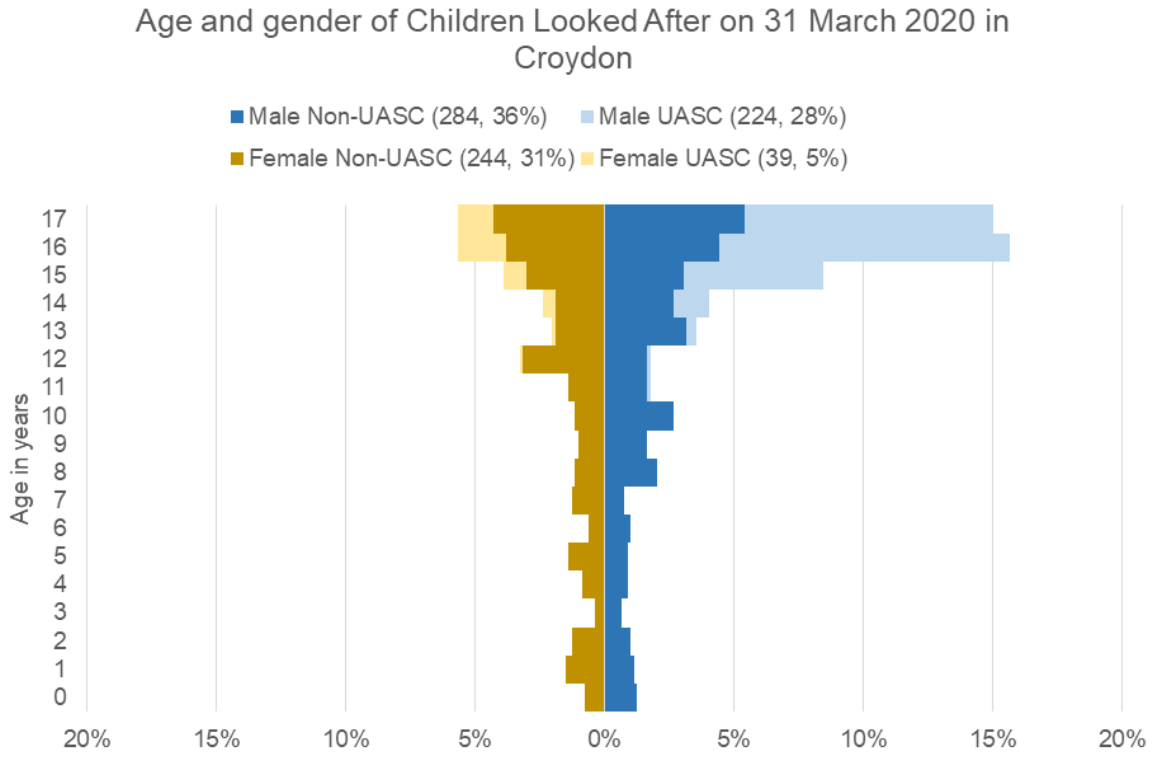
**Figure 1.** Age range of CLA in Croydon (March 2020)




### 3.2 Gender of Children Looked After

Nationally, just over half of CLA on 31 March 2020 were male, 56% compared to 64% in Croydon. This percentage is because of the large numbers of UASC in Croydon, 85% of whom were male. Boys outnumbered girls by almost 3 to 1 in the older ages (aged 16+) [12]

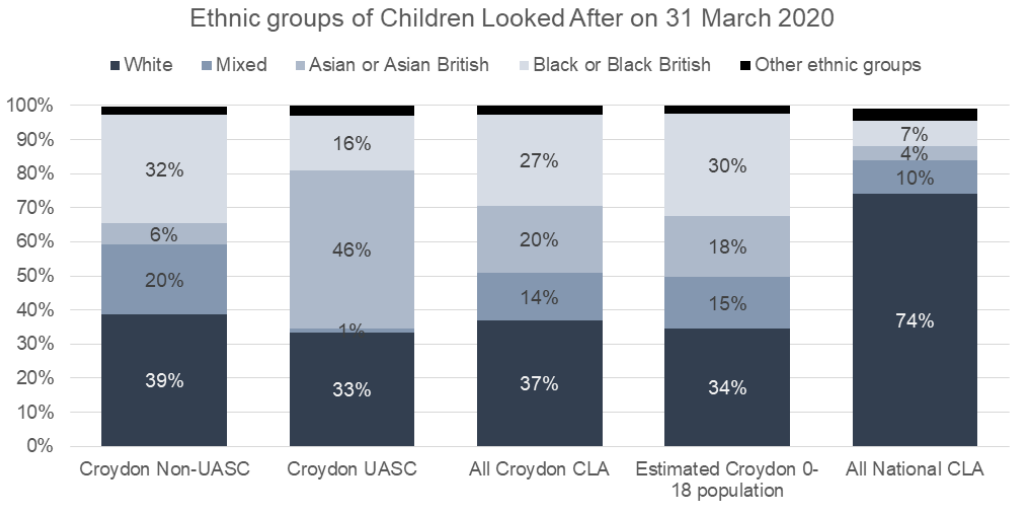
**Figure 2.** Age and gender of CLA in Croydon (March 2020)



### 3.3 Ethnic group of Children Looked After

Nationally, 74% of the children in care on 31 March 2020 were white compared to 37% in Croydon. This both reflects the ethnic groups of Croydon's 0-18 population and Croydon's UASC population which had much higher proportions of children with an Asian or Asian British ethnic group compared to the general 0-18 population. (12)

**Figure 3.** Ethnic groups of CLA in Croydon (2020)

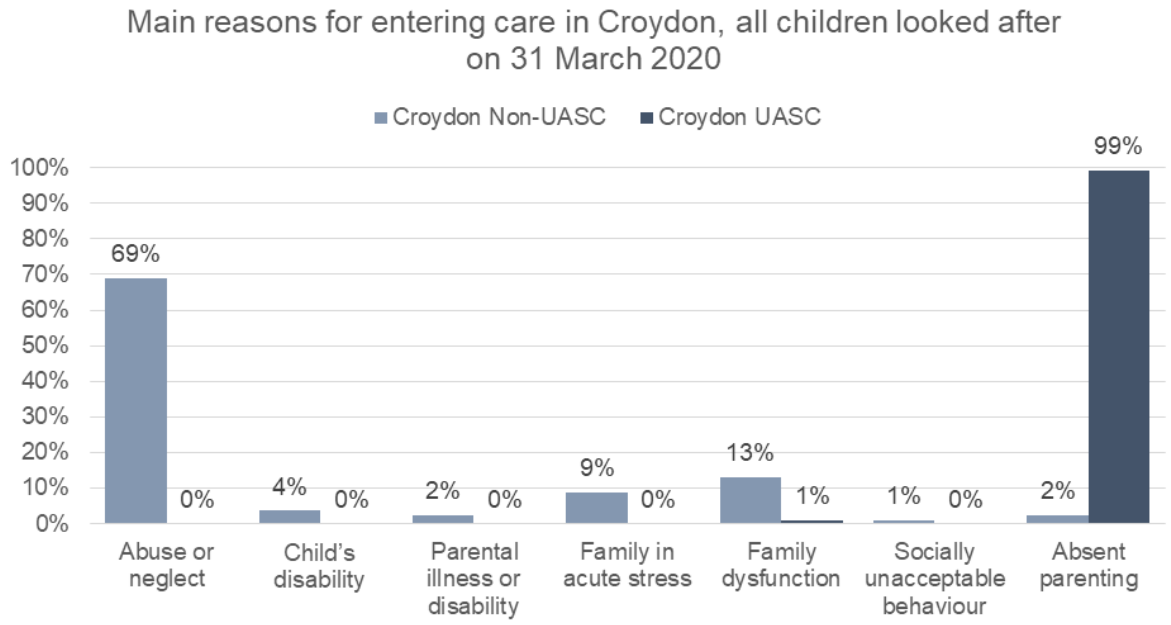



### 3.4 Reasons for entering care in Croydon

Children enter care for a range of reasons including physical, sexual or mental abuse, neglect, and family breakdown. As of 31st March 2020:

- 69% of the non-UASC CLA in Croydon entered care as a result of, or at risk of, abuse or neglect (5)
- 22% entered care for family reasons (where either due to a temporary or longer-term issue parenting capacity is diminished / chronically inadequate)
- 98% UASC entered care due to absent parents (13)

**Figure 4.** Reasons for entering care in Croydon (2020)



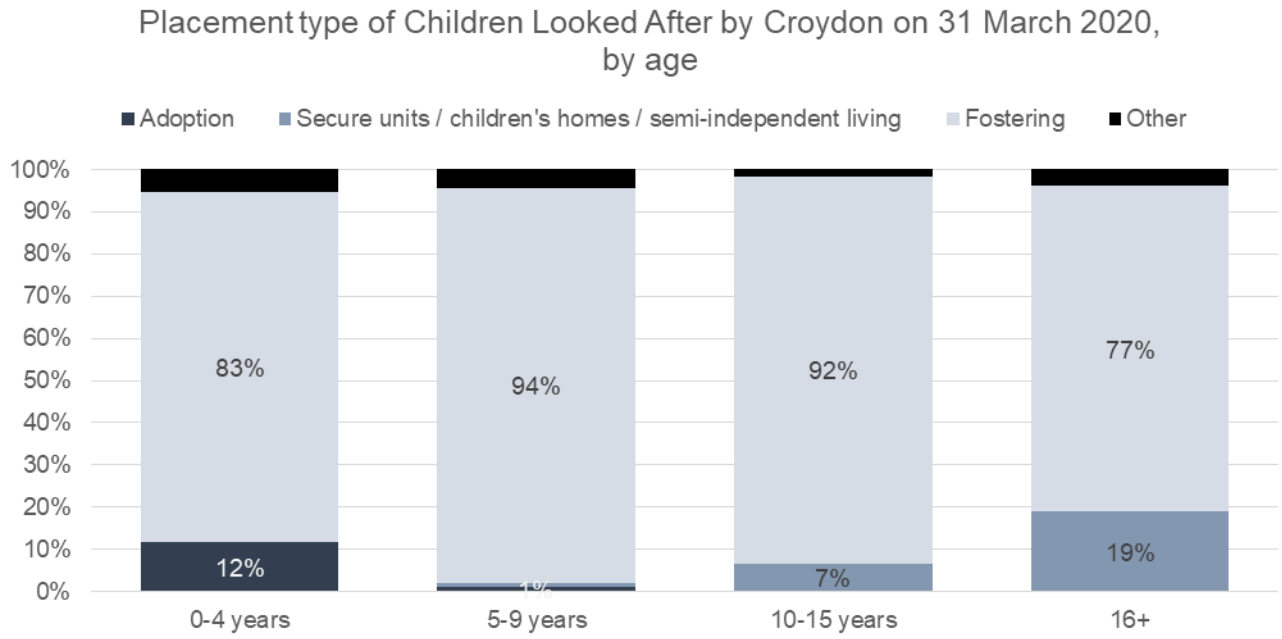

### 3.5 Placements provision in Croydon

CLA should be provided with a stable environment which promotes their physical and emotional development and wellbeing. Research has shown that better outcomes for CLA are achieved where placements offer stability, acceptance and inclusion [14]

Of the children looked after in Croydon on 31 March 2020:

- 85% were in foster placements (93% of UASC and 81% of non-UASC) compared to an average of 72% in England.
- 10% were placed in secure units, children's homes or semi-independent living accommodation
- 3% in other residential settings (including with parents, independent living, in care homes or in custody)
- 1% placed for adoption

**Figure 5.** Placement of CLA in Croydon (2020)

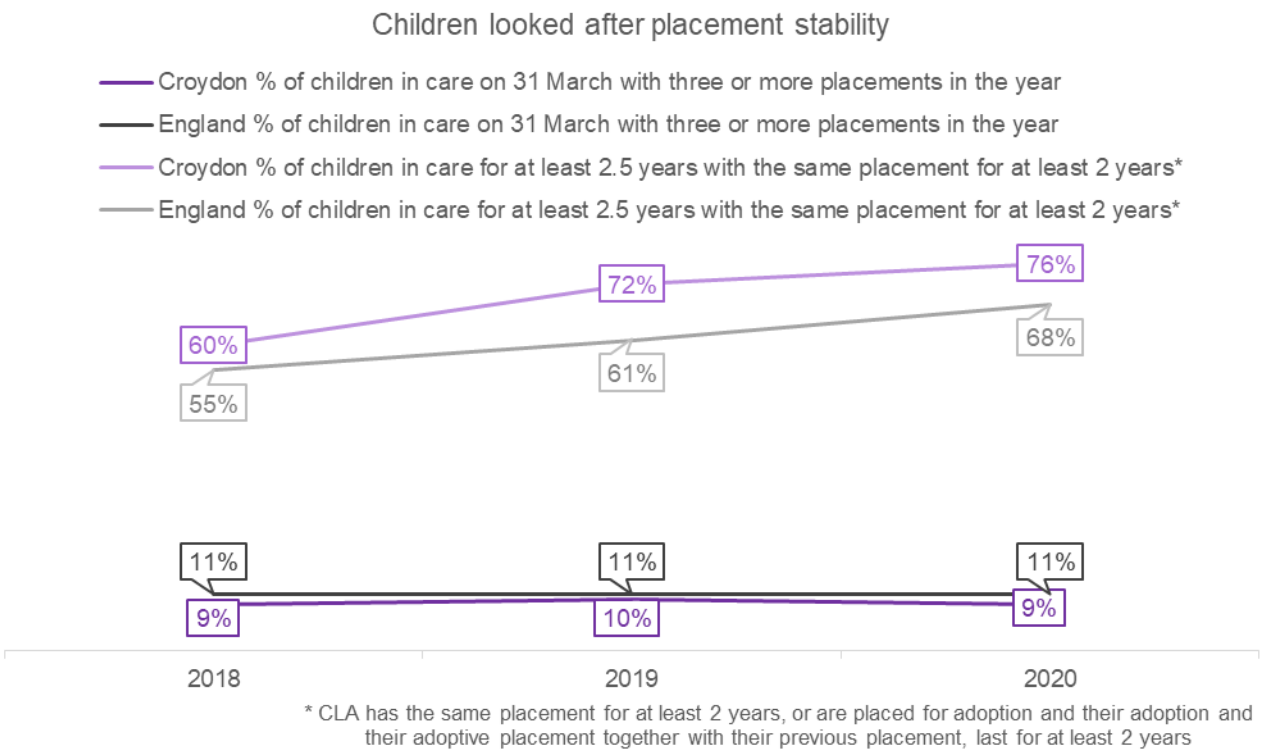



### 3.6 Placement stability

Research shows that improving placement stability can lead to better outcomes for children in care. [6] Data from 31st March 2020 showed that:

- Of Croydon CLA who had been in care for at least 2.5 years, 76% had been in the same placement for at least two years compared to 68% nationally.
- Nationally 11% of CLA had three or more placements and Croydon had 9%. [6]

**Figure 6.** Placement stability in CLA (March 2020)




## 4. The health of Children Looked After

The health and wellbeing of children in care is influenced by multifactorial factors including the care they receive and their background and experiences. (2)

Although CLA have many of the same health issues as their peers, the extent of these is often greater because of their past experiences and this increases the risk of potential health inequalities for CLA. For example:

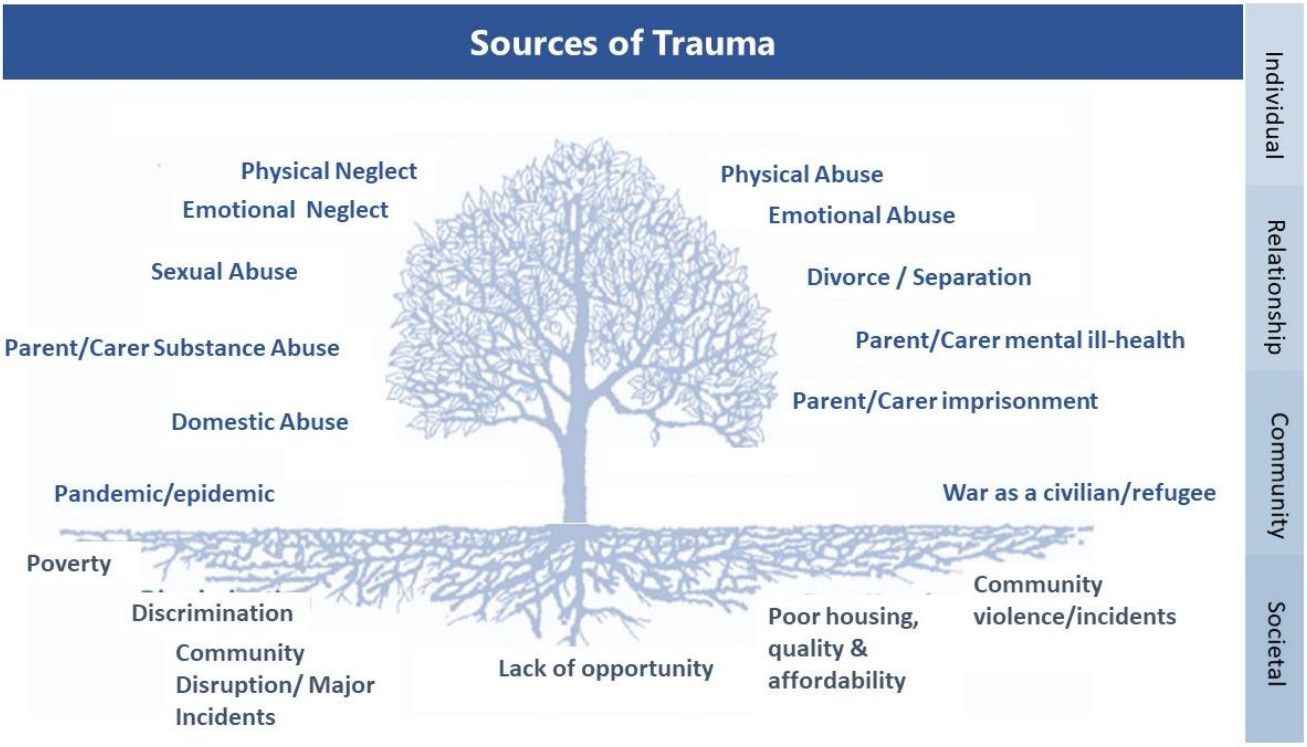
- Around half of all CLA have a diagnosable mental health disorder which is significantly higher than their non-looked after peers. (2)
- Prevalence of behavioural and conduct disorders is particularly high (40%) (7)
- CLA aged 11 to 19 years, have a fourfold increased risk of drug and alcohol use compared to children not in care (8)
- 56% of CLA have special needs (including special educational needs) compared to 15% in the general population (11)

The health and wellbeing needs of the general children in care and UASC share common features but differ in certain needs. Therefore, in following sections the report presents the health needs of the two different cohorts of children separately.

Most children in England come into care because of abuse or neglect or in the case of UASC, parental absence. [3] Evidence suggests that the trauma associated with these early life experiences will have a long-lasting impact on their health, education and life chances [3]

Traumatic events in childhood are also known as Adverse Childhood Experiences (ACEs) and include abuse and neglect, bereavement, parental conflict, substance abuse, or mental illness. [4] Studies have established that experiencing four or more ACEs increases the risk of long-lasting health impacts. [4] [12] For example a 4-12 times increased risk of alcohol and drug dependence, depression, and suicide attempt and a 2-4 times increase in smoking, poor self-rated health, and a 1.4-1.6 times increase in physical inactivity and severe obesity. [4] [12] Due to the reasons why children come into care they are at a high risk of having experienced four or more ACESs or wider traumas. Figure 7 below sets out the broader range of potential sources of traumas.

**Figure 7.** Sources of trauma




An evidence review published by Public Health Wales and Cardiff and Bangor Universities identified interventions to prevent and mitigate the harms relating to adverse childhood experiences [7] [14]:

- supporting parents
- building relationships and resilience
- early identification of adversity

- responding to trauma and specific adverse childhood experiences

### 4.1 Initial and Review health assessments

Inconsistent record keeping can lead to wrong decisions by professionals and adversely affect the child or young person. [17] NICE states that health information held on looked-after babies, children and young people should be accurate, kept up-to-date and transferred at the right time. [17; 18]

National guidance is that CLA should have an IHA within 28 days of coming into care and an RHA every 6 months for children under 5 years and annually thereafter. It should be a collaborative process between the social care and health teams with the carers and the children in care. The steps of the process are: [2]

- The IHAs are conducted by a registered medical practitioner.
- Subsequent assessments are carried out by a registered nurse or registered midwife under the supervision of a registered medical practitioner, who will provide the social worker with a written report.
- The social worker usually liaises with the carer and health team or Designated Nurse for Looked After Children to arrange for the completion of the IHA and completes the IHA referral template and send it to the health team.
- The health professional conducting the assessment completes a relevant form which includes a Health Plan. The completed form is then passed to the child's social worker - who shares copies with the carer.

### 4.2 Audit of Croydon's Health assessments

An audit of 130 randomly selected Health Assessment forms was conducted between January and March 2020. The primary purpose was to increase the understanding of Croydon's CLA health issues as nationally reported health data is limited. A second aim was to identify any data collection / recording issues.

It is recognised that improvements have been made in the process and completion of the Health Assessments since this audit was undertaken; however the information remains useful for understanding the health issues and to provide recommendations for further improvement in areas where gaps or issues still exist.

### 4.2.1 Demographic information of the sample

The data presented in this section is an extract from the full data set which can be found in appendix F. All the data can be seen by type of assessment and age group.

- 50 (36%) of the assessments were for UASC all of whom were between the ages of 11 and 16.
- 96 (74%) of the assessments reviewed were for the 11 to 16 age group
- 86 (66%) of the assessments were for male children

**Table 3.** Gender and age of the sample

| Gender | All | % |
|---|---|---|
| Female | 43 | 33% |
| Male | 86 | 66% |
| Not stated | 1 | 1% |
| **Grand Total** | **130** | **100%** |

| Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|
| 7 | 5 | 31 | 32% | 42% | 32% |
| 14 | 7 | 65 | 64% | 58% | 68% |
| 1 | | | 5% | 0% | 0% |
| **22** | **12** | **96** | **100%** | **100%** | **100%** |

The languages and ethnic group of the random sample were very mixed which will partially reflect the number of UASC children (50) in the sample.

- 30% of the 11 to 16 year olds required an interpreter
- Only 2 children under the age of 11 required an interpreter.
- Need to interpreter was not recorded in 20% of assessments.

There is no specific requirement part from a general statement to record the health needs of different ethnic, cultural or religious groups and, while this does not mean it is not included on a case by case basis, a more systematic approach may be required

**Table 4.** Ethnicity of the sample

| Ethnicity | All | % |
|---|---|---|
| Afghani | 14 | 11% |
| African | 13 | 10% |
| Black Carribean | 7 | 5% |
| British Asian | 27 | 21% |
| Chinese | 1 | 1% |
| Mixed (white and black caribbean) | 4 | 3% |
| Mixed other background | 12 | 9% |
| Not stated | 2 | 2% |
| Other black background | 13 | 10% |
| Unknown | 1 | 1% |
| White British | 21 | 16% |
| White European | 13 | 10% |
| White Irish | 2 | 2% |
| **Grand Total** | **130** | **100%** |

**Table 5.** Language of the sample

| Language(s) | All | % |
|---|---|---|
| Albanian | 12 | 9% |
| Arabic | 1 | 1% |
| Czech,English | 1 | 1% |
| Dari | 1 | 1% |
| English | 66 | 51% |
| English,Farsi | 1 | 1% |
| Korean | 1 | 1% |
| Kurdish | 2 | 2% |
| Mandarin | 1 | 1% |
| NOS | 1 | 1% |
| Pashto | 15 | 12% |
| Pashto,English | 2 | 2% |
| Portuguese | 1 | 1% |
| Tigrinya | 3 | 2% |
| Unknown | 5 | 4% |
| Vietnamese | 17 | 13% |
| **Grand Total** | **130** | **100%** |

### 4.2.2 Health Assessments - Physical Health

Table 6 shows the medical conditions recorded in the assessment. In 61% (79) of assessments no medical concerns were recorded. Of the 36% of children with medical problems the main physical medical problems recorded were:

- Dermatological issues (mainly dry skin) - 12%
- Musculoskeletal concerns - 3%
- Seizures - 2%

**Table 6.** Any current medical concerns and treatment

| Any current medical concerns? | All | % |
|---|---|---|
| Allergy, Dry skin | 1 | 1% |
| Anxiety | 4 | 3% |
| Asthma | 3 | 2% |
| Behavioural | 5 | 4% |
| Behavioural, Asthma | 1 | 1% |
| Behavioural, Headaches | 1 | 1% |
| Chloramphenicol eye ointment needed | 1 | 1% |
| Chronic subdural | 1 | 1% |
| Cough | 1 | 1% |
| Dry skin | 15 | 12% |
| Epistaxis | 1 | 1% |
| Headaches | 3 | 2% |
| Itchiness | 2 | 2% |
| Mild hearing loss | 2 | 2% |
| MSK | 4 | 3% |
| No | 79 | 61% |
| Not stated | 3 | 2% |
| Seizures | 2 | 2% |
| No data | 1 | 1% |
| **Grand Total** | **130** | **100%** |

In a previous review of 154 IHAs completed by Kent Public Health Observatory (2017) the health needs recorded were 17% dermatological, 12% musculoskeletal, 12% anaemia, 5% infectious diseases). [18]

82% (Table 7) of children with review health assessments had received no recorded medical treatment since their last assessment.

**Table 7.** Any medical history since the last assessment

| Medical History since the last assessment, any treatment received? | All | % |
|---|---|---|
| No | 107 | 82% |
| Not stated | 3 | 2% |
| Yes | 19 | 15% |
| No data | 1 | 1% |
| **Grand Total** | **130** | **100%** |

Around 71% of children assessed were not taking any medications (Table 8). The most common medications taken were:

- creams for skin (approx. 5%)
- pumps for asthma ( approx. 5%)
- daily multivitamins (5%)
- medications to help with depression, anxiety and ADHD (5%)

**Table 8.** Current medication

| Current Medication | All | % |
|---|---|---|
| Melatonin | 1 | 1% |
| Antidepressants | 1 | 1% |
| Antidepressants,For ADHD | 1 | 1% |
| Asthma Inhalers | 1 | 1% |
| Blue and brown inhalers | 4 | 3% |
| Blue and brown inhalers, melatonin | 1 | 1% |
| Contraceptive pill | 2 | 2% |
| Creams for skin | 7 | 5% |
| Creams for skin,Asthma Inhalers | 1 | 1% |
| Daily Multivitamins | 6 | 5% |
| For ADHD | 3 | 2% |
| Hayfever medication | 2 | 2% |
| Lamotrigine | 1 | 1% |
| Medication for enuresis | 1 | 1% |
| Mediki | 1 | 1% |
| Movicol | 1 | 1% |
| No | 92 | 71% |
| Not stated | 3 | 2% |
| No data | 1 | 1% |
| **Grand Total** | **130** | **100%** |

Other health professionals involved with children's care are recorded in the health assessments (Table 9). Of these:

- 8.5% (11) assessments recorded that the child was being seen by CAMHS either alone or in combination with other support.

- 8.5% (11) children had been seen by the paediatrician
- 6% (8) were recorded as seeing an educational psychologist either alone or in combination with other support
- In 63% (82) of assessments there was no recorded input by other health professionals

**Table 9.** Seen another health professional

| Seen another Health Professional? | All | % |
|---|---|---|
| CAMHS | 8 | 6% |
| CAMHS, Educational psychologist/therapist | 1 | 1% |
| Dermatology | 2 | 2% |
| Educational psychologist/therapist | 5 | 4% |
| Educational psychologist/therapist, CAMHS | 1 | 1% |
| GP | 2 | 2% |
| Health Visitor | 7 | 5% |
| Health Visitor,Paediatrician | 1 | 1% |
| No | 82 | 63% |
| Not stated | 4 | 3% |
| Orthopaedics,OT,PT,Opthamology, Dermatology, Speech and Language,Educational psychologist/therapist | 1 | 1% |
| Orthotics | 1 | 1% |
| Paediatrician | 5 | 4% |
| Paediatrician,CAMHS | 3 | 2% |
| Paediatrician,Dietician | 1 | 1% |
| Plastic surgeon | 1 | 1% |
| Podiatry | 1 | 1% |
| Speech and Language | 2 | 2% |
| Speech and Language, Podiatry | 1 | 1% |
| Speech and Language,Paediatrician, | 1 | 1% |
| **Grand Total** | **130** | **100%** |

8.46% (11) assessments had a recorded disability. SEND as a specific group is not recorded consistently.

**Table 10.** Disability

| Disability | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| No | 96 | 74% | 16 | 7 | 73 | 73% | 58% | 76% |
| Not stated | 23 | 18% | 5 | 5 | 13 | 23% | 42% | 14% |
| Yes | 11 | 8% | 1 | | 10 | 5% | 0% | 10% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

The percentage of assessments with a recorded visit to the dentist was higher for the older age group (71%, table 11.1) as opposed to 45% and 50% for under-fives and five to elevens. Children's actual dental state was not routinely captured.

**Table 11.** Seen a dentist?

| Seen a Dentist? | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| Appointment made but not yet been seen | 11 | 8% | | 1 | 10 | 0% | 8% | 10% |
| Attempted to but no vacancies | 1 | 1% | 1 | | | 5% | 0% | 0% |
| Dentition assesed but not registered with dentist | 3 | 2% | 3 | | | 14% | 0% | 0% |
| No | 29 | 22% | 6 | 5 | 18 | 27% | 42% | 19% |
| Not stated | 2 | 2% | 2 | | | 9% | 0% | 0% |
| Yes | 84 | 65% | 10 | 6 | 68 | 45% | 50% | 71% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

Attendance at the optician showed a similar pattern to the dentist, with a higher percentage in the older age group having a recorded visit. Both optician and dentist attendance rates are submitted via separate data routes.

**Table 12.** Seen an optician

| Seen an Optician? | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| Booked but not yet seen | 10 | 8% | | 1 | 9 | 0% | 8% | 9% |
| Child too young | 13 | 10% | 12 | | 1 | 55% | 0% | 1% |
| No | 30 | 23% | 2 | 6 | 22 | 9% | 50% | 23% |
| Not recorded | 3 | 2% | | | 3 | 0% | 0% | 3% |
| Several years ago, before current placement | 1 | 1% | | 1 | | 0% | 8% | 0% |
| Yes | 73 | 56% | 8 | 4 | 61 | 36% | 33% | 64% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

A concern with the child's hearing was documented in 3% of consultations, although for 98% of health assessments the date of the last hearing test was not recorded.

In terms of healthy behaviours:

- Data on BMI and obesity was lacking in the health assessments.
- Smoking status was not known in 95% of the forms, of those where it was known 5 were actively smoking while 2 had smoked in the past.
- Health promotion advice was not documented in the health assessments.

### 4.2.3 Health Assessments – Emotional Health and Wellbeing

The review of the health assessments found that mental health concerns were documented in 37% (48) of the records with a higher percentage recorded in the 5 to 11 (50%) age group (Table 13). Only 9% (Table 6) had anxiety / behaviour recorded as a current medical concern.

- Only 11 (8.5%) children were recorded as receiving support from CAMHS and six input from a therapist (Table 9)
- 26% (34) of the children self-reported nightmares, bedwetting and other physical symptoms (Table 14).
- Around 16% (21) of the children stated they needed further help and support (Table 15) but in 35% of assessments there was no record to say if a child was asked.
- To note, no cases of Post-Traumatic Stress Disorder (PTSD) were recorded despite the 50 UASC in the sample.

**Table 13.** Current mental / emotional health concerns and by age

| Are there any current mental/ emotional health concerns? | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| No | 76 | 58% | 12 | 6 | 57 | 55% | 50% | 59% |
| Not stated | 6 | 5% | 4 | | 2 | 18% | 0% | 2% |
| Yes | 48 | 37% | 5 | 6 | 37 | 23% | 50% | 39% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

**Table 14** Nightmares, bedwetting or other physical symptoms and by age

| Do you ever have nightmares, bedwetting or other physical symptoms? | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| No | 87 | 67% | 10 | 10 | 67 | 45% | 83% | 70% |
| Too young but sleeps through the night | 7 | 5% | 7 | | | 32% | 0% | 0% |
| Wakes up at least once during the night | 2 | 2% | 2 | | | 9% | 0% | 0% |
| Yes | 34 | 26% | 3 | 2 | 29 | 14% | 17% | 30% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

**Table 15.** Further help and support for emotional and by age

| Do you need any further help or support? | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| No | 26 | 20% | | | 26 | 0% | 0% | 27% |
| No (too young) | 36 | 28% | 14 | 5 | 17 | 64% | 42% | 18% |
| Not stated | 46 | 35% | 4 | 7 | 35 | 18% | 58% | 36% |
| Yes | 21 | 16% | 4 | | 17 | 18% | 0% | 18% |
| No data | 1 | 1% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

Chronic lack of sleep may also be an issue for many adolescents; the HBSC Survey [18] found that 22% of young people reported not having enough sleep and lack of sleep could be associated with mental health problems. 18% of children in the assessments had concerns about their sleep quality and consultation with stakeholders identified a gap in sleep services.

### 4.3 Health assessment audit: the process

The audit of the assessments identified areas of data that were not routinely captured. See Appendix F for further detail.

- **Follow up actions:** 95% of assessments listed actions that should be completed subsequent to the visit. 42% of these actions were to be taken by the carer or social worker, a further 18% by the GP, 7% by a nurse and 4% by CAMHS. Review health assessments did not routinely document whether the recommended actions from the child's previous health assessments had been completed.
- **Immunisations:** 68% of immunisations were recorded as being up to date. The immunisation record was attached in 32% of consultations. 16% were recorded as not up-to-date, and for 6% immunisation status was not recorded.
- **Hearing:** In 98% of health assessments the date of the last hearing test was not recorded.
- **BMI and obesity:** Data on BMI and obesity was not routinely recorded.
- **Sexual health:** The question was left blank in 97% of the forms which is low relative to the age of the sample. Of those with a record 4 were recorded as being sexually active.
- **Strength and difficulties questionnaire:** Availability of the SDQ was documented in 3% of IHAs and in 8% of RHAs analysed (Table 16) 33% were too young. In 52% there was no response. For more detail about the SDQ process and returns please see the next section.

**Table 16.** Strengths and difficulties questionnaire

| Strengths and Difficulties Questionnaire? | All | % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|
| No | 8 | 6% | | 2 | 6 | 0% | 17% | 6% |
| No (too young) | 43 | 33% | 19 | 6 | 18 | 86% | 50% | 19% |
| No response | 68 | 52% | | 4 | 64 | 0% | 33% | 67% |
| Not stated | 3 | 2% | 3 | | | 14% | 0% | 0% |
| Yes | 7 | 5% | | | 7 | 0% | 0% | 7% |
| Yes not attached | 1 | 1% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

## 4.4 Health of Croydon CLA from national data

### 4.4.1 Health Assessments

National performance data for health assessments is collected for children who have been in care for 12 months or more. At 31st March 2020:

- 84% of CLA in Croydon who had been in care for 12 months had received an annual health assessment compared to 90% nationally (12)
- 83% had an up to date development assessment for under 5 years of age compared to 88% nationally (12)

**Figure 8.** % of children who had their annual Health assessment

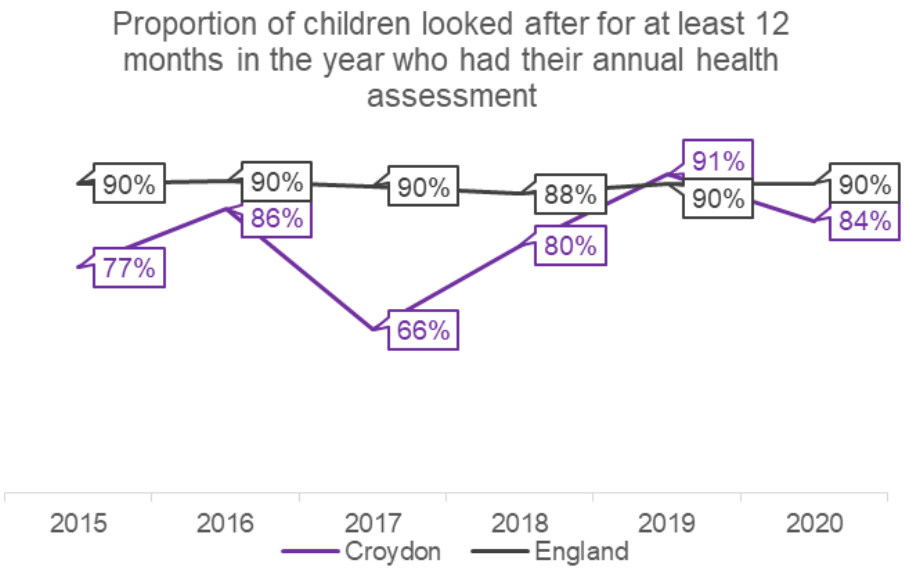
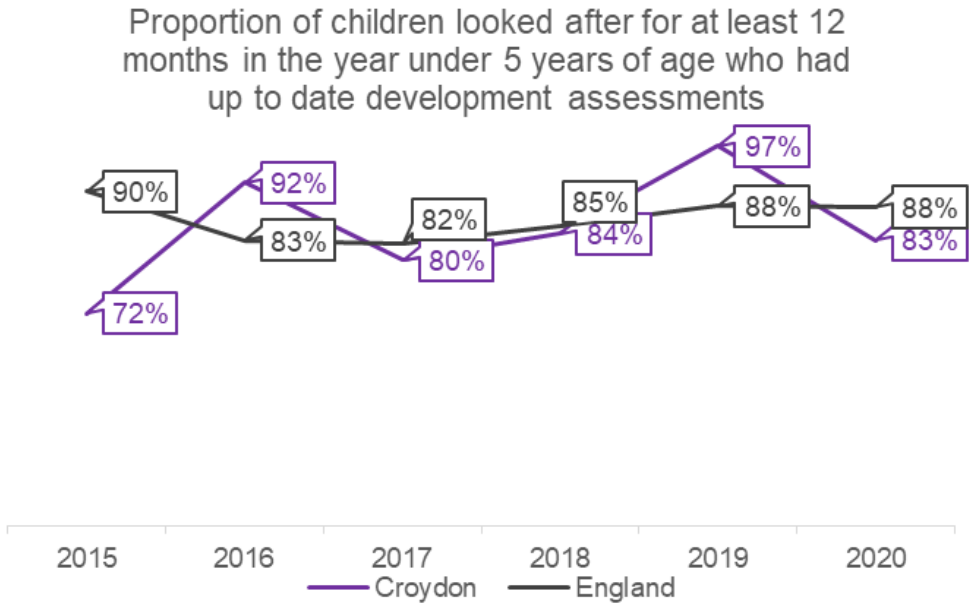


**Figure 9.** % of 5 year olds with up to date development assessments




Discussions with professionals identified the following reasons for delays:

- consent (or absence of consent)
- refusal by CLA to have an assessment
- limited capacity of paediatricians
- delays in returning completed assessments to the local authority.

More work needs to be done to understand reasons why children refuse their health assessments, and how processes can be improved.

### 4.5 SEND

Nationally, CLA are almost four times more likely to have a Special Educational Need than all children and are almost nine times more likely to have an Education, Health and Care (EHC) plan than all children [12].

- In England 55.9% of children looked after had a special educational need, compared to only 14.9% of all children. In Croydon, 46.7% of CLA had a special educational need
- Of the CLA in England with EHCs (40.4%) and SEN support (47.5%), social, emotional and mental health is the most common primary type of special educational need [21]
- In the general child population only 13.3% of those with EHC plans and 18.1% of those with SEN support have social, emotional and mental health as their primary type of educational need [21]

- Looked after children with EHC plans are much less likely to have hearing impairment, visual impairment, autistic spectrum disorder, and physical disability, or speech, language and communication needs as their primary type of special educational need than all children. (21)

**Figure 10.** % of pupils with SEN status 2019/2020 [3]

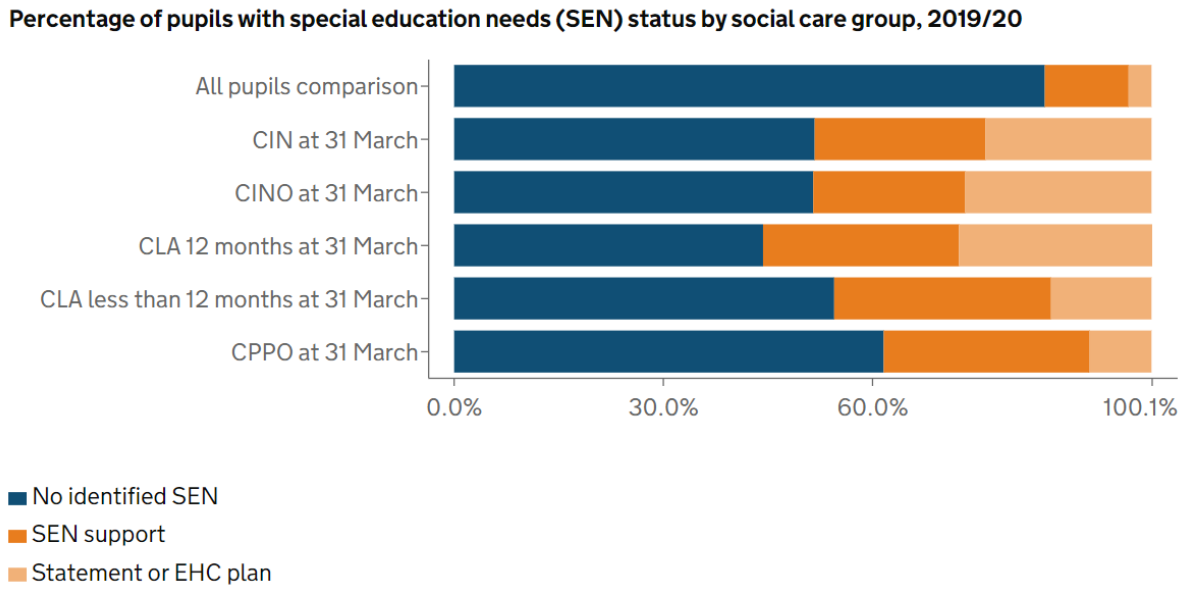
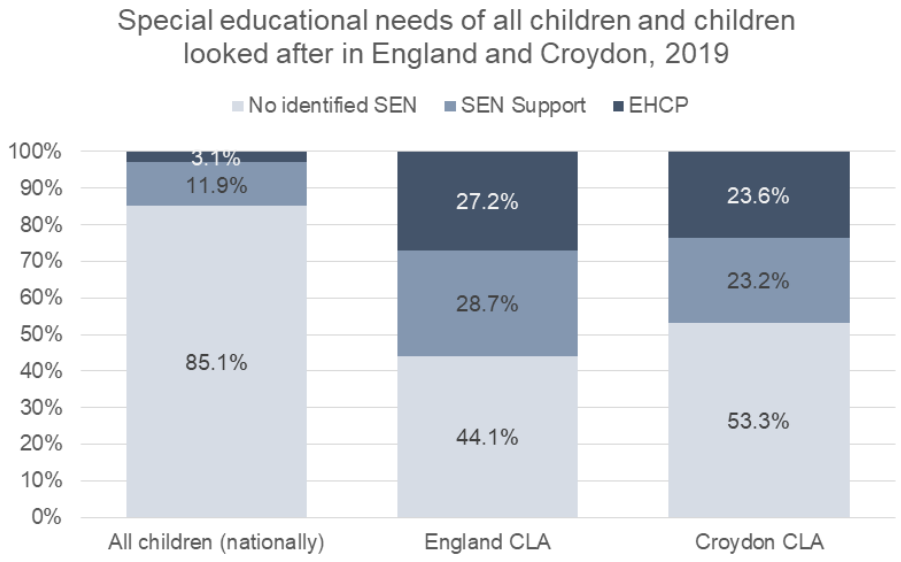



**Figure 11.** SEND of all children and CLA in England and Croydon 2019




A UK-based review of the educational progress of CLA in England considered which SEND were identified as having the biggest impact on educational attainment at Key Stage 4. [22]They found that autism spectrum disorder, “social, emotional and mental health” needs, moderate and severe or multiple learning difficulties were associated with the worst Key Stage 4 outcomes. It observed that

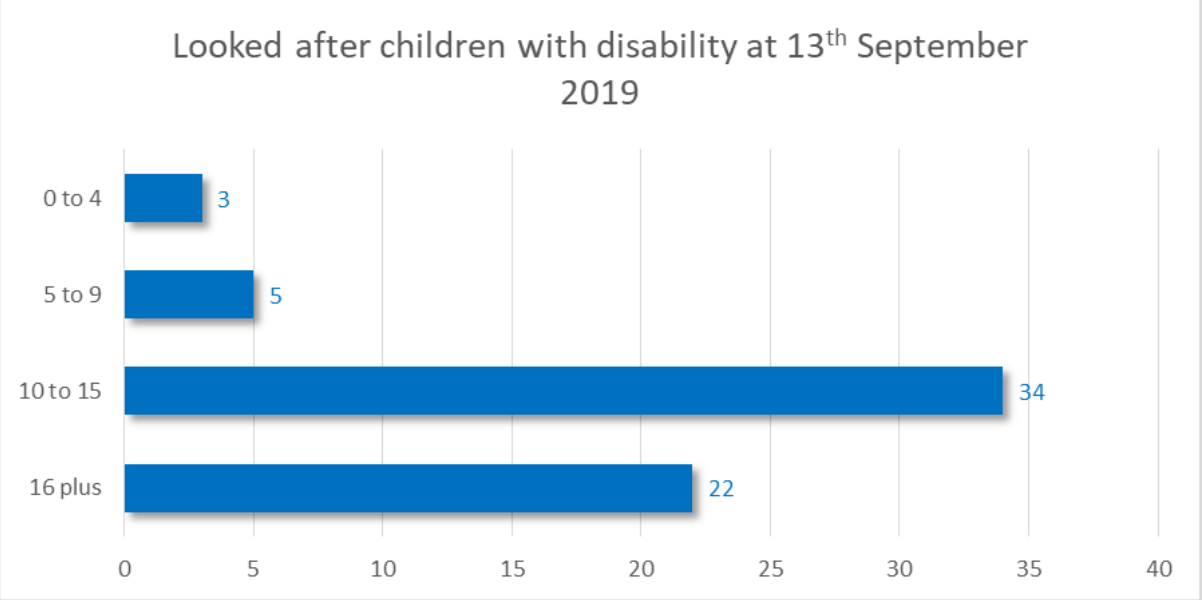
"of all children with identified SEN the children with these four particular types of need were most often also in need or in care" [22] Ensuring access to specialist support, for example through specialist CAMHS services or school counselling services where appropriate, is therefore key for CLA.

### 4.6 Long terms conditions and disability

The percentage of children at 15 diagnosed with a medical condition in Croydon from the latest available data was 16.1%, the third highest rate in London, compared to a London average of 12.3%. [20] In a national survey 23% of young people reported having a long-term condition (LTC) or disability; around 30% said that their condition or disability affected their school attendance and/ or participation. [22]

In September 2019 8% of CLA in Croydon were recorded as having a disability. [23]

**Figure 12.** Looked after children with a disability in Croydon September 2019

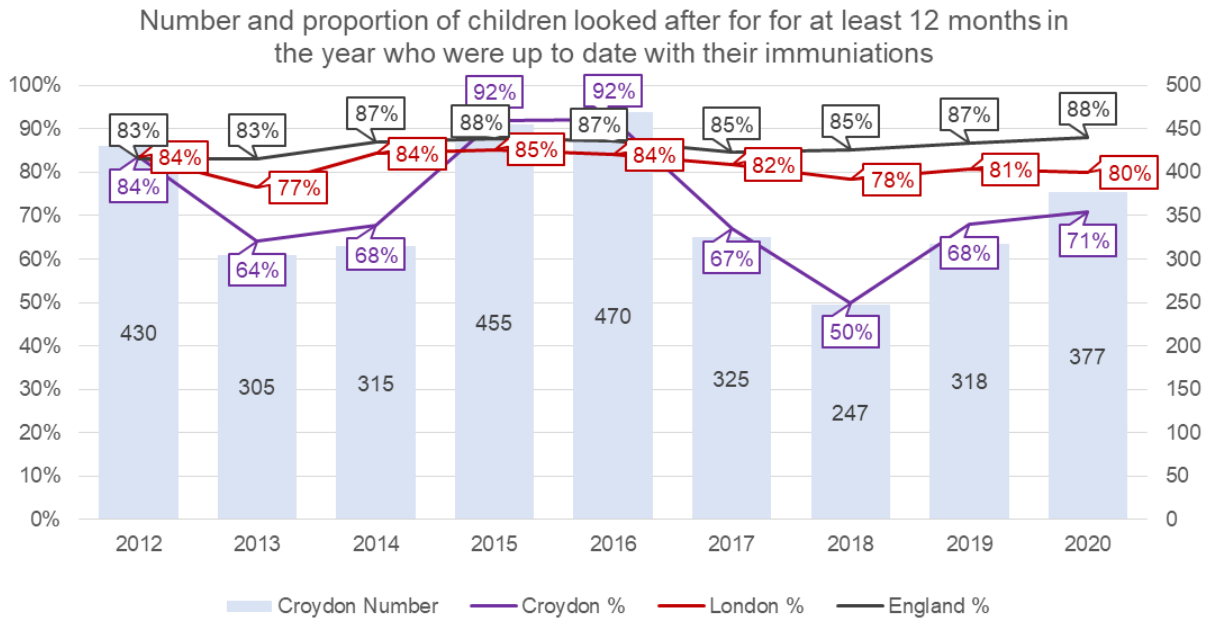



### 4.7 Immunisations:

71% of the 529 CLA who had been in care for 12 months at 31 March 2020 were up to date with their immunisations compared to 88% nationally. [12]

- Croydon has had much lower proportions of children with up to date immunisations than both London and England in the past three years, falling from 92% in 2016.
- A CLA immunisations group has produced an action plan to address the issues particularly with the second dose of the MMR which is the primary problem.

**Figure 13.** Number and % of children with up to date immunisations

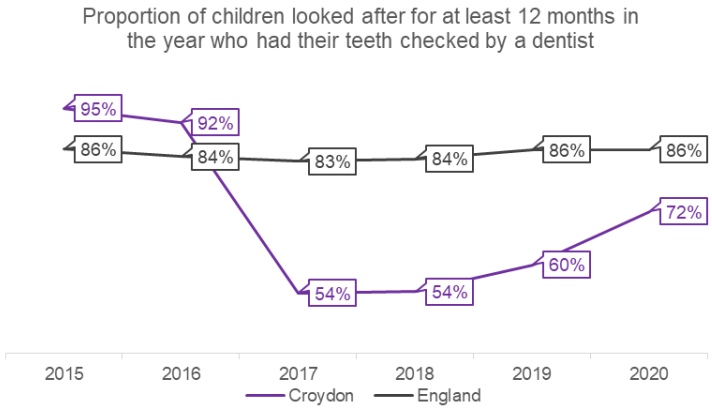



## 4.8 Dental appointments

72% (383 children) of eligible CLA had their teeth checked by a dentist, an increase since 2018 but lower than the national average of 86%. (12)

- There is no data for Croydon CLA with complex oral health needs who are referred to King's dentals, or to orthodontists but a new pathway has been produced that should address this (See appendix E )
- A Scottish study (2018) found that CLA were more likely to have urgent dental treatment needs at 5 years of age (22)

**Figure 14.** % of children who have had their teeth checked by a dentist



### 4.9 Healthy behaviours (nutrition, exercise, sleep, sexual health)

In 2018, a Health Behaviours in School Children (HBSC) survey in England was undertaken as part of a cross-national study by the World Health Organisation. [22] There is no data about healthy behaviours focused specifically on CLA.

The survey found that:

- Only 15% girls and 22% boys are meeting the Chief Medical Officer's recommended daily amount of at least 60 minutes of activity per day.
- 13% of children reported never eating breakfast
- 38% reported eating five portions of fruit and vegetables every day.
- 27% of young people reported not having enough sleep to feel awake and concentrate on school work
- Just over a third (36%) of young people said that they been bullied in the past couple of months.

### 4.10 Child Sexual exploitation

While sexual exploitation can happen to any young person – whatever their background, age, gender, race or sexuality or wherever they live, CLA are at higher risk. London data from 2017 found that 21% of CSE cases were CLA and in 2015/2016 Croydon along with Havering had the highest rates in London. [23]The risk factors include pre-existing mental health issue, a learning disability, self-harm, domestic violence, on the child protection register [23]

In Croydon, there is currently insufficient data with which to track children at risk of child sexual exploitation which limits the ability of undertaking targeted prevention work. This has significant implications for the health and wellbeing of CLA who are at higher risk of being victims of child sexual exploitation.

### 4.11 Sexual health

Consequences of poor sexual health can be serious. Unintended pregnancies and sexually transmitted diseases (STIs) can have long-lasting impacts on people's lives. [26]

A large-scale England prevalence study [25] found that around a third (31%) of CLA had sexual intercourse (after excluding children with a history of rape or sexual abuse).

- Over half (55%) of CLA young people reported that the last time they had sex they did not use contraception,
- 74% of 11-15 year olds reported having had unprotected sex

- Children with a mental health disorders were more likely than those without a disorder to have had unprotected sex the last time they had sexual intercourse.

### 4.12 Mental health and wellbeing

It is estimated that 45% of all children in care in the United Kingdom have a diagnosable mental health disorder and that 70-80% have mental health problems that are recognisable to carers, teachers and social workers. [26] The table below illustrates how much higher the rates of mental disorder are amongst CLA compared to the general population. [27]

**Table 17.** Comparison of rates of mental disorder amongst British children aged 5 to 17 [27]

Table 1: Comparison of rates of mental disorder among British children aged 5–17[a]

| Category of disorder | Non-disadvantaged children (n = 1,253) | Disadvantaged children (n = 761) | Looked after children (n = 9,677) |
|---|---|---|---|
| Any disorder | 8.5% | 14.6% | 46.4% |
| Anxiety disorders | 3.6% | 5.5% | 11.1% |
| Post-traumatic stress disorder | 0.1% | 0.5% | 1.9% |
| Depression | 0.9% | 1.2% | 3.4% |
| Behavioural disorders | 4.3% | 9.7% | 38.9% |
| ADHD | 1.1% | 1.3% | 8.7% |
| Autistic spectrum disorder | 0.3% | 0.1% | 2.6% |
| Other neurodevelopmental disorders | 3.3% | 4.5% | 12.8% |
| Learning disability | 1.3% | 1.5% | 10.7% |

A large 2003 survey found that the prevalence of mental health disorders in CLA was higher among boys compared to girls (49% overall –v- 39% overall) [25] and that:

- Older children were more likely to have generalised and other anxiety disorders, post-traumatic stress disorder (PTSD), depression and conduct disorder
- Younger children were more likely to have oppositional defiant disorder, hyperkinetic disorder and separation anxiety disorder.
- Girls were more likely to be diagnosed with PTSD and emotional disorders and
- Boys were more likely to be diagnosed with hyperkinetic and conduct disorders. [25]

NICE states that ‘conduct disorder is the most common difficulty amongst CLA which can have a significant impact on carers and it puts the children themselves are at risk of school exclusion. Looked-after children and young people are also more likely than their peers to experience depression and anxiety. These children may carry the burden internally, and it may go unnoticed or ignored by professionals. [30]

A significant challenge is the support of CLA who do not meet the criteria for diagnosis of a 'mental health condition' and cannot therefore access CAMHS services. Emotional and behavioural difficulties are reported as an area of need by stakeholders, and a common reason for children and young people to enter crisis[1]. Croydon has recognised this difficulty and a new team of three clinicians has been developed within the Council located within Early Help and CSC has been developed. The team is reviewing how best to provide support and how the offer can be more creative and reflect what the young people say what could work e.g. innovative forms of support rather than traditional therapy. A high risk SDQ score will now trigger a referral to the Croydon clinical team and the team are also training social workers about the SDQ and its importance.

### 4.13 Strength and difficulties questionnaire

It is a government requirement to use the Strengths and Difficulties Questionnaire (SDQ) to assess the wellbeing of CLA. (2) The National Society for the Prevention of Cruelty to Children (NSPCC) found that a high SDQ score appeared to increase the risk of instability on placements, in turn having a detrimental impact on CLA achieving good outcomes. (29) A 2016 report from the Education Select Committee highlighted that the SDQ was just a starting point, and should be accompanied by a full mental health assessment as part of initial and review health assessments. (31)

National good practice states that the SDQ should be completed well in advance of any health assessment so that the completed SDQ can meaningfully inform the wider assessment. 'If mental health needs are unmet it can increase children's risk of a variety of poor outcomes, including placement instability and poor educational attainment' (29)

At 31st March 2020, nationally 81% of CLA aged 5 to 16 years (42,500 children), had a reported SDQ score. Of these:

- 49% had 'normal' emotional and behavioural health (same as last year)
- 13% had 'borderline' scores (same as last year)
- 38% had scores which were a cause for concern (down slightly from 39% last year).

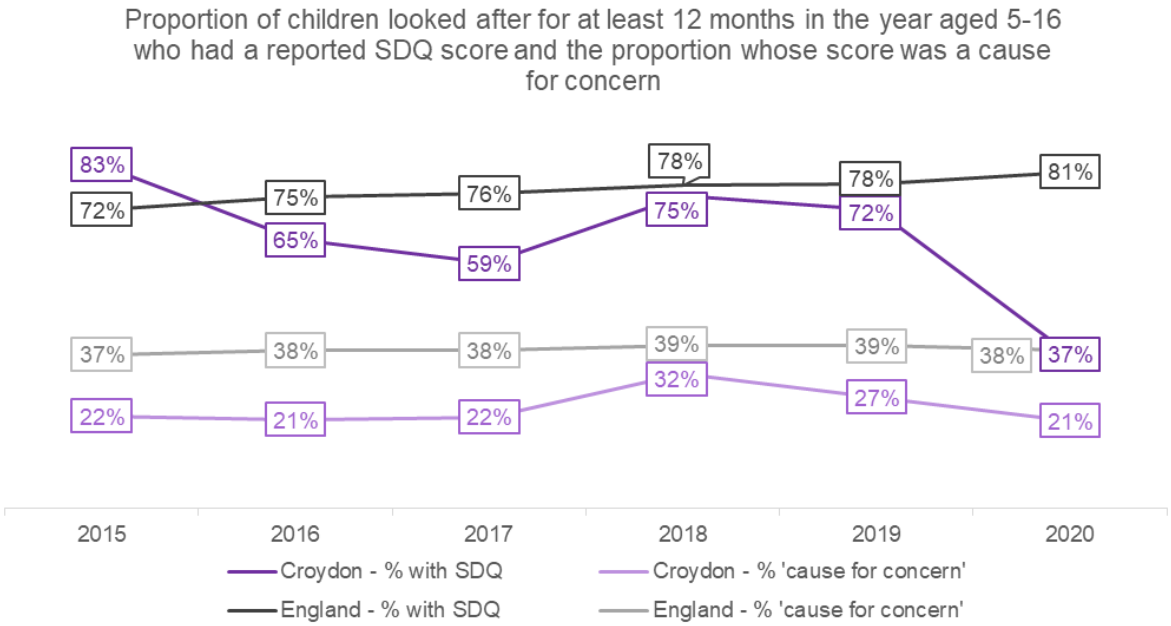
Across almost all ages, males are more likely to have scores which were a cause for concern. In 2020 41% of males had a score which was a cause for concern, compared to 34% of females. (12)

Of the 315 Croydon children aged 5 to 16 years looked after at 31 March 2020 for at least 12 months 37% had a reported SDQ score. Of these:

- 70% had 'normal' emotional and behavioural health (higher than the 62% seen in 2019 and much higher than the national average of 49%).
- 8% had 'borderline' scores (slightly down from 12% in 2019)

- 21% had scores which were a cause for concern (slightly down from 27% in 2018 and lower than the national average of 38%) [12]

**Figure 15.** % of children who had a reported SDQ and % where there was cause for concern




To note there was a significant reduction of children with a recorded completed SDQ in between 2019 and 2020 There is considerable work underway to improve these processes. The CLA health teams health assessment QA process identified that SDQS were not available at the assessments but also that they were only been sent a score without any accompanying narrative. More information is now being provided by the performance team e.g. who is completed the SDQ and the CLA health team are highlighting the SDQs at their roadshows. Following a practice review ad task and finish group, new SDQ training for social workers was implemented. Due to staff changes this training needs to be refreshed and SDQ completion by social workers currently remains an issue. Substance misuse

NICE states that CLA young people are a group that are at increased risk of drug misuse. [32]

### 4.14 The health of unaccompanied Asylum-Seeking Children

CLA who are also UASC have additional and different complex needs following their separation from family, community and home and they may also have experienced or witnessed extreme violence, abuse and rape. [34] Their physical and emotional health needs will require specialist interventions.

Nationally in 2020, 87% of UASC were assessed as having a primary need of absent parenting, 8% abuse or neglect, 3% family in acute stress and 1% of family dysfunction. [3]

NICE [35] states that LA's should 'Ensure that unaccompanied asylum-seeking children and young people have access to specialist psychological services (including CAMHS) with the necessary capacity, skills and expertise to address their particular and exceptional health and wellbeing needs, including:

- post-traumatic stress
- dislocation from country, family, culture, language and religion
- risk of sexual exploitation
- lack of parental support and advocacy in a foreign country
- stress related to the immigration process
- physical and emotional trauma from war and disruption at home such as torture, beatings, rape and death of family members
- increased risk for suicide and mental illness' [35]

A 2019 study of UASC health in Kent [36] found that:

- The majority (57%, n=94) had experienced abuse; 82 disclosed physical abuse, and 18 disclosed sexual abuse.
- 55% (90) reported symptoms of mental health problems.
- 76% (127) had specific health issues, commonly skin conditions, sleep issues or non-specific pain.
- 35% (57) were assessed high-risk of TB contact; 12 had TB symptoms. Referrals for TB screening were made in 103 cases.
- 44 UASCs were referred to sexual health services; 25% of those required specialist sexual abuse centres.
- Over a third (60) of UASCs were referred to mental health services.
- 47 UASCs had health needs identified requiring GP follow-up. [36]

UASC are at risk from TB and FGM. Guidelines recommend all entrants from high incidence of TB countries (>40/100,000) and asylum seekers, regardless of their country of origin, should be offered TB screening and this should be arranged by referral to the TB Nursing Service. Since October 2015 registered professionals in health, social care and teaching have a statutory duty (known as the Mandatory Reporting duty) to report cases of FGM to the police in cases where a girl under 18 either discloses that she has had FGM or a professional observes physical signs of FGM. [37]

Workshop feedback was that Kent, the other area with large numbers of UASC have established a UASC mental health team which they report as having very positive outcomes. The team members

come from relevant cultural backgrounds and therefore are able to provide specific support to the UAS children and young people.

## 5. Youth Voice

The Children's Commissioner published a report August 2015 on the experiences of children in care and care leavers and stated that it was essential that children's views were sought and influence all decisions that are made about them and that all decisions are fully explained to them.

A virtual session with the Children in Care Council in Croydon (EMPIRE) focused on their definition of health. Whilst there was a small cohort size (n=8), valuable insight was provided. Children were asked 'what does health mean to them' and many of the children focused on the emotional health and wellbeing and how important it is in their definition of health. A few gaps were mentioned including:

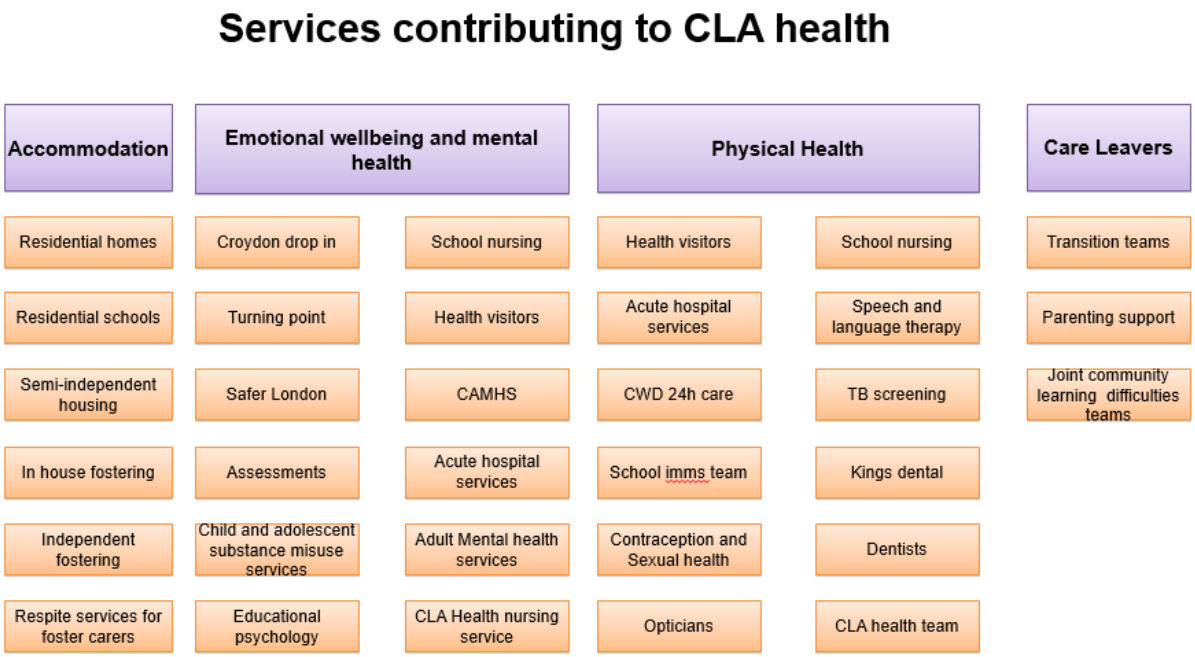
- Access to healthcare services, especially throughout the pandemic (access to GP)
- Anxiety, sleep and low mood issues. This was exacerbated by the pandemic and lockdowns.

Even though similar workshops have been conducted by the CLA team, there was no systematic way of collecting information/feedback from CLA. A regular survey or other feedback mechanism would help inform service delivery and planning.

## 6. Services for CLA

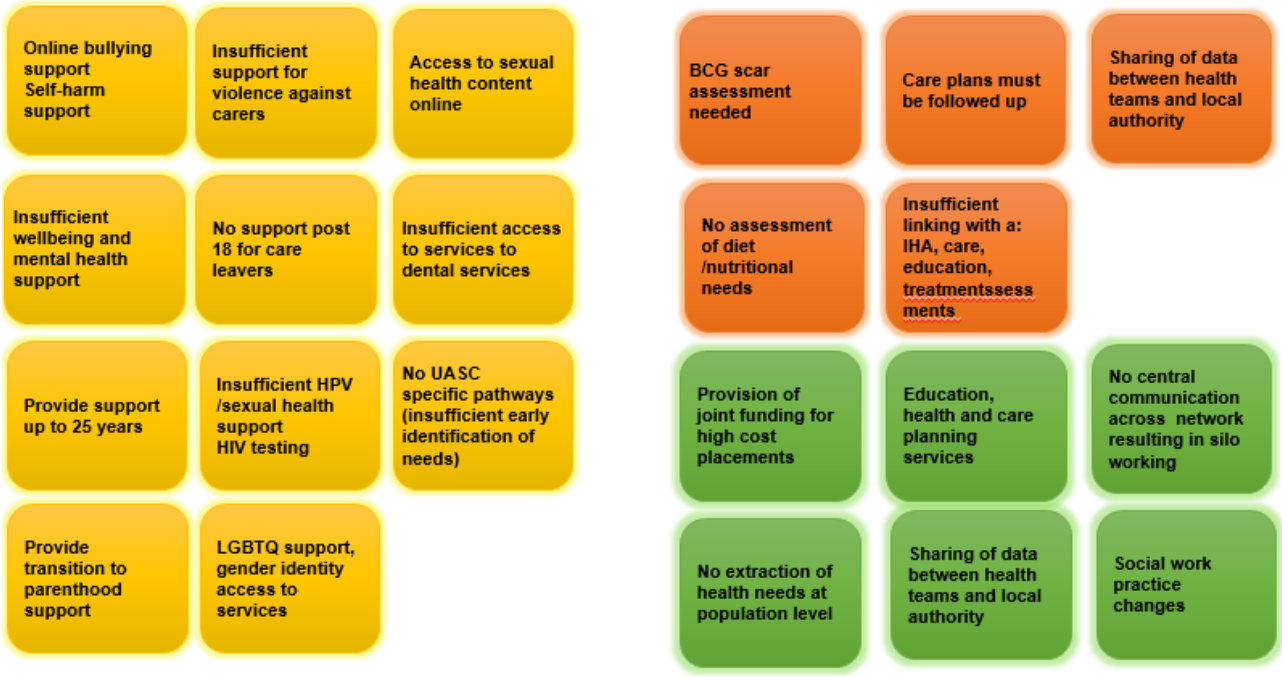
There is a complex web of services (Figure 17) that need to work collaboratively to provide effective coordinated and informed health and wellbeing support for CLA. Figure 17 was generated from workshops /meetings with staff and CLA.

**Figure 16.** Services contributing to CLA Health




Staff and CLA were also asked to feedback on the issues they felt existed for CLA Health. These are shown in figure 18. A number of these gaps and issues are being addressed. For example the CLA health team are receiving training about LGBTQ to ensure that they are skilled and confident to have difficult conversations with young people and a memorandum of understanding has been agreed between health and social care to enable better information sharing.

**Figure 17.** Gaps and issues identified by staff and CLA




## 7. The implications for level of need and findings and recommendations.

Table 17 below summarises data on the risk factors and health issues for CLA in Croydon and uses this to provide an estimate of the possible numbers of children in Croydon with particular health issues. The data sources range from specific CLA data sets, general data for children and young people and the audit of the health assessments. The table is divided into risk factors for health conditions, physical and emotional health and wellbeing.

- The number of UASC (270) and/or BAME (366) children indicates a need for services and staff who have the skills to support children with a wide range of health, ethnic, language and cultural needs.
- Nearly 400 of the CLA at March 31st 2020, had special educational needs. The evidence is that for nearly 50% of these the reason for EHCP or SEN support will be their social, emotional and mental health.
- On the basis of national estimated rates (45%) 356 of the CLA in Croydon at March 31st 2020 could have a diagnosable mental health condition.
- The numbers of CLA experiencing some form of emotional and mental health problems could be as high as 600 based on estimated rates.
- There is not much physical health information specific to CLA and rates for the general Croydon's children population have been applied to the CLA population.

- Using the Year 6 overweight and obesity percentage of 39%, 301 of the current CLA may be overweight and obese, and 200 are likely to be obese.
- 729 of them are likely not to be meeting the required levels of physical activity
- 230 will not be up to date with their immunisations
- 200 plus were likely to have dental caries
- 127 are likely to have a physical disability or LTC

These numbers indicate how important it is that CLA and their foster carers are provided with appropriate support to maximise their chances of healthy behaviours.

**Table 18.** Estimated levels of health need and underlying risk factors

| | CLA specific or general child rate | Time period | National % | Croydon % | Croydon numbers (where known) | Estimated Croydon numbers (local or national rate applied to local CLA population) | Data source |
|---|---|---|---|---|---|---|---|
| **Risk factor for physical and emotional and mental health issues** | | | | | | | |
| Number of Croydon CLA March 2020 | CLA | Mar-20 | n/a | n/a | 791 | n/a | DfE, Children looked after in England including adoptions |
| Under 1 year | CLA | Mar-20 | n/a | n/a | 16 | n/a | DfE, Children looked after in England including adoptions |
| Age 1 to 4 | CLA | Mar-20 | n/a | n/a | 61 | n/a | DfE, Children looked after in England including adoptions |
| Age 5 to 9 | CLA | Mar-20 | n/a | n/a | 94 | n/a | DfE, Children looked after in England including adoptions |
| Age 10 to 15 | CLA | Mar-20 | n/a | n/a | 287 | n/a | DfE, Children looked after in England including adoptions |
| Age 16 and over | CLA | Mar-20 | n/a | n/a | 333 | n/a | DfE, Children looked after in England including adoptions |
| Female | CLA | Mar-20 | n/a | n/a | 283 | n/a | DfE, Children looked after in England including adoptions |
| Male | CLA | Mar-20 | n/a | n/a | 508 | n/a | DfE, Children looked after in England including adoptions |
| BAME | CLA | Mar-20 | n/a | n/a | 498 | n/a | DfE, Children looked after in England including adoptions |
| CLA non UASC | CLA | Mar-20 | n/a | n/a | 521 | n/a | DfE, Children looked after in England including adoptions |
| UASC | CLA | Mar-20 | n/a | n/a | 270 | n/a | DfE, Children looked after in England including adoptions |
| % of children who come into care because of abuse, neglect (exl. UASC) | CLA | Mar-20 | 68% | 69% | 364 | n/a | Croydon figures from local data extract. National figures from above DfE source. |
| % who came into care because of absent parenting (UASC) | CLA | Mar-20 | 87% | 99% | 261 | n/a | Croydon figures from local data extract. National figures from above DfE source. |
| % of CLA not in a stable placement | CLA | Mar-20 | 32% | 24% | 31 | n/a | DfE, Local Authority Interactive Tool |
| % of CLA SEN without EHCP | CLA | Mar-19 | 29% | 24% | n/a | 187 | DfE, Local Authority Interactive Tool |
| % of CLA with an EHCP | CLA | Mar-19 | 27% | 23% | n/a | 184 | DfE, Local Authority Interactive Tool |
| **Physical health** | | | | | | | |
| % overweight or obese (year 6) | General | 2019/20 | 35% | 40% | n/a | 312 | National Childhood Measurement Programme, from PHE Fingertips |
| % obese (year 6) | General | 2019/20 | 21% | 25% | n/a | 199 | National Childhood Measurement Programme, from PHE Fingertips |
| % of physically inactive young people (aged 5-16 years) | General | 2018/19 | 47% | 47% | n/a | 372 | Sport England Active Lives Survey, from PHE Fingertips |
| % not eating 5 a day (aged 15) | General | 2014/15 | 48% | 47% | n/a | 372 | What About YOUth survey, from PHE Fingertips |
| % not meeting recommended exercise per day (aged 15) | General | 2014/15 | 86% | 90% | n/a | 713 | What About YOUth survey, from PHE Fingertips |
| % CLA with all immunisations | CLA | Mar-20 | 88% | 71% | 377 | n/a | DfE, Children looked after in England including adoptions |
| % HPV vaccination coverage (females aged 12-13) | General | 2018/2019 | 88% | 88% | n/a | | PHE Fingertips |
| % of children, with decayed missing or filled teeth (aged 5) | General | 2016-2017 | 23% | 29% | n/a | 225 | National Dental Epidemiology Programme for England: oral health survey of five-year-old children, from PHE Fingertips |
| % of children with a long term illness, disability or medical condition diagnosed by doctor at 15 (aged 15) | General | 2014/15 | 14% | 16% | n/a | 127 | What About YOUth survey, from PHE Fingertips |
| **Emotional and mental health** | | | | | | | |
| Estimated % with a diagnosable mental health conditon | CLA | ? | 45% | n/a | n/a | 356 | NICE guidance and evidence, PH28 |
| Estimated % with emotional and mental health problems | CLA | 2012 | 60% | n/a | n/a | 475 | NICE guidance, QS31 |
| Emotional wellbeing issue recognisable to carers, teachers and social workers | CLA | | 75% | | | 593 | NICE guidance and evidence, PH28 |
| % with an SDQ score indicating that emotional v | CLA | Mar-20 | 38% | 21% | 28 | 166 | DfE, Children looked after in England including adoptions |
| % with identified substance misuse | CLA | Mar-20 | 3% | 4% | 19 | 25 | DfE, Children looked after in England including adoptions |
| % of children who were bullied in the last couple of months (aged 15) | General | 2014/15 | 55% | 51% | n/a | 503 | What About YOUth survey, from PHE Fingertips |

Table 19 below takes the content from Tables 1 and 2 setting out the statutory responsibilities and NICE guidance and guidelines about CLA health and wellbeing and provides a brief summary of Croydon's position including recommendations.

CLA health and wellbeing requires a whole system approach. Most health and wellbeing needs are inter-related and therefore solutions to address the identified needs require a joint, coordinated, collaborative and multi-agency response. On this basis, the recommendations in this HNA are for/relevant to all stakeholders looking after children, whether working in health or social settings.

| Table 19<br>Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 1: Planning, responsibilities, governance and voice of the child** | Key responsibilities for planning and commissioning health services. This includes the role of the Designated Doctor and Nurse (1)<br>Quality Statement 2. Looked-after children and young people receive care from services and professionals that work collaboratively. (1)<br>Ensure services are developed taking account of the views of looked-after children and young people (2) | There is good evidence of partners working collaboratively to improve services for CLA health, through for example the CLA Operational group, the Quality Assurance meetings, and attendance by the designated nurse and doctor at corporate parenting panels.<br><br>Partnership development has been one of the main priorities over the last year with for example the development of CLA health champion role in the social care workforce.<br><br>The audit of the health assessments showed that the full range of health issues and needs as identified by the wider range of professionals (e.g. GPs, SEN team) were not being recorded in this one shared document.<br><br>It was unclear whether there is an ongoing and systematic approach to capturing the voice of the child in CLA health. | **Rec 26** Ensure that each member of the wider CLA team understands theirs and others roles with respect to CLA health and ensure that they input to the health assessment process.<br>**Rec 27** Use the governance processes to ensure that the roles and responsibilities for implementing DOH guidance and NICE recommendations for CLA health are understood and implemented by all stakeholders working with CLA.<br>**Rec 28** Assess the extent to which the Croydon system is adhering to the NICE 'Looked-after children and young people [PH28]' guidelines, to identify gaps in service provision.<br>**Rec 29** Improve access to training courses to support social workers and other non-health staff and carers for identifying managing and underlying health needs and promoting healthy behaviours<br>**Rec 30** Develop a systematic way to capture children's views and experiences and use this to develop, plan and improve CLA health services and is used to inform the design of tailored and culturally appropriate services.<br>**Rec 31** Use estimated data on health risk factors and numbers with different physical, educational and emotional health needs to identify possible gaps in service provision |

| Table 19<br>Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 2: Information sharing** | Ensure there are effective arrangements in place to share information about a child's health.<br>- Ensure that healthcare professionals share health information with social workers and other professionals. (1)<br>- Ensure health information is incorporated into relevant assessments and shared with healthcare professionals, as appropriate. (1) | A memorandum of understanding between health services and the council has enabled improved information sharing over the last year.<br><br>The CHS CLA health team now has link nurses for other key services such as sexual health, drugs and alcohol, CAMHS and YOS to strengthen sharing information sharing. A due diligence check has been added to the RHAs where the team records who they have been contact with in preparing the health assessment.<br><br>In the audit of records from 2019/2020 it had been unclear how and to what extent health information was being shared effectively by all professionals involved with children's care or what mechanisms there are in place to do this. | **Rec 32** Continue to develop ways to understand and capture the full range of contributions to CLA health.<br>**Rec 33** Continue the routine monitoring of health assessments to ensure these are completed in full and shared with relevant professionals. |

| Table 19 | | | |
|---|---|---|---|
| **Theme** | **Detail from guidance** | **Croydon situation** | **Recommendations** |
| **Theme 3: Health assessments and planning** | A health assessment of physical, emotional and mental health needs take place on entry to care and at regular intervals to support effective health planning<br>Social care, education and healthcare staff refer looked-after children and young people to specialist and dedicated services within agreed timescales, and monitor and update health plans to ensure their needs are continuously met | The low number of health professionals recorded as being involved with children's care on the audit of the health assessments could suggest that referrals were not being made, however it is more likely they were not being recorded.<br>The low number of SDQs attached to the health assessments suggested that this process needs improvement and considerable work is underway to improve this.<br>There was evidence from the audit of the health assessments and workshop feedback that action plans were not being routinely followed up.<br>The audit identified that some of the information was focused on process as opposed to actual health status e.g. seen a dentist, seen an optician. | **Rec 34** All professionals to take responsibility for ensuring that all health needs identified are captured in the IHAs and RHAs.<br>**Rec 35** Review the process for updating, and recording health assessment actions.<br>**Rec 36** Establish processes to ensure that all CLA have 100% of the 0 to 5 mandated health checks.<br>**Rec 37** Review the SDQ processes to ensure they are available at the health assessments and to other mental health and wellbeing services.<br>**Rec 38** Provide opportunities for children to talk about their worries and fears, through direct work, an advocate / mentor / befriender or trusted adult. |

| Table 19 | | | |
|---|---|---|---|
| **Theme** | **Detail from guidance** | **Croydon situation** | **Recommendations** |
| **Theme 4: Support for mental health and emotional health and wellbeing** | Flexible and accessible emotional health and wellbeing and mental health services are needed that offer skilled interventions to looked-after children and young people and their carers.<br>Providers of health services and key partners should provide services for looked-after children and young people that: meet the full range of their needs including emotional health and wellbeing | While there are CAMHS services for the highest need and Council clinical mental health and wellbeing support has been established, (three clinical staff) it is unclear whether there is sufficient capacity to support the high numbers of CLA who may require emotional wellbeing and mental health support.<br>The health assessment audit showed much lower numbers being recorded as receiving CAMHS and other therapist support than would be expected.<br>Children have reported that many of the CAMHS services are too generic in their approach, and would prefer tailored services (e.g. the child with anger issues, who would prefer to do boxing classes rather than getting referred to CAMHS). | **Rec 39** Develop a holistic, child-centred pathway for the emotional wellbeing and mental health of CLA.<br>**Rec 40** Review the level of commissioned support for CLA emotional wellbeing and mental health in comparison with estimated need in the CLA population. |

| Table 19<br>Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 5: Diversity** | Providers of health services and key partners should provide services for looked-after children and young people that are sensitive to the needs of black and minority ethnic children and young people and can provide appropriate interventions for emotional and mental health problems associated with racism and cultural identify | The health assessment forms do not appear to allow for the in depth explorations of health issues relating to the diversity of the CLA in Croydon.<br>See appendix B for the requirements for different ages [2] | **Rec 41** Ensure that the needs of vulnerable cohorts e.g. children with disabilities are captured and known by all professionals interacting with a child.<br>**Rec 42** Ensure mental health services are sensitive to the needs of BAME, different cultural and religious groups and UASC, and can provide appropriate interventions for emotional and mental health problems associated with racism and cultural identity and PTSD<br>**Rec 43** Ensure health assessment content reflects the diversity (e.g. sexual, religious, ethnic, cultural, language) of CLA in Croydon |

| Table 19 | | | |
|---|---|---|---|
| **Theme** | **Detail from guidance** | **Croydon situation** | **Recommendations** |
| **Theme 6: SEND** | Special Educational Needs (SEN): acknowledging that around two-thirds of looked-after-children have SEN there is a responsibility to ensure needs are identified and met | It is not clear how SEND status and input from the early years team is routinely incorporated into the IHAs and RHAs | **Rec 44** Use the IHA and RHA processes and liaison with health visiting and the early years' teams, early years providers and schools to support the early identification of SEND.<br>**Rec 45** Review systems for information sharing, learning and intelligence between the Virtual School and health services to improve understanding of health needs in the CLA SEND population |

| Table 19<br>Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 7: Promoting Health** | Role of health and non-health professionals in promoting and supporting health: including the role of social workers, primary care teams, Virtual School Heads and Independent Reviewing Officers (IROs)<br>Provide services that promote and support healthy lifestyles | The risks from overweight and obesity rates, dental caries, low levels of physical activity mean that anyone working with CLA needs the skills to have informed conversations about healthy lifestyles including immunisations<br>The assessment found that informed conversation about healthy lifestyles (e.g. weight, physical activity, oral health, etc.) are not routinely recorded in the IHAs and RHAs.<br>The numbers of children with up to date immunisations is lower than national average, in particular MMR2; although this is not solely a CLA issue in Croydon | **Rec 46** Ensure all professionals are skilled to promote health and the conversations about healthy lifestyles are recorded in the IHA and RHAs<br>**Rec 47** Work with primary care and the school immunisation team to ensure that CLA immunisation rates increase and ensure up to date immunisation status is included as part of the IHAs / RHAs and other records<br>**Rec 48** Finish and implement the draft CLA immunisations action plan 2020 produced by the CLA immunisations task and finish group |

| Table 19<br>Theme | Detail from guidance | Croydon situation | Recommendations |
|---|---|---|---|
| **Theme 8: UASC** | Ensure that unaccompanied asylum-seeking children and young people have access to specialist psychological services (including CAMHS) with the necessary capacity, skills and expertise to address their particular and exceptional health and wellbeing needs | The specific health and wellbeing needs of UASC did not appear from the audit to be systematically addressed in the IHAs, RHAs.<br>A pathway for UASC was cited as a gap in a staff workshop. | **Rec 49** Consider the development of a UASC specific health pathway<br>**Rec 50** Rec 25 Review the health assessment content to ensure it addresses the specific needs of UASC e.g. PTSD, FGM. For reference, review Kent's specific UASC form (see appendix H) |

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# 9. Appendices

## 9.1 Appendix A: Interviews

For the purposes of this health needs assessment for children in care, the following professionals were interviewed:

- Lead Commissioner (Children, Families and Education)
- Service manager for CLA
- Head of safeguarding and CLA
- Designated nurse for CLA
- Designated Clinical Officer for SEND
- Public Health Principal- Sexual Health
- Public Health Principal- Oral Health

These groups have been consulted:

- EMPIRE: Children in care council workshop
- CLA Health operational group
- CHIST Children steering group

## 9.2 Appendix B: Roles of different professionals in promoting CLA health [3]

### The role of social workers in promoting health

62. Social workers have an important role in promoting the health and welfare of looked-after children. In particular they should:

- work in partnership with carers, looked-after children, their birth parents where appropriate and health professionals to contribute to the formulation of the health plan
- ensure that all the necessary consents and delegated authority permissions have been obtained so that decisions are not delayed
- take action to liaise with relevant health professionals if actions identified in the health plan are not being followed up. Given the impact that poor physical, emotional and mental health can have on learning, they should also ensure the child's virtual school head is involved in resolving any health care needs that impact on the child's education
- ensure the child has a copy of the care plan and the health plan
- support foster carers, or the appropriate person in the children's home where a child is placed, to promote the child's physical and emotional health on a day-to-day basis. That should include providing them with information on the child's state of health, including a copy of the child's latest health plan[27]
- ensure that there is clarity for carers, GPs and dentists, and for the child, about what health care decisions have been delegated to carers.

63. Social workers and health professionals should give carers information on how to contact designated and named health professionals for looked-after children and the looked-after children team, and on how to access services, including CAMHS consultations, that the child needs. Supervising social workers should also support and give information to carers about managing their own health.

64. Social workers and carers require regular training to understand their roles in identifying and responding to the emotional and mental health needs of looked-after children.

65. Social workers should also ensure:

- that foster carers and residential care staff know it is their responsibility to make sure a child attends their health assessment and all other medical, dental and optical appointments, and facilitate any required treatment regimes

[27] Where the child is 'competent' in line with Fraser Guidelines, their consent should be obtained. NSPCC factsheet on Gillick competency and Fraser Guidelines. For further information on consent, see annex C.

- that the children their authority looks after, including teenage parents, have access to available positive activities such as arts, sport and culture, in order to promote their sense of well-being.

66. Social workers and other local authority professionals should ensure that information about any health needs or behaviours which could pose a risk of harm to the child, the carer or members of his or her family or household is passed to the carer (or residential care worker) at the time of the placement. At the same time, the carer should receive information about the support that will be available to the child and carer to address or manage these difficulties.

## The roles of Virtual School Heads (VSHs) and designated teachers

67. Every local authority in England is required to appoint an officer (called a Virtual School Head) to discharge the local authority's duty to promote the educational achievement of the children it looks after, regardless of where they are placed. Maintained schools and academies are required to have a designated teacher for looked-after children. Given the interrelationship between health and education outcomes, social workers should ensure that the authority's VSH and the designated teacher for looked-after children are aware of information about the child's physical, emotional or mental health that may have an impact on his or her learning and educational progress.

## The role of Independent Reviewing Officers (IROs)

68. The IRO should, as part of the child's case review, note any actions and updates to ensure that the health plan continues to meet the child's needs. The IRO should be proactive in bringing any deficiencies in the quality of the health plan or its delivery to the attention of the appropriate level of management within the local authority, using the local dispute resolution process if necessary. The local authority should, in turn, discuss any concerns with the designated nurse, so that outstanding issues are addressed without unnecessary delay. IROs should always ensure that looked-after children are involved in the review of their care plan and its component parts, and have their wishes and feelings heard and respected. Further information relating to the statutory requirements of the IRO's role can be found in the *Independent reviewing officers' handbook*.

## The contribution of primary care teams

69. Primary care teams have a vital role in identifying the individual health care needs of looked-after children. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions. They may also have continuing responsibility for the child when he or she returns home.

70. From 1 April 2015, all patients (including children) should have a named GP at the practice with which they are registered, who is responsible for the coordination of services provided under the GP contract.

71. GP practices should:

- ensure timely access to a GP or other appropriate health professional when a looked-after child requires a consultation
- provide summaries of the health history of a child who is looked after, including information on immunisations and covering their family history where relevant and appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments
- maintain a record of the health assessment and contribute to any necessary action within the health plan
- make sure the GP-held clinical record for a looked-after child is maintained and updated and that health records are transferred quickly if the child registers with a new GP practice, such as when he or she moves into another CCG area, leaves care or is adopted.

72. Treating a patient as a temporary resident should be avoided if possible, as the medical record is not available to the treating medical practitioner. If it cannot be avoided, the treating practitioner will normally wish to talk to the child's named GP to avoid treating the patient "blind". Temporary registration is for those who intend to be in an area for more than 24 hours but less than three months, and where there is any doubt over the potential length of stay the GP practice should opt for full registration.

## Health professionals and the role of named health professionals for looked-after children

73. All healthcare staff who come into contact with looked-after children should work within the Royal Colleges' intercollegiate framework. This framework identifies the competences that enable healthcare staff to promote the health and well-being of looked-after children. They are a combination of the skills, knowledge, values and attitudes that are required for safe and effective practice.

74. All staff should have access to appropriate continuing professional development opportunities, clinical supervision and support to facilitate their understanding of the clinical aspects of child welfare and information sharing in relation to looked-after children.

75. Named nurses and doctors for looked-after children have an important role in promoting good professional practice within their organisation and providing advice and expertise for fellow professionals. The named health professional will work in (and usually be employed by) a health provider organisation. He or she will act as a principal

health contact for children's social care and should have up-to-date specialist knowledge of the health needs of looked-after children or know how to access it.[28]

76. Working with the designated professionals for looked-after children, named health professionals should:

- coordinate the provision of local health services for individual looked-after children and the input into health assessments and their reviews for individual looked-after children
- ensure the timeliness and quality of health assessments for looked-after children and ensure actions taken to implement the health care plan are tracked
- act as a key conduit and contact point for the child and their carer, where they have difficulties accessing health services.

## 9.3 Appendix C: NICE Children Looked After quality statements

Statement 1. Looked-after children and young people experience warm, nurturing care.
Statement 2. Looked-after children and young people receive care from services and professionals that work collaboratively.
Statement 3. Looked-after children and young people live in stable placements that take account of their needs and preferences.
Statement 4. Looked-after children and young people have ongoing opportunities to explore and make sense of their identity and relationships.
Statement 5. Looked-after children and young people receive specialist and dedicated services within agreed timescales.
Statement 6. Looked-after children and young people who move across local authority or health boundaries continue to receive the services they need.
Statement 7. Looked-after children and young people are supported to fulfil their potential.
Statement 8. Care leavers move to independence at their own pace.
Other quality standards that should also be considered when commissioning and providing a high-quality service are listed in related NICE quality standards.

From <https://www.nice.org.uk/guidance/qs31/chapter/List-of-quality-statements>

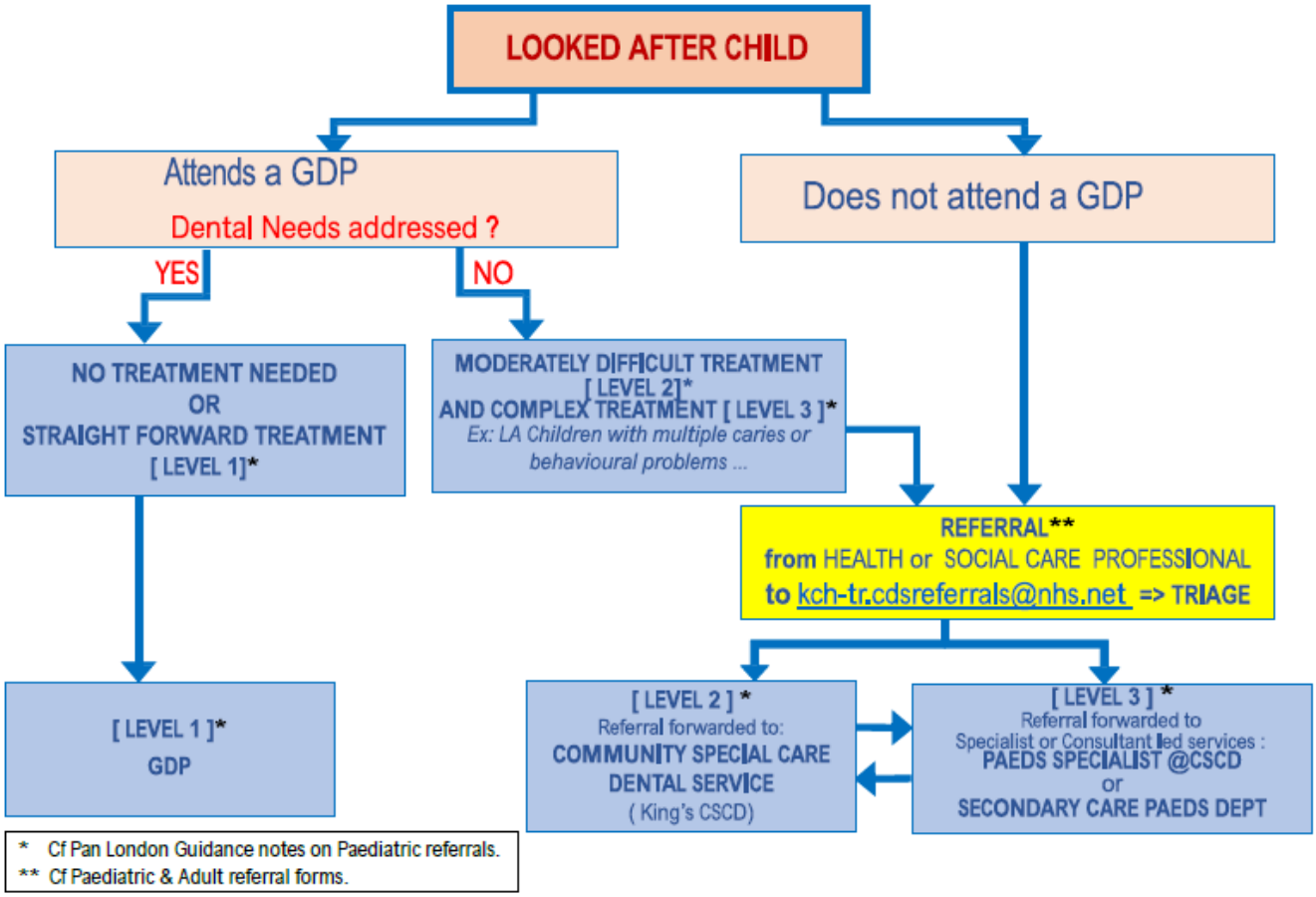
## 9.4 Appendix D: NICE Children Looked After Principles and values

The recommendations in this guideline are supported by the following principles [1]:

- Put the voices of children, young people and their families at the heart of service design and delivery.
- Deliver services that are tailored to the individual and diverse needs of children and young people by ensuring effective joint commissioning and integrated professional working.
- Develop services that address health and wellbeing and promote high-quality care.
- Encourage warm and caring relationships between child and carer that nurture attachment and create a sense of belonging so that the child or young person feels safe, valued and protected.
- Help children and young people to develop a strong sense of personal identity and maintain the cultural and religious beliefs they choose.
- Ensure young people are prepared for and supported in their transition to adulthood.
- Support the child or young person to participate in the wider network of peer, school and community activities to help build resilience and a sense of belonging.
- Ensure children and young people have a stable experience of education that encourages high aspiration and supports them in achieving their potential.

From <https://www.nice.org.uk/guidance/ph28/chapter/Principles-and-values>

## 9.5 Appendix E: CLA dental pathway



## 9.6 Appendix F: Tables

| Seen a Dentist? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Appointment made but not yet been seen | 11 | 8% | 10 | 1 | 15% | 2% | | 1 | 10 | 0% | 8% | 10% |
| Attempted to but no vacancies | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Dentition assesed but not registered with dentist | 3 | 2% | | 3 | 0% | 5% | 3 | | | 14% | 0% | 0% |
| No | 29 | 22% | 21 | 8 | 31% | 13% | 6 | 5 | 18 | 27% | 42% | 19% |
| Not stated | 2 | 2% | 1 | 1 | 1% | 2% | 2 | | | 9% | 0% | 0% |
| Yes | 84 | 65% | 35 | 49 | 52% | 78% | 10 | 6 | 68 | 45% | 50% | 71% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Seen an Optician? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Booked but not yet seen | 10 | 8% | 10 | | 15% | 0% | | 1 | 9 | 0% | 8% | 9% |
| Child too young | 13 | 10% | 3 | 10 | 4% | 16% | 12 | | 1 | 55% | 0% | 1% |
| No | 30 | 23% | 24 | 6 | 36% | 10% | 2 | 6 | 22 | 9% | 50% | 23% |
| Not recorded | 3 | 2% | 2 | 1 | 3% | 2% | | | 3 | 0% | 0% | 3% |
| Several years ago, before current placement | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| Yes | 73 | 56% | 27 | 46 | 40% | 73% | 8 | 4 | 61 | 36% | 33% | 64% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Seen another Health Professional? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS | 8 | 6% | 2 | 6 | 3% | 10% | | | 8 | 0% | 0% | 8% |
| CAMHS, Educational psychologist/therapist | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Dermatology | 2 | 2% | 1 | 1 | 1% | 2% | | | 2 | 0% | 0% | 2% |
| Educational psychologist/therapist | 5 | 4% | 3 | 2 | 4% | 3% | | 1 | 4 | 0% | 8% | 4% |
| Educational psychologist/therapist, CAMHS | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| GP | 2 | 2% | 1 | 1 | 1% | 2% | 1 | | 1 | 5% | 0% | 1% |
| Health Visitor | 7 | 5% | 1 | 6 | 1% | 10% | 7 | | | 32% | 0% | 0% |
| Health Visitor,Paediatrician | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| No | 82 | 63% | 49 | 33 | 73% | 52% | 5 | 8 | 69 | 23% | 67% | 72% |
| Not stated | 4 | 3% | 4 | | 6% | 0% | | 2 | 2 | 0% | 17% | 2% |
| Orthopaedics,OT,PT,Opthamology, Dermatology, Speech and | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Orthotics | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Paediatrician | 5 | 4% | 4 | 1 | 6% | 2% | 3 | | 2 | 14% | 0% | 2% |
| Paediatrician,CAMHS | 3 | 2% | 1 | 2 | 1% | 3% | | | 3 | 0% | 0% | 3% |
| Paediatrician,Dietician | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Plastic surgeon | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Podiatry | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Speech and Language | 2 | 2% | | 2 | 0% | 3% | 2 | | | 9% | 0% | 0% |
| Speech and Language, Podiatry | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Speech and Language,Paediatrician | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Any concerns with hearing? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 122 | 94% | 63 | 59 | 94% | 94% | 20 | 11 | 91 | 91% | 92% | 95% |
| Not stated | 4 | 3% | 3 | 1 | 4% | 2% | | 1 | 3 | 0% | 8% | 3% |
| Yes | 4 | 3% | 1 | 3 | 1% | 5% | 2 | | 2 | 9% | 0% | 2% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Date of last hearing test | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Not recorded | 127 | 98% | 66 | 61 | 99% | 97% | 21 | 11 | 95 | 95% | 92% | 99% |
| 06/02/2010 | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| 27/03/2019 | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| (blank) | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Imms up to date? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 30 | 23% | 20 | 10 | 30% | 16% | 4 | | 26 | 18% | 0% | 27% |
| Not recorded | 20 | 15% | 16 | 4 | 24% | 6% | | 5 | 15 | 0% | 42% | 16% |
| Patient believes so but no evidence | 19 | 15% | 13 | 6 | 19% | 10% | | | 19 | 0% | 0% | 20% |
| Yes | 60 | 46% | 17 | 43 | 25% | 68% | 18 | 6 | 36 | 82% | 50% | 38% |
| Yes (verbal report) | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Imms record attached? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 89 | 68% | 57 | 32 | 85% | 51% | 16 | 12 | 61 | 73% | 100% | 64% |
| Not recorded | 17 | 13% | 6 | 11 | 9% | 17% | | | 17 | 0% | 0% | 18% |
| Yes | 24 | 18% | 4 | 20 | 6% | 32% | 6 | | 18 | 27% | 0% | 19% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Are there any current mental/ emotional health concerns? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 76 | 58% | 39 | 37 | 58% | 59% | 12 | 6 | 57 | 55% | 50% | 59% |
| Not stated | 5 | 4% | 1 | 4 | 1% | 6% | 4 | | 1 | 18% | 0% | 1% |
| Yes | 48 | 37% | 27 | 21 | 40% | 33% | 5 | 6 | 37 | 23% | 50% | 39% |
| (blank) | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Do you ever have nightmares, bedwetting or other physical | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 87 | 67% | 43 | 44 | 64% | 70% | 10 | 10 | 67 | 45% | 83% | 70% |
| Too young but sleeps through the night | 7 | 5% | | 7 | 0% | 11% | 7 | | | 32% | 0% | 0% |
| Wakes up at least once during the night | 2 | 2% | | 2 | 0% | 3% | 2 | | | 9% | 0% | 0% |
| Yes | 34 | 26% | 24 | 10 | 36% | 16% | 3 | 2 | 29 | 14% | 17% | 30% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Do you need any further help or support? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 26 | 20% | 5 | 21 | 7% | 33% | | | 26 | 0% | 0% | 27% |
| No (too young) | 36 | 28% | 22 | 14 | 33% | 22% | 14 | 5 | 17 | 64% | 42% | 18% |
| Not stated | 46 | 35% | 31 | 15 | 46% | 24% | 4 | 7 | 35 | 18% | 58% | 36% |
| Yes | 21 | 16% | 9 | 12 | 13% | 19% | 4 | | 17 | 18% | 0% | 18% |
| No data | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Strengths and Difficulties Questionnaire? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 8 | 6% | 4 | 4 | 6% | 6% | | 2 | 6 | 0% | 17% | 6% |
| No (too young) | 43 | 33% | 26 | 17 | 39% | 27% | 19 | 6 | 18 | 86% | 50% | 19% |
| No response | 68 | 52% | 33 | 35 | 49% | 56% | | 4 | 64 | 0% | 33% | 67% |
| Not stated | 3 | 2% | 2 | 1 | 3% | 2% | 3 | | | 14% | 0% | 0% |
| Yes | 7 | 5% | 2 | 5 | 3% | 8% | | | 7 | 0% | 0% | 7% |
| Yes not attached | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| ASQ attached? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 127 | 98% | 65 | 62 | 97% | 98% | 22 | 12 | 93 | 100% | 100% | 97% |
| Yes | 3 | 2% | 2 | 1 | 3% | 2% | | | 3 | 0% | 0% | 3% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Any concerns from ASQ? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 49 | 38% | 27 | 22 | 40% | 35% | 11 | 2 | 36 | 50% | 17% | 38% |
| Not stated | 78 | 60% | 40 | 38 | 60% | 60% | 11 | 10 | 57 | 50% | 83% | 59% |
| Yes | 3 | 2% | | 3 | 0% | 5% | | | 3 | 0% | 0% | 3% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| General behaviours | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Concerning | 25 | 19% | 14 | 11 | 21% | 17% | 2 | | 23 | 9% | 0% | 24% |
| No comment | 8 | 6% | 8 | | 12% | 0% | | 7 | 1 | 0% | 58% | 1% |
| No concerns | 77 | 59% | 40 | 37 | 60% | 59% | | 5 | 72 | 0% | 42% | 75% |
| Positive | 20 | 15% | 5 | 15 | 7% | 24% | 20 | | | 91% | 0% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Sleep | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Concerning | 16 | 12% | 12 | 4 | 18% | 6% | | | 16 | 0% | 0% | 17% |
| Mild concerns | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| No comment | 10 | 8% | 10 | | 15% | 0% | | 9 | 1 | 0% | 75% | 1% |
| No concerns | 103 | 79% | 44 | 59 | 66% | 94% | 21 | 3 | 79 | 95% | 25% | 82% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Toilet Training / Bowel | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age appropriate | 21 | 16% | 6 | 15 | 9% | 24% | 21 | | | 95% | 0% | 0% |
| Concerning | 3 | 2% | 2 | 1 | 3% | 2% | | | 3 | 0% | 0% | 3% |
| Developmentally delayed | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| No comment | 10 | 8% | 10 | | 15% | 0% | | 9 | 1 | 0% | 75% | 1% |
| No concerns | 95 | 73% | 49 | 46 | 73% | 73% | | 3 | 92 | 0% | 25% | 96% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Speech and Language/ Communication | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age appropriate | 18 | 14% | 5 | 13 | 7% | 21% | 18 | | | 82% | 0% | 0% |
| Concerning | 5 | 4% | 3 | 2 | 4% | 3% | | 1 | 4 | 0% | 8% | 4% |
| Mild difficulties | 3 | 2% | | 3 | 0% | 5% | 3 | | | 14% | 0% | 0% |
| No comment | 9 | 7% | 9 | | 13% | 0% | | 8 | 1 | 0% | 67% | 1% |
| No concerns | 94 | 72% | 49 | 45 | 73% | 71% | | 3 | 91 | 0% | 25% | 95% |
| (blank) | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Wishes and Feelings | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Concerning | 9 | 7% | 5 | 4 | 7% | 6% | 1 | | 8 | 5% | 0% | 8% |
| No comment | 11 | 8% | 11 | | 16% | 0% | | 9 | 2 | 0% | 75% | 2% |
| No concerns | 89 | 68% | 45 | 44 | 67% | 70% | | 3 | 86 | 0% | 25% | 90% |
| Positive | 3 | 2% | | 3 | 0% | 5% | 3 | | | 14% | 0% | 0% |
| Too young | 18 | 14% | 6 | 12 | 9% | 19% | 18 | | | 82% | 0% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Observation | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Concerning | 6 | 5% | 3 | 3 | 4% | 5% | | | 6 | 0% | 0% | 6% |
| No comment | 5 | 4% | 5 | | 7% | 0% | | 4 | 1 | 0% | 33% | 1% |
| No concerns | 119 | 92% | 59 | 60 | 88% | 95% | 22 | 8 | 89 | 100% | 67% | 93% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Carers comment | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Concern re need for health referral | 8 | 6% | 5 | 3 | 7% | 5% | 1 | | 7 | 5% | 0% | 7% |
| General concern | 4 | 3% | | 4 | 0% | 6% | 4 | | | 18% | 0% | 0% |
| General concern mild | 10 | 8% | 10 | | 15% | 0% | | 2 | 8 | 0% | 17% | 8% |
| General moderate concern | 2 | 2% | | 2 | 0% | 3% | | | 2 | 0% | 0% | 2% |

| Action by? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Carer | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| Carer & social worker | 54 | 42% | 14 | 40 | 21% | 63% | 7 | 6 | 41 | 32% | 50% | 43% |
| Carer & social worker, Audiology | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Carer & social worker, GP | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| Carer & social worker, GP, LA | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker, GP, Mother & social worker | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Carer & social worker, Health Visitor | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Carer & social worker, LA | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| Carer & social worker, LAC nurse | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| Carer & social worker, Social worker & adoptive parents | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Carer & social worker,CAMHS | 2 | 2% | | 2 | 0% | 3% | | | 2 | 0% | 0% | 2% |
| Carer & social worker,CLA Nurse | 5 | 4% | 3 | 2 | 4% | 3% | | 1 | 4 | 0% | 8% | 4% |
| Carer & social worker,CLA Nurse | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,CLA Nurse,CAMHS | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,CLA Nurse,GP | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,CLA Nurse,GP,CAMHS,Repl Key | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,CLA Nurse,Paediatrician,CAMHS | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,GP | 24 | 18% | 21 | 3 | 31% | 5% | | | 24 | 0% | 0% | 25% |
| Carer & social worker,GP, | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,GP, Key worker, CLA Nurse | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,GP,CLA Nurse | 2 | 2% | 2 | | 3% | 0% | | | 2 | 0% | 0% | 2% |
| Carer & social worker,GP,LA | 3 | 2% | 3 | | 4% | 0% | | 1 | 2 | 0% | 8% | 2% |
| Carer & social worker,Key worker | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,LA | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Carer & social worker,LA,GP | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| Carer, Neurosurgery | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| CLA nurse, Mother & social worker | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| CLA Nurse,LA | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Educational psychologist, Carer & social worker | 1 | 1% | 1 | | 1% | 0% | | 1 | | 0% | 8% | 0% |
| GP | 2 | 2% | 2 | | 3% | 0% | | | 2 | 0% | 0% | 2% |
| GP, Health Visitor | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| Key worker,Carer & social worker | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Mother & social worker | 3 | 2% | | 3 | 0% | 5% | 3 | | | 14% | 0% | 0% |
| Mother & social worker, CLA Nurse, Key worker | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| None | 5 | 4% | 1 | 4 | 1% | 6% | | 1 | 4 | 0% | 8% | 4% |
| Opthamology clinic, Carer & social worker, sleep advice | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| Paediatrician | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Social worker & adoptive parents | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| (blank) | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Neurodevelopmental disorder? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No | 81 | 62% | 32 | 49 | 48% | 78% | 11 | 12 | 58 | 50% | 100% | 60% |
| No,No5 | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Not recorded | 44 | 34% | 33 | 11 | 49% | 17% | 11 | | 33 | 50% | 0% | 34% |
| Yes | 3 | 2% | 1 | 2 | 1% | 3% | | | 3 | 0% | 0% | 3% |
| (blank) | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Sexual active? | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | 4 | 3% | 3 | 1 | 4% | 2% | | | 4 | 0% | 0% | 4% |
| (blank) | 126 | 97% | 64 | 62 | 96% | 98% | 22 | 12 | 92 | 100% | 100% | 96% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Smoking | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ex-smoker | 2 | 2% | 2 | | 3% | 0% | | | 2 | 0% | 0% | 2% |
| Yes | 5 | 4% | 1 | 4 | 1% | 6% | | | 5 | 0% | 0% | 5% |
| (blank) | 123 | 95% | 64 | 59 | 96% | 94% | 22 | 12 | 89 | 100% | 100% | 93% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| UASC | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | 50 | 38% | 29 | 21 | 43% | 33% | | | 50 | 0% | 0% | 52% |
| No | 27 | 21% | 1 | 26 | 1% | 41% | | | 27 | 0% | 0% | 28% |
| Not stated | 19 | 15% | 19 | | 28% | 0% | | | 19 | 0% | 0% | 20% |
| Unknown | 34 | 26% | 18 | 16 | 27% | 25% | 22 | 12 | | 100% | 100% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Gender | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | 43 | 33% | 19 | 24 | 28% | 38% | 7 | 5 | 31 | 32% | 42% | 32% |
| Male | 86 | 66% | 48 | 38 | 72% | 60% | 14 | 7 | 65 | 64% | 58% | 68% |
| Not stated | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Ethnicity | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Afghani | 14 | 11% | 10 | 4 | 15% | 6% | 2 | | 12 | 9% | 0% | 13% |
| African | 13 | 10% | 5 | 8 | 7% | 13% | 2 | | 11 | 9% | 0% | 11% |
| Black Carribean | 7 | 5% | 3 | 4 | 4% | 6% | | 1 | 6 | 0% | 8% | 6% |
| British Asian | 27 | 21% | 15 | 12 | 22% | 19% | 2 | 1 | 24 | 9% | 8% | 25% |
| Chinese | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Mixed (white and black caribbean) | 4 | 3% | 1 | 3 | 1% | 5% | 1 | 1 | 2 | 5% | 8% | 2% |
| Mixed other background | 12 | 9% | 4 | 8 | 6% | 13% | 4 | | 8 | 18% | 0% | 8% |
| Not stated | 2 | 2% | 2 | | 3% | 0% | | | 2 | 0% | 0% | 2% |
| Other black background | 13 | 10% | 3 | 10 | 4% | 16% | 2 | 1 | 10 | 9% | 8% | 10% |
| Unknown | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| White British | 21 | 16% | 13 | 8 | 19% | 13% | 7 | 8 | 6 | 32% | 67% | 6% |
| White European | 13 | 10% | 10 | 3 | 15% | 5% | 1 | | 12 | 5% | 0% | 13% |
| White Irish | 2 | 2% | | 2 | 0% | 3% | 1 | | 1 | 5% | 0% | 1% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

| Language(s) | All | % | Initial HA | Review HA | IHA % | RHA % | Under 5 | 5 to 11 | 11 to 16 | U5 % | 5-11 % | 11-16 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Albanian | 12 | 9% | 8 | 4 | 12% | 6% | | | 12 | 0% | 0% | 13% |
| Arabic | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Czech,English | 1 | 1% | 1 | | 1% | 0% | 1 | | | 5% | 0% | 0% |
| Dari | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| English | 66 | 51% | 27 | 39 | 40% | 62% | 13 | 11 | 42 | 59% | 92% | 44% |
| English,Farsi | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Korean | 1 | 1% | | 1 | 0% | 2% | | | 1 | 0% | 0% | 1% |
| Kurdish | 2 | 2% | 2 | | 3% | 0% | | | 2 | 0% | 0% | 2% |
| Mandarin | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| NOS | 1 | 1% | | 1 | 0% | 2% | 1 | | | 5% | 0% | 0% |
| Pashto | 15 | 12% | 10 | 5 | 15% | 8% | | 1 | 14 | 0% | 8% | 15% |
| Pashto,English | 2 | 2% | 2 | | 3% | 0% | 2 | | | 9% | 0% | 0% |
| Portuguese | 1 | 1% | 1 | | 1% | 0% | | | 1 | 0% | 0% | 1% |
| Tigrinya | 3 | 2% | 1 | 2 | 1% | 3% | | | 3 | 0% | 0% | 3% |
| Unknown | 5 | 4% | 3 | 2 | 4% | 3% | 4 | | 1 | 18% | 0% | 1% |
| Vietnamese | 17 | 13% | 10 | 7 | 15% | 11% | | | 17 | 0% | 0% | 18% |
| **Grand Total** | **130** | **100%** | **67** | **63** | **100%** | **100%** | **22** | **12** | **96** | **100%** | **100%** | **100%** |

## 9.7 Appendix G. Stakeholders engagement workshop summary

On Thursday 22nd April 2021 the public health team hosted a virtual stakeholder engagement workshop with the aims of:

- Presenting the CLA HNA report
- Discussing findings and proposed recommendations and progress already made
- Prioritising the recommendations
- Collecting feedback to inform and shape the final CLA HNA report
- Agreeing who else the HNA report should be presented to and who should own the document.

A wide range of stakeholders working with CLA in Croydon, both from the social and healthcare field, were invited to the session. A total of 14 stakeholders attended including CLA Service Managers, Designated Doctor and Nurse, and clinical psychologist and commissioners.

Table B below records the feedback that was received under each of the themes. This feedback has also been reflected and incorporated into the HNA, including in the main findings and recommendations table.

In terms of further feedback of the findings and recommendations the participants agreed that the Parent Forum, chaired by the Councillor for Children, Young People & Learning (Cllr Alisa Fleming), would find it helpful, as would the quality group. It was also felt important that the content be shared wider amongst the non-health CLA teams at the Council to ensure engagement of the wider teams in supporting CLA health and well-being and thereby recognising that the health and well-being of CLA is a responsibility of all professional working with them.

**Table B: Feedback received and amendments made to recommendations**

| Theme | Progress made |
|---|---|
| **Theme 1**<br><br>**Planning, responsibilities, governance and voice of the child** | Collaboration through for example the CLA Operational group and the Quality Assurance meetings.<br><br>Progress has been made in that there is now attendance by the designated nurse and doctor at corporate parenting panels.<br><br>A CLA health champion role has been created in the social care workforce<br><br>Recommendation 2 has been amended to reflect this: |

| | |
|---|---|
| | Use the governance processes to ensure that roles and responsibilities for implementing DOH guidance and NICE recommendations for CLA health are understood and implemented by all stakeholders working with CLA.<br><br>It was clarified that any professional engaging with a CLA has a responsibility for their health and wellbeing, not just the CLA health team |
| **Theme 2**<br><br>**Information sharing** | A memorandum of understanding between health and the council for information sharing is now in place.<br><br>The CHS CLA health team now has link nurses with key services such as sexual health, drugs and alcohol, CAMHS and YOS to strengthen two way information sharing.<br><br>A due diligence check has been added to the RHAs where the team records who they have been contact with in preparing the health assessment.<br><br>Recommendation 7 and 8 were amended to reflect the progress made:<br><br>Continue to develop ways to understand and capture the full range of contributions to CLA health in the health assessments<br><br>Continue the routine monitoring of health assessments to ensure these are completed in line with guidelines, and shared with relevant professionals. |
| **Theme 3**<br><br>**Health assessments and planning** | The CLA health teams QA process had identified that SDQs were not available at the health assessments and they were only been sent a score without any accompanying narrative.<br><br>More information about the SDQs is now being provided by the performance team e.g. who completed the SDQ and the CLA health team are highlighting the SDQs at their roadshows.<br><br>Following a practice review and task and finish group, new SDQ training for social workers was implemented. Due to staff changes this training needs to be refreshed and SDQ completion by social workers currently remains an issue. |
| **Theme 4**<br><br>**Support for mental health and emotional health and wellbeing** | There are now three mental health clinicians in the Council who are able to support CLA emotional and mental health issues.<br><br>The team is reviewing how best to provide support to children and young people and how the offer can be more creative and reflect what the young people think would help e.g. other forms of support rather than traditional therapy. A high risk SDQ score will now trigger a referral to the Croydon clinical team.<br><br>The clinical team are training social workers about the SDQ |
| **Theme 5**<br><br>**Diversity** | The CLA health team are receiving training about LGBTQ to ensure that they are skilled and confident to have difficult conversations with young people<br>There is greater recognition of diversity due to religion as well as cultural and ethnic background |

| | |
|---|---|
| | The recommendations were amended to reflect the points about wider diversity:<br>Rec 17 Ensure mental health services are sensitive to the needs of BAME, different cultural and religious groups and UASC, and can provide appropriate interventions for emotional and mental health problems associated with racism and cultural identity and PTSD<br>Rec 18 Ensure health assessment content reflects the diversity (e.g. sexual, religious, ethnic, cultural, language) of CLA in Croydon |
| **Theme 6**<br>**SEND** | No comments |
| **Theme 7**<br>**Promoting Health** | No comments |
| **Theme 8**<br>**UASC** | Kent has established a UASC mental health team which they report as having very positive outcomes. The team members come from relevant cultural backgrounds and therefore are able to provide specific support to the UAS children and young people. |

### 9.8 Appendix H: Initial Health Assessment of Unaccompanied Asylum Seeking Child or Young Person

PROFORMA FOR ASSESSMENT AND SUMMARY REPORT: REVISED OCTOBER 2019

| **Young person's details – Pages 1 and 2 to be completed by Social Services or populated using information from Social care submitted on Coram BAAF IHA request form as per local practice** | | | |
|---|---|---|---|
| First Name (s) | | Family Name | |
| Likes to be known as | | Previously known as | |
| Date of Birth | | Gender | |
| Age assessment being undertaken | Y / N | NHS Number | |
| Legal Status / Current Legal Proceedings | | Keyworker / Main contact at accommodation | |
| | | | |
| Date and mode of arrival in the UK | | Young person's address | |
| | | | |

| | | | |
|---|---|---|---|
| Country of origin | | Postcode | |
| | | Telephone number | |

| | | | |
|---|---|---|---|
| Reason for being Looked after | | *Unaccompanied minor* | |
| Person(s) with parental responsibility | | | |
| Number of placements since arrival in the UK | | | |
| Is a further move planned? | | Y / N If yes, please detail | |
| Ethnicity | | Religion | |
| First Language | | Other languages | |
| Interpreter required | | Y / N If Yes, Specify language | |
| School / Educational placement | | Y / Not yet<br>Give details | |
| Specify any known health, learning, developmental, emotional, behavioural, vision or hearing needs | | | |
| | | | |

| **Social Services / Local Authority details** | |
|---|---|
| Name of Social worker and team | |
| Address | |
| Telephone | |
| Email | |
| Name of Team Manager | |

| |
|---|
| **To reduce need for YP to repeat their story, please complete this section as fully as possible prior to the health assessment - using information already gathered. Assessing Doctor to add additional information obtained during assessment.** |
| **Describe any known health risks or potentially relevant adverse experiences**. Include what is already known of YP journey - time taken to travel to UK and detail countries of transit. Include experience of conflict, bereavement, poor conditions, time in desert, food deprivation, assault, torture, sexual abuse |
| |
| **Detail whether YP has already been has had any other acute health evaluation or referred to services e.g. sexual health or refugee council** |
| |
| **Birth family details - specify if not available. Include bereavement, contact.** |
| |

| | |
|---|---|
| Please state if a referral has been made / will be made to Red Cross Family Tracing | Yes / No |

| **GP registration** | **Dentist** |
|---|---|
| – *please circle*<br>Permanent / Temporary / Not yet registered | – *please circle*<br>Permanent / Temporary / Not yet registered |
| Date seen | Date seen |
| Name of GP or Practice | Name of Dental Practice |

| | |
|---|---|
| Address | Address |
| Telephone No. | Telephone No. |

| **Other health professionals involved** | **Optician** |
|---|---|
| *– please detail all other heath services / professionals involved since arrival in UK* | Date seen |
| | Name of Optician |
| | Address |
| | Telephone No. |

| **Consent for examination**<br>*Unless younger than 15 years, the young person should normally give consent for the examination and distribution of reports - assisted by the interpreter if necessary.* |
|---|
| **I agree to having a medical assessment including limited physical examination (as explained by the medical practitioner) and to a health plan being produced with my involvement.**<br>Permission given for report / health plan to be copied to GP / Social worker (Summary) / Other (delete not applicable)<br><br>**Print name:** **Signature:**<br>**Date:** |

| **Date of assessment** | | **Venue** | |
|---|---|---|---|
| **Those present at assessment and relationship to young person** | | | |
| | | | |
| **Was the young person given an opportunity to see the Dr/Nurse without the carer?** | | | Y / N |
| **Name of interpreter** / Contact agency | | | |

| | |
|---|---|
| **Language** | |
| **Name of Doctor / Nurse carrying out health assessment** | |
| | |
| **Main current health concerns / issues** | |
| *Specify concerns of carer or young person*<br>*Include review of systems (skin, musculoskeletal problems, headaches, chest pain, palpitations, breathing etc)* | |
| **Medication and any allergies** | |
| | |
| **Past health history** | |
| Birth history if known<br><br>Any significant past illness, operations, blood transfusions, tattoos, accident<br><br>Any screening known – sickle status, thalassaemia status?<br><br>Risk factors for Blood borne infections? Risk factors for Hepatitis B, C / HIV or Syphilis include tattoos,<br>surgery, FGM, blood Tx or sexually active Note: if YP from a Hepatitis B/C or HIV endemic country then<br>they will need screening for BBV.<br><br>Risk factors for latent TB infection- do they come from a TB endemic country, or exposure en-route to UK? | |

See PHE Migrant Health Guide 2014

https://www.gov.uk/government/collections/migrant-health-guide-countries-a-to-z

**Family health history**

**Physical examination**

*Discuss weight loss / gain; any gastric or bowel symptoms (GORD common); any past or present pregnancy; consider skin infestations (scabies is very common); consider malnutrition and vitamin deficiencies; discuss Vitamin D deficiency prevention; include check of eyes (including fundi for sun damage if travelled through Sahara – if not possible ensure specific request to check fundi is passed onto optician); heart sounds; chest; BCG scar; tattoos; record any scars from injuries and maltreatment; musculoskeletal or neurological examination as indicated*

| Weight | Kg ( centile) | Height | cm ( centile) | BMI | ( centile) |
|---|---|---|---|---|---|

General appearance:

Oral Health:

Skin:

| |
|---|
| BCG scar Y / N recorded today/ previously? |
| ENT: |
| Eyes:<br>Any visual disturbance? |
| Chest: |
| Cardiovascular system: |
| Abdomen: |
| Pubertal status; verbal report both testicles descended; discuss regular esticular self-examination |
| Nervous system: |
| Musculoskeletal system: |
| *Consider risk of FGM: ask regarding female circumcision/cutting if appropriate:* |
| **Lifestyle assessment** |
| *Are you eating a healthy diet?* |
| *Able to cook? Eating with others?* |
| *Are you exercising regularly?* |
| *What exercise* |
| *Do you use alcohol, tobacco, drugs to relax?* |
| *Amounts used; escalating?; associated concerning symptoms? (use tool e.g. CRAAFT)* |
| *Are you currently or previously sexually active?* |
| *Discuss partners; contraceptives; non-consensual sex; information about local sexual health services, any concerns indicating need for referral e.g. GUM clinic; any indication of sexual exploitation (use CSE tool)* |

| | |
|---|---|
| | |
| **Functional assessment** | |
| *Record any concerns noted during the assessment regarding skills:* | |
| *Motor skills* | |
| *General cognition* | |
| *Communication skills* | |
| *Social skills / social interaction skills* | |
| *Personal care* | |
| **Assessment of emotional and psychological well being** | |
| **1. COMPLETE MOODS AND FEELINGS QUESTIONNAIRE WITH INTERPRETER** | |
| MOODS AND FEELINGS QUESTIONNAIRE (MFQ) SCORES | |
| **2. POST TRAUMATIC STRESS DISORDER AND DEPRESSION SCREEN** | |
| *Can you tell me how all that you have experienced has made you feel?* | |
| | |
| **(a) Post traumatic stress reactions:** *In particular, can you tell me about the following stress reactions that many young refugees experience?* | |
| *Do you have distressing memories or 'flashbacks' of past events that upset you?* | Y / N |
| Describe | |
| *Do you get distressing nightmares?* | Y / N |
| Describe | |
| *Do you avoid people or situations that could remind you of what you experienced?* | Y / N |

| | |
|---|---|
| Describe | |
| *Do you experience a racing heart, sweaty palms or feeling dizzy when there are reminders?* | Y / N |
| Describe | |
| *Have you ever thought about / made plans about harming yourself if you feel very sad / hopeless?* | Y / N |
| Describe circumstances | |
| **(b) Low mood/change in mood:** | |
| *How do you feel most of the time*? | Happy / Sad / Other…….. |
| *Has what you have experienced affected your temper?* | Y / N<br>Describe |
| *Do you have difficulties sleeping*? *Ask young person (and carer) about young person's sleep pattern and give appropriate advice / Sleep Pack if available. A disrupted sleep pattern is common after a long journey or if experiencing post trauma symptoms.* | Y / N<br>Getting to sleep / waking early / restless / sleepwalking / nightmares / other<br>Describe |
| *Do you have any difficulties eating*? | Y / N<br>Poor appetite / overeating / other<br>Describe |
| *How do you think the future will be*? | Same / better / worse<br>(Give reasons) |
| **(c) Worries** | |
| *What sorts of things do you worry about?* | |

| | | | |
|---|---|---|---|
| Getting a good education | Y / N | Making and keeping friends | Y / N |
| Being allowed to stay in UK | Y / N | My health, getting ill | Y / N |
| My accommodation | Y / N | Feeling that I am going mad | Y / N |
| Being able to follow my religion | Y / N | My family's welfare and safety | Y / N |
| Other | | Describe | |
| *What is your biggest worry right now?* | | Describe | |

**(d) Coping and Support**

*Who or what has helped you to cope with the stresses of being a refugee?*

*Where do you get your strength from?*

*Who do you turn to if you feel very sad or worried or when you feel you need advice?*

Friend / social worker / relative / no-one

*Would you like to see someone to talk about these problems now?*

**Y / N**

**Doctor to complete:**

| | |
|---|---|
| Are there indications for a referral to a child and adolescent mental health team? | Y / N |

Are there any factors that put this young person at risk of harm?

**Include any highlighted / potentially relevant information regarding bereavements, separations, bad experiences, detention, torture**

**What factors are present that seem protective or supportive?**

*Alternatively to screening outlined above ask young person to complete locally agreed screening questionnaires (that consider post trauma symtoms and depression) e.g. SDQ, PTSD screen and*

| |
|---|
| *Depression screen. Be aware of high incidence of post traumatic symptoms. If significant symptoms have lasted more than a month, young person should be referred for Trauma Based CBT or management as recommended by CAMHS. If post traumatic symptoms are reducing: discuss waxing and waning of post trauma symptoms and encourage seeking further support if needed (for example if not settled in 3 - 6 months). Resuming a 'normal' pattern of daily life is very important to recovery from trauma. Discuss and encourage engagement in regular activities, education, leisure activities.* |
| COMMENT, IF INDICATED, ON PRESENTATION AND PHYSICAL EXAMINATION IN RELATION TO AGE |
| **State 'No concerns' if you have no significant concerns in relation to stated age. Significant concerns include that the young person presents as "much older" or "much younger" than stated age. Note the considerable variability in pubertal development, height and presentation of 'maturity' and resilience among unaccompanied young people. Follow RCPCH guidance when giving advice towards an age assessment prcess. You are <u>not</u> asked to make an estimate of age as this is not possible through physical examination and is undertaken by senior social work colleagues by an agreed robust process.** |

# SUMMARY

***Ensure young person's consent gained to share any information in the summary***

| **Main current health concerns / issues** |
|---|
| |
| **Medication and any allergies** |
| |
| **Significant past health history** |
| |

| |
|---|
| |
| **Physical examination** Include any significant findings |
| |
| **Any significant lifestyle factors** |
| |
| **Any significant concerns about current functioning / learning** |
| |
| **Assessment of emotional and psychological well being** |
| MOODS AND FEELINGS QUESTIONNAIRE (MFQ) SCORES AND COMMENT |
| SUMMARISE FINDINGS OF OTHER MENTAL HEALTH SCREENING AND COMMENT |

| | |
|---|---|
| **Are there indications for a referral to a child and adolescent mental health team?** | **Y / N** |

| |
|---|
| **Are there any factors that put this young person at risk of harm?** |
| |

| |
|---|
| |
| What factors are present that seem protective or supportive? |
| |
| COMMENT, IF INDICATED, ON PRESENTATION AND PHYSICAL EXAMINATION IN RELATION TO AGE |
| **You are <u>not</u> asked to make an estimate of age as this is not possible through physical examination and is undertaken by senior social work colleagues by an agreed robust process.** |

### 9.8 Appendix I: Health care plan

# HEALTH CARE PLAN

*Clinician to add and delete issues and recommendations as appropriate*

| | |
|---|---|
| The health report is robust and comprehensive aS young person is near care leaving age | Y / N |
| A copy has been sent to the young person | Y / N |
| Health promotion / contact information sent as per local 'health passport' protocol | Y / N |
| Discussion has taken place regarding the role of GP, Urgent Care, A&E and 999 | Y / N |

| **Date of next health assessment:** | | | |
|---|---|---|---|
| **Issues** | **Action required** | **By when (date)** | **Named person responsible** |

| | | | |
|---|---|---|---|
| Incomplete or unknown immunisations | Refer all young people with unknown immunisations to GP for 'catch up' course as recommended by Public Health England:<br>1st dT/IPV + MMR + Men ACWY<br>4 week gap<br>2nd dT/IPV + MMR<br>4 week gap<br>dT/IPV<br><br>For female YP – HPV course | | |
| At risk of blood borne infections | Obtain signed consent with interpreter so that it is clear young person understands what tests are being requested | | Assessing clinican |
| | Arrange blood testing as soon as possible for HIV, Hepatitis B, C and Syphilis | | |
| At risk of latent TB infection (LTBI)<br><br>(NB If there are concerns regarding acute TB make immediate referral to TB clinic) | Referral for TB screening as per local protocol<br>e.g IGRA testing Interferon gamma release assay | | Assessing clinician |
| At risk other infectious diseases, | Arrange baseline bloods: Full Blood count, U&E; | | |

| | | | |
|---|---|---|---|
| worms and malnutirition | bone and renal profile; vitamin D; ferritin<br>Urine MC&S<br>Stool OCP | | |
| Sexual health concerns | Referral to the Sexual Health specialist service | | |
| Visual problems and/or Visual check up needed | Visual assessment by optician required | | |
| Concerns regarding hearing | Audiology screening | | |
| Dental decay and/or Dental check up needed | Dental assessment | | |
| Experiencing significant symptoms of Post trauma stress and/or depression | ?Referral to CAMHS | | |
| History of likely torture and is experiencing related difficulties | Referral to specialist services | | Referral to specialist services such as Freedom from Torture |
| Young person has indicated they would like support in tracing their family | Referral to Red Cross family tracing | | Social worker to liaise with young person and refer to Red Cross family tracing |
| History suggestive of being trafficked and at risk of exploitation | Referral to support services such as Refugee Council Trafficked girls or boys projects | | Social worker to liaise with young person and refer to Refugee Council Trafficked girls or boys projects |
| **Assessment and health plan completed by:** | | | |

| | | | |
|---|---|---|---|
| **Name:** | | **Qualifications:** | |
| **Title / Role:** | | **GMC Number:** | |
| **Office email:** | | **Office telephone:** | |
| **Signature:** | | **Date:** | |

| |
|---|
| **Quality Assured by:** |

| |
|---|
| **Copy of full report to:** |
| Young Person |
| GP |
| File |
| **Copy of Summary and Health Care Plan ONLY to:** |
| Social Worker – check consent |