GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

NHS Wales Looked After Children

HEALTH ASSESSMENT FRAMEWORK

The NHS Wales Health Assessment Framework for Looked After Children provides standards of good practice for Health Boards working with children who are currently Looked After by the local authority.

The framework has been professionally developed in collaboration with all Health Boards across Wales. It aims to support a consistent approach to the Health Assessment process and the quality of the health assessment and report for each looked after child or young person. The framework also supports the development of a toolkit to enable qualitative audits of the health assessment process for all Health Boards across NHS Wales.

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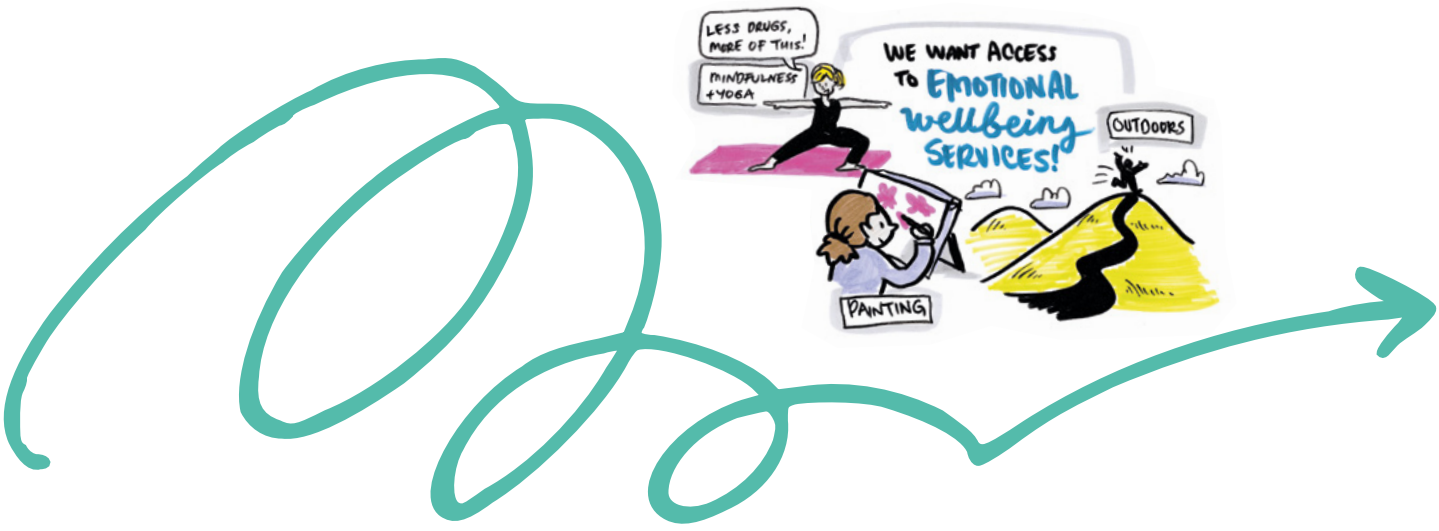


1 Introduction and Purpose of the Framework

Children and young people who are looked after share many of the same health risks and problems as their peers, but often to a greater degree and in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect before they enter the care system. (Merredew and Sampeys 2015).

There are currently 6,846 Looked After Children in Wales (March 2019). This is a mobile population with 2,125 Looked After Children entering care and 1,678 Looked After Children leaving care in 2019. Although outcomes are improving, care-experienced children and young people have poorer outcomes in terms of education, social and health outcomes.

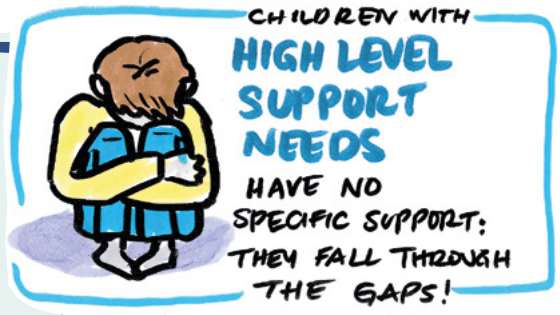
The statutory Looked After Children health assessment provides a vital interface with a specialist health professional and the opportunity to identify and address health needs and have a positive impact on health outcomes.

A quality Looked After Children health assessment is essential for improving health outcomes in the short and long term.

The NHS Wales Health Assessment Framework for Looked After Children provides standards of good practice for Health Boards working with children who are currently Looked After by the local authority, including those who are being twin tracked for adoption.

The framework has been professionally developed in collaboration with all Health Boards across Wales. It aims to support a consistent approach to the Health Assessment process for each looked after child or young person. The framework also supports the development of a toolkit to enable audits of the quality of the health assessment for all Health Boards across NHS Wales.

A quality LAC health assessment is essential for improving health outcomes in the short and long term.



This guidance has been developed to support health professionals in providing the best quality service for Looked After Children.

The Health Assessment and report should:

- Collate all available health information
- Identify the source of the information
- Identify the risk factors for the child
- Consider the impact and outcomes of the assessment
- Ensure that all actions are specific, measurable, achievable, relevant and time-based
- Ensure all information is summarised and health recommendation are recorded.

The subsequent Heath Care Plan should address all the identified needs as this will enable effective information sharing.

A small number of Looked After Children/Young People leave care through adoption (309 in Wales in 2019). It is essential for information sharing, matching and continuity of care that a quality health assessment is undertaken to enable an adoption report to be compiled (Adoption Agencies (Wales) Regulations 2005). Statutory health assessments should continue until adoptive placement and it is best practice to continue to monitor until the Adoption Order is granted.

2 Practice Guidance for the Completion of Health Assessments

2.1 Introduction

A health assessment for a child or young person in care is a holistic assessment of their physical, emotional and behavioural needs. The assessment also includes aspects of health education and health promotion. It is not an isolated event, but part of a process of continuous care including monitoring and promoting the child's health.

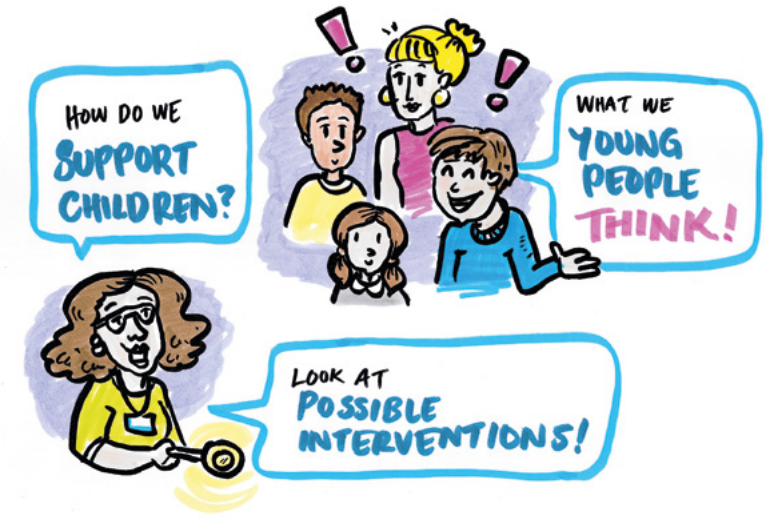
The Looked After Children Health Assessment system provides a statutory health assessment process which means all children and young people aged 0-18yrs who are in care are offered regular health assessments. All Looked After Children must also have a Lead Health Professional who ensures the health assessments take place, health care is coordinated and actions are delegated and followed up. They are a key point of contact for both carers and other professionals. The Lead Health Professional for each Looked After Child is the Health Visitor, School Nurse, Specialist LAC Nurse or Paediatrician.

2.2 Health Needs of Looked After Children/Young People (LAC/YP)

Looked After Children/Young People are amongst the most socially excluded groups in our society and have been found to have significantly increased health needs in comparison with children from comparable socio-economic backgrounds (Merredew and Sampeys 2015).

All children entering care will have an Initial Health Assessment undertaken by a Paediatrician or in some areas an appropriately trained professional as identified by the Intercollegiate Role Framework for Looked After Children: Knowledge, Skills and Competencies of Healthcare Staff (RCPCH and RCN 2015). A Health Plan is developed and the Lead Health Professional ensures that the actions are progressed.

Review Health Assessments are undertaken six-monthly for children aged 0-5yrs and annually for children aged 5-18yrs. These are completed by appropriately trained professionals as identified by the Intercollegiate Role framework for Looked After Children (2015). Any Looked After Child resident in a health board area will have a health assessment regardless of originating authority. Any Looked After Children living outside the area will have a health assessment requested from the LAC Health Team from the placing authority where the child resides.



2.3 The Independent Reviewing Process

All children in care are subject to statutory independent reviews of their placement. These are led by an Independent Reviewing Officer who is responsible for monitoring the child's care plan. The health plan should inform the child's care plan and health needs must be considered at every review. IRO's are responsible for identifying any outstanding health actions from the existing health plan in accordance with national guidance. *Social Services and Well-being (Wales) Act 2014. Part 6 – Code of Practice (Looked After and Accommodated Children).*

2.4 Health Assessments

The Code of Practice Part 6 Social Services and Wellbeing Act 2014 states that:

The local authority is required to make arrangements for a registered medical practitioner or a registered nurse to carry out an initial assessment of the child's state of health, and to provide a written report of the assessment. Particular reference must be made to the child's mental health.

The aim of the health assessment is to provide a comprehensive health profile of the child, to identify those issues that have been overlooked in the past and that may need to be addressed in order to improve physical and mental health and well-being, and to provide a basis for monitoring the child's future development. The UN Convention on the Rights of the Child adopted by the Welsh Government and reinforced by the Rights of Children and Young People Measure (2011) states the right of involvement of children and young people to have a say about decisions that affect them.

The key principles for a Looked After Child health assessment are:

- The individual child should be at the centre of the process of health assessment, planning, intervention and review.
- Each child or young person should be given the opportunity at all stages to express their views or concerns and they should be listened to. Health professionals should conduct health assessments in a way that enable and empowers children and young people to take appropriate responsibility for their own health.
- Health assessments and services for children and young people who are looked after should be sensitive to age, gender, disability, race, culture and language.
- Children whose first language is not English should have the opportunity to have a health assessment carried out in the language of their choice.

2.5 Arranging an Appointment

Statutory Guidance states the initial health assessment must take place and a written report provided before the child is first placed by the local authority or, if this is not practicable, by the time of the first review of the child's care plan.

2.6 Initial Health Assessments

The LAC Administration Team receives notification of Looked After Children placed by local authorities and this triggers the process of organising or requesting an Initial Health Assessment. In line with the regulations the local authorities need to inform the health LAC staff within 5 working days.

Appointments for Initial Health Assessments are arranged by the LAC Health Team. The LAC Health Team will aim to offer an appointment within 20 working days in readiness for the first LAC review. An assessment does not need to be carried out if a health assessment has been carried out within the 3 months prior to commencement of the placement. The health professional will liaise with the carer and social worker and request the child health records and GP information prior to the appointment. Appropriate consent should accompany any referral to the LAC Health Team.

2.7 Review Health Assessments

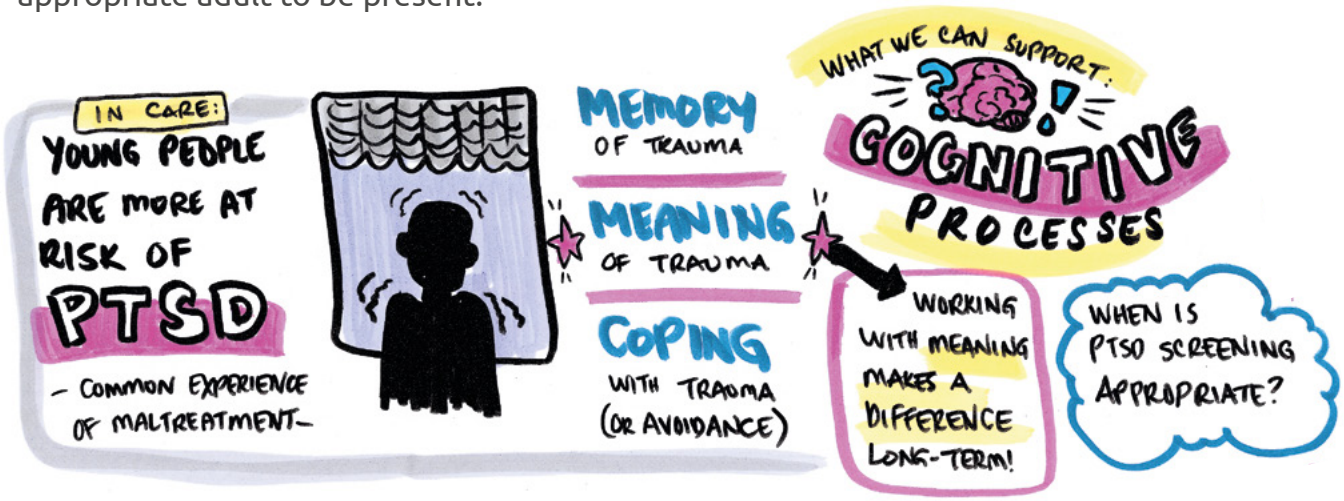
While it remains the Local Authority's responsibility to initiate the statutory health assessment process, practicably it is beneficial to the child if the Lead Health Professional works as part of the multi-agency team to prompt them if the paperwork is not forthcoming in the correct timescale.

The LAC health team will send out requests for review health assessments as they receive them and will also have a process of identifying which health assessments are due each calendar month.

Appointments for health assessments should ideally be arranged at least 4 weeks before they are due to ensure cancellations or staff holidays do not impact upon the system. They need to be carried out at a time and venue convenient to the child and their carers.

Information should be included from all those involved with the care of the child.

Review assessments of a school age child should cause minimum disruption to the child's school day and consideration should be given at all times to the need for an appropriate adult to be present.



2.8 Prior to the Health Assessment

Initial Health Assessments

Before a child or young person receives a health assessment, it is essential to gather as much relevant information as possible by accessing appropriate electronic systems such as Child health, Welsh PAS, etc. It is important to review the records in full, complete birth and family details, contact the GP Practice if appropriate and ensure all immunisations given have been recorded by the child health system.

Review Health Assessments

Always refer to the previous health care plan to identify any key issues and state how they have progressed.

On receipt of the Review Health Assessment the health professional should confirm the details provided are correct as a change of placement/circumstances may have occurred. It is important that any professional involved in the care of the child is consulted prior to the completion of the review health assessment. Information should be included from the GP, CAMHS services and the carer.

Consent

Consent needs to have been obtained for the health assessment. If not indicated on the form, the health professional completing the assessment must discuss this with Social Worker. If the CoramBAAF form is not used each area has their own placement agreement which includes consent for health assessment. If the child is of an age and understanding where they can consent for themselves, the health assessment should be fully discussed and consent obtained.

Consent for immunisations

Consent for routine immunisations can be delegated to the carer at the time of placement via the placement agreement. Any objections from parents are also indicated at this point and recorded on the placement plan/foster carer agreement. A copy of the delegated responsibility should be made available to the health professional.

Confidentiality

The issue of confidentiality must always be explained to the child at the start of the health assessment. Careful consideration must be given at all times to the need for information sharing and health professionals must follow Safeguarding policy with regard to confidentiality and information sharing.

Speaking with the child alone

Part of the assessment should be with the child only (unless not age appropriate or the child does not agree to this). During this time discussion regarding feelings or concerns regarding their health and placement may be discussed. It is a good opportunity to explore with the young person any emotional problems or need for additional support.

It is also the time to sensitively discuss issues of smoking, alcohol, substance misuse problems, puberty and/or sexual health.

Discussion with the carer

If the young person is seen on their own, the health professional completing the assessment must also contact the carer as part of the assessment. Be clear with the carers what information discussed will be shared with the young person. Ensure it is written on the summary that you have spoken to the carer.

Referrals

Ensure you have agreement/consent for any referrals you make. This may have to be identified as an action on the Health Plan for the Social Worker to obtain from birth parents or from the Service Manager.

Supervision

All health staff who work with looked after children should access safeguarding supervision in accordance with the health Boards supervision policy.

Children or young people living away from home must be afforded the same level of protection as children or young people living within their family. If safeguarding concerns are identified. Wales Safeguarding Procedures (2019) must be followed. Advice can be sought from the Health Board Safeguarding Team or the Local Authority Children Services Safeguarding Team.

Any allegation or concern about abuse or suspected abuse by staff employed in a residential setting, a foster carer or a member of the foster carer's household, must be referred to the Local Authority Children Services Department. (Wales Safeguarding Procedures 2019).

Record keeping and Information sharing

Information should preferably be typed but if handwritten the form must be legible and written in black ink.

Do not assume others already know information about family history, lifestyle issues for the child or birth parents etc.

The summary and health assessment should provide comprehensive information about past medical history and current health issues. It should also contain relevant family history. It may be the only comprehensive health information available to the GP and Social Worker.

What is added to the health care plan should if possible be agreed with the young person. However, you may need to share information even if the young person does not agree, particularly in relation to any child protection concerns. Specific details may not be included but more general terms such as "lifestyle issues addressed" can be used if the young person is unhappy with more detailed information being shared.

If sexual health or other issues are not discussed during the assessment, the reason should be documented and included in the summary and health care plan that this needs to be addressed at a later date and by whom and the timescale.

A copy of the whole health assessment document is retained in the health professional record before being returned to the LAC Health Team. The health assessment/summary and the Health Care Plan are shared with key professionals in line with agreed local arrangements.

All health records should be kept as per health board policy.

2.9 When a Young Person does not attend (DNA) or is not brought to an appointment

For Health Assessments:

When a Looked After Child does not attend the 1st appointment the health professional must contact the carer (preferably) or Social Worker to determine the reason.

If a 2nd appointment is not attended you must inform the Social Worker (phone/email). It is the Social Worker's responsibility to discuss the importance of the health assessment with the young person/carer. The Social Worker should support the young person/carer in keeping further appointments.

If there is a legitimate reason for not attending it is the responsibility of the health professional to assess whether a further appointment is sent.

If the Health Assessment is refused by the child or young person the health professional must inform the LAC Health Team. The health professional should discuss with the Social Worker and carer regarding access to appropriate health services. When the child/young person are placed in a host health board area it is important that the LAC Health Team in the host area informs the placing LAC Health Team who can have the appropriate discussions with the named social worker.

The young person should also be provided with information regarding access to health services via the carer/Social Worker and any relevant written health information. The young person will also need to be informed that a health assessment can be arranged at any point should the young person request this.

The health assessment form can still be completed even if the young person does not engage in the health assessment process and it is decided in the best interest of the young person that their health needs are reviewed and a health care plan generated. The health professional can review the records and it is essential that discussions are held with both the carer and the Social Worker.

It must be clearly detailed on the health assessment form where any information has been obtained from in response to the questions posed.

And it should also clearly state that the young person would not attend and from where the health information has been obtained. The Health Plan should also reference where the young person can access health services and information and that another health assessment appointment can be made, with a clear contact process (i.e. the carer will contact you).

2.10 The Health Assessment – Content Guide

Guidelines for the completion health assessments for Looked After Children

The aim of these guidelines is to assist practitioners in the completion of statutory health assessments. It can be used to support a holistic nursing assessment of children in order to help identify health needs at the time of assessment and assist in the completion of a health care plan.

Consent	Practitioner should ensure that consent for completing a health assessment is current for all children. Consent may be in the form of a Placement Information Record which is signed at the point when a child initially becomes 'looked after.' Alternatively, there may be a signed Delegated Authority form in place which is subject to annual review.
Initial and review assessments 10+	Older children who have capacity may also self-consent for a health assessment should be able to do so. Section to sign on Part A of form. Self-consenting young persons should also be made aware that the summary (Part B) will be share with professionals listed in Part A. Social workers should ensure that a signed consent is available to the health professional on request. (CoramBAAF, 2017)
Planning for the health assessment	**Contact:** Practitioners should endeavour to contact the named carer/ placement provider/young person (if age appropriate) to arrange a mutually convenient time to complete the statutory health assessment. This should ideally be undertaken at a minimum of two weeks prior to the 'due date' of the health assessment. Practitioners may wish to send a text message reminder to the designated carer 24 hours prior to their attendance. **Preparation:** Practitioners should review the previous health assessment (if available) prior to undertaking planned visits. School-age children may have also have a school-entry health questionnaire which may have been completed by a parent. Clinical systems should also be accessed in order to review whether the young person has any new health referrals or appointments. This will also provide practitioners and overview of any new hospital/clinic attendances. If appropriate, the practitioner may also decide to contact the young person's dental practitioner to obtain details of any dental attendances/referrals, etc. For children who are placed in a host area, the Health Care Needs form should be reviewed. (NHS Wales Notification Pathway for LAC (2015), Care Planning, Placement and Case Review (Wales) Regulations 2015

Initial and review health assessments: completing the Health Assessment Domains

Part A: basic information	Demographics may be completed by LAC administrator. The details will also need to be checked at the planned health assessment and any missing information completed.
Initial Health Assessments only: 0-9 and 10+	Complete birth information (if available). For children who are placed into a host area, the LAC health team may be able to assist with this information. Family health information: complete if information is available. If information not available please record not known. Also include any familial history including any known genetic information and consider referral to community Paediatrics (in accordance with local procedures). Social care: consider lifestyle issues and any risk of Blood Borne Viruses: refer as needed with consent. Child health history: previous and current health information prior to becoming accommodated. Does the child have a current health diagnosis? Is this still current, is it stable or has this now resolved e.g. childhood asthma, previous resolved allergy. If not completed with the young person then state clearly who the information is from and their relationship to that young person. Ascertain outstanding appointments and place on waiting lists.
IHA: 0-9 only:	Healthy Child Wales Programme: complete if information available – if not known ensure this is also completed in the fields provided.
For review health assessments only: 0-9 and 10+	Review the previous health plan. Have the actions in the health plan been achieved/implemented. E.g. outstanding immunisations now given? Also record if any referrals actioned and any updated information can be included in the summary analysis. If the child does have an existing diagnosis – is this stable or has this now resolved. Also consider any CAMHS intervention or support from other services e.g. CDT, private therapies. Ascertain outstanding appointments and place on waiting lists. Comment on any changes in health (accidents; immunisations; significant illnesses). Note any other significant changes in the child's life (do not forget family contact issues; placement; household).
Immunisation status	Any additional immunisations in last year? Record here and list any that remain outstanding or will be due by next health assessment. Also record if there are any contra-indications to immunisations. The information gathered can be added to the summary health plan as an action.

0-9 only: Developmental assessment (both IHA/RHA)	Overview and example of gross and fine motor skills; communication and cognitive skills. Include social and self-care skills and toileting. Include examples to demonstrate current level of development. Has the child had any developmental checks since last health assessment? Are there any developmental concerns reported by carer/school? Any Ruth Griffiths assessments completed? Are there any active referrals in place for developmental concerns? Ensure conclusion field is completed. This will inform the health summary and assist the practitioner with any referrals that need to be detailed in the health plan.
General health information: both IHA/RHA 0-9 and 10+	GP visits: document any GP visits and outcome over the past year. Also consider access to GP record and consent.
Current medication:	Complete medication fields – carer should have this information available. GP record can also be accessed if consent is available accordance with local HB policies. Specific details required; name/ route/ dose/ frequency. State `no medication at present' if this is the case.
Allergies:	Record any allergy information and add more detail as needed into text box. Consider if formal testing completed or whether a referral is needed.
Hospital and A&E attendances:	A&E, hospital attendances: check clinical systems prior to visit. If this is not possible, check post visit if information not available pre visit. Complete fields and review if any follow-up needed. Sub-box can be used to elaborate on above to capture any further details and highlight actions required from assessing practitioner. This can be added to health care plan summary. Future/planned appointments (if known/applicable). This information can also be used to inform the health plan summary and alert the IRO, Social Worker and health professional, e.g. change of address, placement, and transfer of care in order to reduce the need for re-referral, discharge for missed appointments.

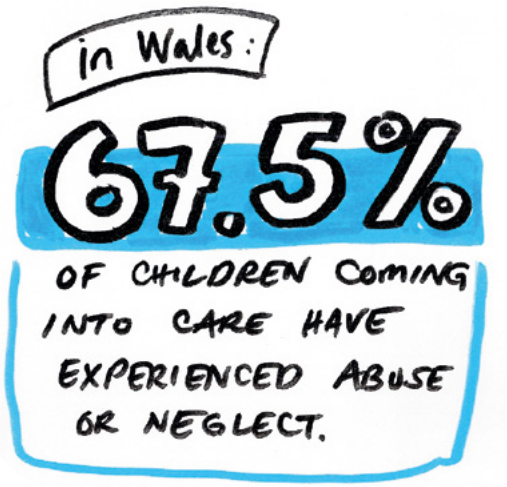
Developmental/ Functional (0-9s: IHA/RHA)	Overview and example of gross and fine motor skills; communication and cognitive skills. Sub-box can be expanded to record development achievements e.g. walking, talking; age-skills (where information available).
General health including planned reviews and previous diagnosis. Medications Allergies	GP visits: list GP attendances and any planned follow-up over past year. (For RHAs list any attendances as above since last HA). OPD appointments and future planned appointments. A&E attendances Also consider private/non-NHS health Sub-box can be used to elaborate on above to capture any further details and highlight actions required from assessing practitioner. This can be added to health plan summary
Growth	Height, weight, etc. Review centiles – if referral needed LAC Health will action. Comment on any differences in previous centiles? Any concerns relating to growth? Document any identified issues/advice given/referrals needed. Ensure BMI is calculated for all children age 2+
Physical activity	Record physical activities (age appropriate): is the child exercising for one hour a day? Add detail as appropriate.
Diet	**Dietary review:** **For 0-1 year old children:** completed identified fields to include any additional information e.g. feeding patterns, difficulties, allergies. **For children aged 6 months+:** record dietary intake, self-feeding skills, etc. Also consider additional aid if prescribed- are these in placement. **For school-aged children:** dietary intake at school – school meal or packet lunch (review usual lunch box contents). Does the child attend Breakfast club? **For children of secondary school-age:** review dietary intake pre-school; what does the child eat at school? Review food choices. Is the child eating a healthy balanced diet? Are there any concerns? fussy eater, overeating, special dietary requirements, culturally appropriate foods, supplements)
Hearing	Was New-born hearing check passed? (0-9 RHA only) Check school-entry test (if applicable) prior to assessment. Does the YP, carer, school have any concerns relating to hearing? Use sub-box to expand above in addition to record any ongoing monitoring and if appropriate, date of recent hearing test.

Vision	Does the YP, carer or others have any concerns with vision? Use sub-box to refer to any recent optician attendances, and reports of concerns; discuss if any difficulties reading school whiteboard, close reading, headaches. Use sub-box to record any advice provided to YP/carer. Also consider if previous referral to Orthodontist if change or new placement/newly LAC. List actions required.
Dental Health review	Comment on dental hygiene Also consider if previous referral to Orthodontist if change or new placement/newly LAC. List actions required. If uncertainty of last attendance, request updated information via carer contact with dentist or contact dental practice for details in accordance with local arrangements. List actions required. If the child is not registered with a dentist, ensure you make necessary referral.
Environment: 0-9 year (IHA/RHA)	Complete identified fields documenting any relevant additional information/advice given. Consider home safety e.g. safety equipment at home, appropriate toy safety, storage of chemicals, medications, stair gates, etc. Also consider travel safety e.g. appropriate car seat, cycle helmet. Also consider age appropriate road safety, behaviour when out of the home environment e.g. stranger danger.
Sleep pattern:	Record usual sleep pattern: also include say time naps as age appropriate. Consider bed time routines, comforters, sleep quality, bed wetting, night terrors or any other difficulties. Document any additional information/advice given as needed.

IHA/RHA 0-9 only: Emotional health and well-being (2- 2.5 years plus)	If appropriate: Complete fields as per form. If not completed, document in appropriate field. Also consider visual impairment, learning difficulties and adjust assessment as needed. Consider whether there any identified difficulties in emotional health and well-being. Is addition support being access or is a referral/signposting needed? Does the carer have any concerns? Observations of interactions: record as per form.
Emotional health and well-being: 10+	As above. Also review behaviours, anger outbursts, self-harm, input from CAMHS. Is the child accessing any support via school e.g. school–based counselling services, therapeutic interventions? Document additional detail a needed and any advice given. Also record any actions needed. • Presentation at time of assessment: (e.g. appearance, eye contact, speech, facial expression and body language) • Responds appropriately to questions • Characteristics of temperament • Behaviour in different settings (degree of appropriate self-control). • Communication skills - for increasing independence • Adaption to change (what changes have occurred) • Response to stress (include eating disorders/self-harm etc.) • Attachment behaviours (include interaction with carers) • Does the carer have any concerns regarding the child's behaviour, mental and emotional health? How does the carer manage the identified issues? • Identify feelings/ actions towards/ relationship with carer, siblings, family, peers and other significant people • If you feel down, what do you do that helps you feel better? (talk to friends, adult, carer, listen to music, draw, play, go out) • Is there anything specific you are not happy with at the moment? (prompt home, family, school, friends, bullying, being looked after

IHA/RHA 0-9: and 10+ Family and sibling contact	Complete fields as per form. Comment on any effects for child and young person.
IHA/RHA 0-9 and 10+: Education review	Note any additional help at school, ALN. Sub-box can be populated to include SEN (check date of review and any additional provisions e.g. S&L); 1:1 support at school; alternative educational provision, reduced timetable, etc. Also include favourite subjects; likes/dislikes about school. Does the YP participate in any school activities/groups, etc. Are they attending their nursery/school/project? Experiences of success and achievements.
Education: peer relationships	Does the YP enjoy school and have school friends? Are there any difficulties e.g. friendships/bullying? Do they have adult support at school to speak to? Does carer attend parents evening? Diet at school? Use sub-box to capture the above information as needed including dietary advice given (as required); also include any actions required due to school concerns and agree any actions for practitioner with YP at assessment. Also use sub-box to capture out of school activities, hobbies and interest; out-of-school friendships.
IHA/RHA 10+ only: Self-care and independent living skills	As age appropriate: complete fields as per form. Is there additional support in place? Does the child/young person have a Personal Assistant? Is the young person developing independent living skills? Does the young person know how to access health services independently? Record and additional information, advice given, actions needed. Social presentation; appearance cleanliness (personal hygiene) and self-care skills.
Puberty, Sexual Health	Consider age of child and school PSE programmes in place (as appropriate); also consider whether the carer will need additional support for subjects e.g. learning difficulties of YP; previous history. Use sub-box to record discussion and advice given. Knowledge of puberty (don't assume knowledge) Puberty/sexual health — note if discussed and /or issues and concerns (details do not need to be explicit if not appropriate, discuss with young person that if accessing appropriate information, services and support so it can be noted that `needs are being addressed'). Be clear if this will need to be followed up by yourself/other person in action plan.

Puberty, Sexual Health (Continued)	Note that if the YP needs to attend a Sexual Health clinic – record on Part A but only include on Part B with the specific consent of YP. Is the YP aware of local Sexual Health services/NHS Direct Wales resources/where to access Emergency Hormonal Contraceptive. **Child Sexual Exploitation Risk Questionnaire (CSERQ)** See Guidance for completion Also consider if input/support is needed from School Nurse. If any concerns arise regarding this domain e.g. sexual health, CSE, trafficking, FGM, normal safeguarding process should be followed.
Self-care skills, Smoking and Alcohol	Complete as directed. Also consider keeping safe, road safety, and personal safety within this domain. Does the YP and carer have arrangements for keeping in touch when YP out with friends? Use sub-box to record information provided by YP and carer. Record outcome of discussion e.g. advice given, referrals needed; can also include if topics addressed via school PSE programme. Identify if further information/advice if needed for YP/carer and document actions needed as required. Note if declined
Substance misuse	Complete as indicated. Use sub-box to expand on above area: Explore school based provision of PSE re: health promotion; YP's knowledge of substances; sources of support and information; also consider if carer required additional information/sign-posting. Document any advice or actions required. Note if declined



Young person's wishes, feelings	Capture in text box The child's 'voice' must be evident throughout the documentation. This includes observations as well as comments and information obtained from assessment. Their views re their health as well. How is the child or young person currently feeling (mood)? Have they any specific worries regarding their health that it is appropriate to share? Be clear to young person re the issues you are aware that carer has (and carer has agreed can be discussed) Basic care — satisfied basic needs are met Safety issues Emotional warmth (tactile? Child/young person and them?) Stimulation (do things together? — involved in activities/ go out socially as a family). Guidance/boundaries Stability (of placement) Any other issues identified by young person
Your observations	See forms
Carers/Parenting issues at placement	Always talk to carers, particularly when not present - contact by phone and note when spoken to (PRIOR to assessment). Be clear to carers re what information discussed will be shared with young person. Basic care — satisfied basic needs are met (may have concerns re hygiene for example). Safety issues (may have concerns re friends/going missing etc.). Emotional warmth (tactile? Child/ young person and them?). Stimulation (do things together, involved in activities, social as family). Guidance/boundaries. Stability (of placement). Do refer to child's views (if age appropriate) in this section too.

Health plan Summary	Information obtained from Part A add into Part B health plan and summary. Include Health updates/changes since last health assessment. Include new referrals, follow-up, planned appointments. General health since last RHA Consider right of confidentiality of information shared and comply with CPP if needed
New health plan	The Health Care Plan should include ALL issues identified within the health assessment/summary. The Health plan must include information on: • GP and Dental registrations. • Vision checks as directed by Optician. • Emotional and psychological health and support. • Specific medical conditions; who/where follow up taking place. • Allergies. • Medication; who monitoring/following up. • Other identified health needs. • Lifestyle/independence skills/risk taking behaviours. • Give clear timescales for actions. Do not use 'asap' Can use 'By next LAC review'. • Identify clearly who is responsible for ensuring actions take place, for each point on plan. The 'named person' should have name and profession/role, unless it is the young person and their first name will suffice. • Complete the date for the next health assessment and add to your caseload management. At present the law requires that all Looked After Children under 5 years are reviewed 6 monthly and all children over 5 years are reviewed annually. It is the Lead Health Professional's responsibility to review the health care plan and check that actions have progressed at each LAC review. The completed health assessment form must be returned to the LAC Team within 5 working days. The LAC Health Team will process the completed health assessment form according to local agreements. All documents must be dated and signed.

2.11 Monitoring Compliance and Quality

Initial and Review Health Assessments

Quality

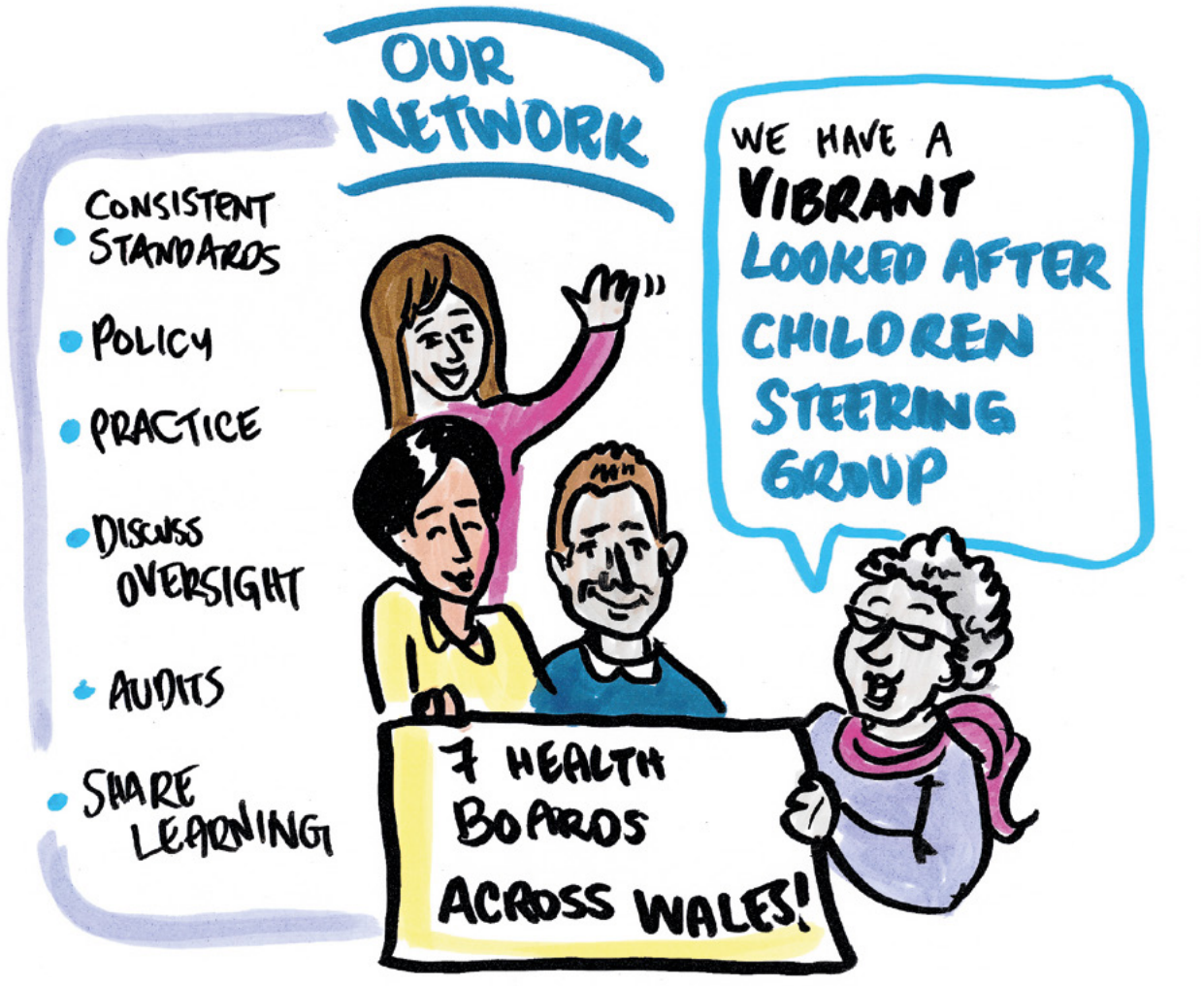
In accordance to local agreements completed health assessments can be reviewed against a quality assurance practitioner checklist adapted from the standards set as part of the Health Assessment Framework. All health assessments should be compliant with the practitioner checklist.

Incomplete/inadequate health assessment/summaries and health care plans will be returned to the health professional to be amended. Health professionals will be given the opportunity to self-assess their assessments against the quality standards expected.

Audit

The framework also supports the development of a toolkit for Service managers and the LAC Health Team who will be involved in the quality assurance process in accordance with local arrangements for all Health Boards across NHS Wales.

Sections or all the health assessment can be used to audit the quality of the health assessment with either using the practice standard or practitioner checklist.



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Appendix 1

Professionally Developed Best Practice Standards

STANDARD All essential demographic and care history information should be available at the LAC Health Assessment	
Minimum Considerations for core demographics	
Full name of child/young person	
Date of Birth	
Date child became Looked After	
Legal status	
Length of time in care	
NHS number	
Name of Carers – Kinship?	
Telephone numbers of carers	
Name of Social Worker	
Was consent provided – by whom?	
Child residing in or out of area	
Name of others present	
Child given the opportunity to be seen alone	
Venue	

STANDARD The LAC Health Assessment will record the birth and family health history where available	
Minimum Considerations at Initial Health Assessment	
Genetic conditions in family	
Obstetric and birth history	
Neonatal history	
Risk factors for blood borne viruses	
Antenatal alcohol/substance misuse	
Family lifestyle concerns (ACEs), Domestic violence	
Current contact with family/ siblings, etc.	

STANDARD The LAC Health Assessment will record all essential health and developmental information	
Minimum Considerations	
Past Medical History:	
Known/pre-existing health issues/medical conditions	
Current Medical History:	
Physical examination undertaken if seen by paediatrician	
Hearing – Audiologist	
Dentist - Registration	
Orthodontist	
Local GP	
Vision – Optician	
Speech –SALT	
Medication	
Allergies	
Growth –Height, Weight, BMI, comment on growth	
Immunisation	
Hospital admissions	
Nutrition	
Sleep routines	
Toileting	
Gross motor, fine motor, social skills	
Chronology of medical history	
Summary of health screening	
Review previous health plan and have actions been implemented	
Changes in health since last assessment if a review	

STANDARD The LAC Health Assessment will record all emotional wellbeing and mental health information	
Minimum Considerations	
Child presentation and demeanour	
How would foster carer/parent/guardian describe the child	
How does the child respond to routines/ boundaries	
Who does the child identify as a trusted adult/OR go to for comfort	
What works well to calm/pacify child	
What triggers escalation of behaviour	
Self-harming behaviour - Hospital/A&E attendance	
Emotional well-being Assessment Tool used	
Identify therapeutic involvement or need for further input e.g. CAMHS/Primary Mental Health	
Drug and Alcohol Team involvement	
Diagnosis: traits/plans/assessments (Ed, psych, court, CAMHS)	
Childs concerns/comments recorded	
Evidence of carers concerns/comments recorded	
Impact of contact on child/young person	

STANDARD The LAC Health Assessment will record lifestyle risk taking activities and health promotion opportunities	
Minimum Considerations	
Behaviours, lifestyle	
Criminality who is involved e.g. YOS, Police	
County Lines	
Sexual health/Contraception	
Exploitation	
Drug and Alcohol use	
Smoking	
Exercise	
Keeping safe	
Internet safety, social media	
Evidence of considering independence and gaining the skills discussed	

STANDARD The quality LAC Health Assessment Summary Plan will include the following as a minimum	
Minimum Considerations	
All Health needs are clearly identified and recorded in the plan	
Actions and timescales required to meet health need to be clear. Do not use ASAP or ongoing	
Identify clearly who is responsible for ensuring actions take place for each point on the plan. Name and professional role should be included.	
Date of health assessment	
Previous health action plan reviewed	
Type of assessment - Initial or review	
Name and designation of person undertaking health assessment	
Typed and written clearly, all information legible	
Next review date recorded	
Signed and dated, with contact details provided	
Record sources of information. Identify if lack of information and/or notes not been shared prior to health assessment	
Health Action Plan to include: GP Dentist Vision Allergies Medication Weight, Height, centiles BMI for over 2's Immunisations Emotional Health Specific Health Needs New Health Needs identified during Assessment	

Appendix 2

Looked After Children Health Assessment – Practitioner Checklist

The checklist guides practitioners through the criteria and quality indicators for completion of the assessment. Evidence of quality indicators must be documented within the Health Assessment.

Please complete and return along with full Health Assessment

Child's Name:	Date of Birth:
	NHS Number:
Type of Assessment Initial Review (Delete as appropriate)	Date Assessment due:
Date of Request:	Date of Completion of Assessment:

Part A of Paperwork	Yes/No N/A	Comments
Evidence that information has been gathered to inform assessment from Child's Social Worker and other Health Agencies providing care (eg CAMHS, GP, Therapists)		
Evidence of discussion to consider health events since last assessment ie A & E Attendance, Illness, Immunisations)		
Physical Health: Management of medical conditions, sleep issues, diet, illness, physical activity, height & weight (BMI must be calculated) and allergies.		
Developmental Health: Gross & fine motor skills, developmental milestones (ages & stages), puberty, education overview including key transitions in school and independence skills.		
Emotional Health / Behavioural: Attachment, anxiety, stress, depression, self-harm, positive mental health, friendships, self-esteem, and behaviour.		

Part A of Paperwork	Yes/No N/A	Comments
Dental Health: Discussion around oral health, sugar intake, drinks, diet, tooth brushing needs to evident.		
Vision: Date of last vision test and use of glasses		
Health Professional Involvement: Details of health agency involvement including last/ future appointments.		
Immunisation Status: Immunised as per schedule, details of recent immunisations and any required by next health assessment.		
Medication: Details of any medication or equipment required.		
Keeping Safe: **Children 0 to 9 years** – safety in the home, appropriate supervision, road safety, exposure to second hand smoke. **Children 10 to 18 years** – consider risk of CSE, missing from care episodes, internet safety and road safety.		
Health Relationships: Including personal checks, puberty and body changes, sexual health and access to services. (Must be evidence of appropriate discussion for ALL children over 10 years of age.)		
Exposure to Substance: Evidence that alcohol and substances have been discussed,		
Voice of the Child: For younger children evidence this by considering interaction with carers, for older children reflect how they feel about their health. Have they been given an opportunity to be seen alone?		

PART B: Summary Report and Health Plan	Yes/No N/A	Comments
Overview of health since last assessment: Summarise Part A of assessment and ensure it includes all domains		
Present physical Must include overview of growth (BMI) and centiles		
Timescales and identified responsible person: Recommendations have specific timescales, avoid 'ongoing'.		
I agree the completed Initial/Review Health Assessment meets the criteria and quality standards of the Practitioner Checklist		
Name of Practitioner completing Health Assessment:		
Designation:		
Date:		

Internal Quality Assurance		
Assessment meets required standard?	**Yes**	**No**
Name:		
Designation:		
Date:		

'RCGP, RCN, RCPCH (2015) Looked After Children: Knowledge, skills and competences of health care staff;

Appendix 3

Guidance on Completion of Child Sexual Exploitation Risk Questionnaire (CSERQ15) + footnote

Box 1: Priority Services[2]

- General Practice
- Sexual Health Services
- Sexual Assault Services
- Looked after children (LAC) teams
- Learning Disability Services
- Paediatric Services
- Child and Adolescent Mental Health Services
- Midwifery
- Health visiting
- School health Nursing
- Advice and counselling services
- Accident and Emergency Services
- Welsh Ambulance Services
- Pharmacists

Box 2: Priority children and young people[2]

- Looked after children
- Children with sexually transmitted infection
- Children who are pregnant
- Children with poor school attendance
- Children who self-harm/have suicidal thoughts
- Children who abuse alcohol/substances
- Children with behavioural issues
- Children with physical/learning difficulties

Also

- Children seen for pregnancy testing, contraceptive advice/treatment (including emergency contraception)
- Domestic violence in home

Box 3: Limits of confidentiality

Explain that if child discloses something that raises concern for their safety or that of other children you have a duty to act.

Box 4: Disclosure of statement

Explain your concerns to the child and seek permission to share information. "I need to share my concerns with colleagues (e.g. in Children's Services) who are in a position to help and support you."

Remember that the safety of the child is paramount and if consent is refused you MUST still act.

Box 5: Uncertain what action to take?

Discuss your concerns with an appropriate person according to your child protection protocol. This may be your manager, child protection lead or duty social worker. Include responses to CSERQ in your child protection referral.

CSE risk assessment requires a child-centred approach which considers the holistic needs of the child. THE CSERQ15 checklist is intended to help health practitioners in assessing a childs risk and to support their **professional judgement** on deciding when to make a child protection referral.

(See box 1 for priority services)

ANY child (10-17 year olds) from **ANY** background can be at risk of sexual exploitation.

Box 2 lists those considered most vulnerable

Be mindful not to make assumptions

Explain limits of confidentiality

(See box 3)

Introduce the questions

"I would like to ask you some questions to check that you are safe and no one is harming you or pressurising you to have sex"

Complete CSERQ15 checklist

Every child is unique. With over 100 potential risk indicators for CSE in common use,[3] you may need to consider other risk indicators and protective factors

Use professional judgement

If you have other concerns for health, safety or welfare of a child you **MUST** refer

CSERQ4: 1 or more positive responses

CSERQ15: 5 or more positive responses

suggest a significant risk of CSE

You must take action

However, if you have other concerns, you may decide to refer at a lower threshold.

Explain need to share information and seek consent (See box 4)

Make child protection referral. If uncertain what action to take see box 5. Document your findings and action taken

Child Sexual Exploitation Risk Questionnaire (CSERQ15)[1]

All health professionals are encouraged to complete the CSERQ15 checklist. However, it is recognised that some professionals with very limited experience of asking the questions, or in services where there are significant time constraints, it may be more appropriate to complete the CSERQ4 questions.

CSERQ checklist		Y/N
1	Have you ever stayed out overnight or longer without permission from your parent(s) or guardian? (Going missing)	
2	How old is your partner or the person(s) you have sex with? Age of partner _____ Age of client/patient _____ Age difference _____ If age difference is 4 or more years* then tick 'YES'. N.B. For 17-year olds, in the absence of any other risk indicators, an age difference of up to 6 years may be acceptable. (Older partner)	
3	Does your partner stop you from doing things you want to do? (Controlling relationship)	
4	Thinking about where you go to hang out, or to have sex. Do you feel unsafe there or are your parent(s) or guardian worried about your safety? (Frequenting areas known for sexual exploitation)	
5	Do you live with someone other than your parent or guardian?	
6	Does your parent/guardian or the person you live with have drug, alcohol and/or mental health problem?	
7	Are you unable to, or not allowed to, go out with friends your own age?	
8	Do you lack confidence or feel bad about yourself?	
9	Have you ever felt the need to hurt yourself on purpose or to starve yourself to make you feel better in yourself?	
10	Do you drink alcohol to get drunk?	
11	Do you see anyone for counselling or have extra support with your schoolwork?	
12	Have you ever been excluded from school or stayed off school without permission?	
13	Does anyone physically or sexually hurt you or make you feel unsafe?	
14	Have you ever had a relationship with someone you met on the internet?	

CSERQ checklist		Y/N
15	**Males:** Have you ever had a sexually transmitted infection? **Females:** Have you ever had a sexually transmitted infection, pregnancy or had a termination of pregnancy? ACTION: There is good correlation between high risk of CSE and a) five or more positive responses to CSERQ15, or b) one or more positive responses if the CSERQ4 is used. Therefore, if either of these thresholds is met you MUST take action. HOWEVER: each child is unique and their circumstances will be different. New risk indicators are regularly identified. A holistic approach to CSE risk must be taken. It is absolutely acceptable to decide to refer at a lower threshold (e.g. when CSERQ4 is negative or fewer than five of the remaining CSERQ5-15 questions are positive) especially if you have other concerns for the health, safety or welfare of the child or other siblings.	

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[1] Cook, L. 2017. Child sexual exploitation risk questionnaire (CSERQ15). Aneurin Bevan University Health Board (ABUHB). http://www.wales.nhs.uk/sitesplus/866/page/95439

[2] Mott, A; Price, L. 2016. Child Sexual Exploitation (CSE) Prevention Strategy for the NHS in Wales 2016 – 2019. Public Health Wales http://www.wales.nhs.uk/sitesplus/888/page/91733#CSE

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