Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

BNSSG CCG Governing Body Meeting

Date: Tuesday 6th November 2018
Time: 9.00 am
Location: Batch Country House, Lympsham, Nr Weston-super-Mare, Somerset, BS24 0EX

Agenda number: 7.1

Report title: Children Looked After Update Report

Report Author: Julie Henderson, DNCLA
Report Sponsor: Anne Morris, Director of Nursing and Quality

1. Purpose

To provide a report and update on performance data for Children Looked After (CLA) for the Governing Body to highlight gaps in the provision of timely health assessments for CLA across Bristol and South Gloucestershire.

2. Recommendations

The Governing Body is asked to note:

- the contents of this report.
- the possible financial implications implicated in this report.
- the action plan to improve performance appended to this report.
- agree to receive quarterly progress reports on the action plan.

3. Executive Summary

- Both Initial Health Assessments and Review Health Assessments in South Gloucestershire and Bristol are not being carried out within the statutory timeframe and an action plan has been drawn up to address these issues as a matter of urgency.

- The appended action plan sets out the agenda for improvement which has been produced by both health and local authority partners across BNSSG and monitoring will be reported at BNSSG Quality Committee.

- Actions set to improve performance are unlikely to show improvement until Q3 as changes made within provider services did not take place until the middle of Q2.

4. Financial resource implications

There are no direct financial or resource implications in the immediate term, however following the completion of the needs-led evaluation in December 2018 a review of the allocated resource for CLA may be necessary. This will include the health needs of care leavers.

5. Legal implications

There are no identified legal implications in this report.

6. Risk implications

If children and young people in care do not have their health needs assessed there is a risk that they will continue to have unfavourable outcomes compared to their peers and will therefore be more vulnerable to chronic physical and mental impairment and disadvantage.

7. Implications for health inequalities

Children and young people in care are among the most socially excluded in children in England. There are significant inequalities in health and social outcomes compared with all children and these contribute to poor health and social exclusion of care leavers later in life.

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

There are no identified inequalities for children and young people with protected characteristics.

9. Implications for Public Involvement

It is expected that the voices of children and young people in care and their carers will be considered through the Corporate Parenting Boards of each locality.

Agenda item: 7.1

Report title: Children Looked After Update Report

1. Background

Duties set out in the Children Act 1989 give CCGs guidance on standards for the provision of healthcare for CLA including early recognition of both physical and emotional health needs. It is the responsibility of the Local Authority to make sure that health assessments are carried out and CCGs have a duty to comply with requests by local authorities for assistance to make sure that the assessment happens. The responsible authority must inform the CCG (or the local health board if a child is being placed in Wales), as well as the GP, when a child starts to be looked after or changes placement.

In order to assess these needs children coming into care are required by statute to have an Initial Health Assessment (IHA) within 28 days of coming into care. In order for this to take place the Local Authority (LA) has to notify the CLA health team within 72 hours that a child has become looked after which will then trigger providers to arrange an IHA. Current guidance states that an IHA must be completed by a physician and local practice is that Community Paediatricians undertake this work with specially trained GPs carrying out some IHAs in Bristol.

Evidence indicates that accurate and up-to-date personal health information has significant implications for the immediate and future wellbeing of children and young people during their time in care and afterwards. Understanding their own 'health history' is an essential part of growing up securely. Inconsistent record keeping can lead to wrong decisions by professionals and adversely affect the child or young person. A key element of good quality care for children and young people is early diagnosis and initiation of effective interventions. Evidence suggests that delayed time to diagnosis and starting treatment leads to poor outcomes and increased mortality, particularly for vulnerable groups.

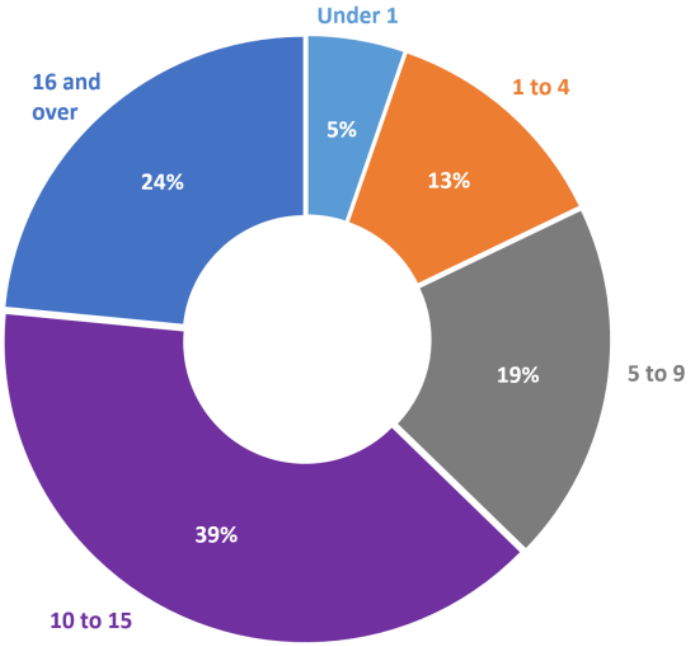
Key performance indicators are collated annually in partnership with Local Authorities and which contribute to the national Annual Child Looked After Return (SSDA903) to the Department for Education. The aim of the data collection is to provide a complete care history of every child in care and has been in existence since 1992. Key elements of the dataset include Initial and Review Health Assessments, health surveillance for under 5s, dental checks, immunisation history, substance misuse data and Strengths and Difficulties Questionnaire (SDQ) which is completed by the child's social worker alongside the carer and child or young person.

Demographics of Children Looked After

Figures from the Department for Education 2016-17 Children Looked After in England (including adoption), year ending 31 March 2017 sets out the demographic information for this group of children across England and reports that the increase in CLA reflects that more children started to be looked after in 2017 than left care. For the last two years, the changes seen in the characteristics of looked after children, those who become looked after and care leavers are influenced by the unaccompanied asylum-seeking children cohort who tend to be non-white British, older children, with a main category of need of absent parenting.

There were slightly more males than females looked after at 31 March 2017 of which 56% were male and 44% were female. These proportions have been quite stable in recent years. The numbers of both males and females increased in 2017, both increasing by around 3% compared to 2016. Over the last five years there were greater increases in the numbers of CLA who are male – there was an increase of 9% between 2013 and 2017, compared to an increase of 4% for females. This difference has largely been driven by the increase in unaccompanied asylum-seeking children over this period, the majority of whom are male.

Fig 1: Proportions of children looked after at 31 March by age group (in years)
England, 2017
Source: SSDA



The age profile of looked after children is very similar to last year, with little change in the proportion of children in each age group. Over recent years the numbers of looked after children aged under 1 year decreased by 11% compared to five years ago, however there was a slight increase this year of 280 children (8%) between 2016 and 2017. There was very little change in the number of 1-4 year olds and 5-9 year olds in the year ending 2017, after decreasing slightly in recent years the 1-4 year old group has stabilised around 9,200 children in 2017 and the 5-9 year old group, after increasing in recent years, has stabilised to around 14,100. Bristol and North Somerset broadly mirror this picture but with fewer children (16% compared to UK 19%) in the 5 – 9 age group) in Bristol. In North Somerset there were fewer 10-15 year olds in care (33% compared to UK 39%) than in the UK as a whole. Demographics have not been made available for South Gloucestershire but will be included in future reports.

Fig 2: Age demographics of Children Looked After in Bristol (October 2018)

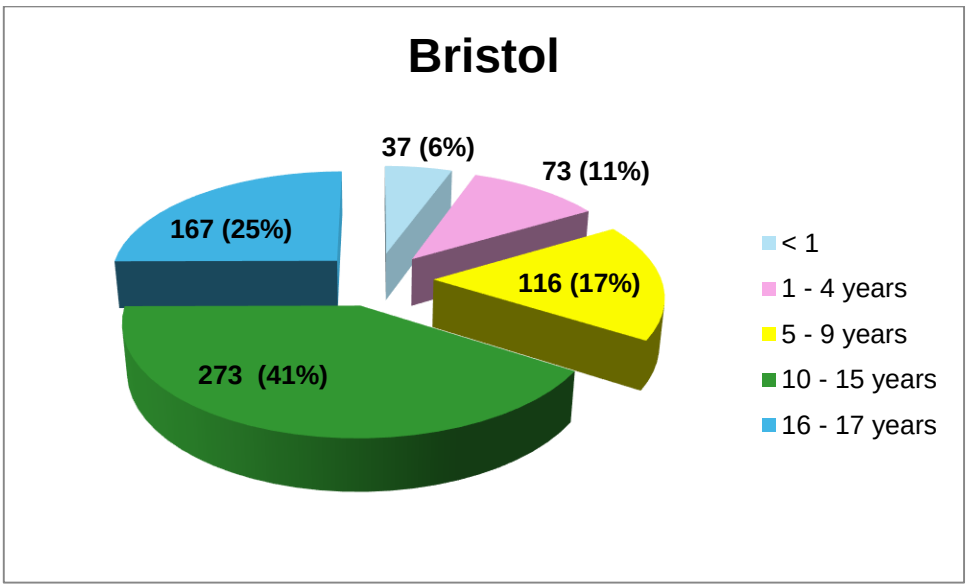
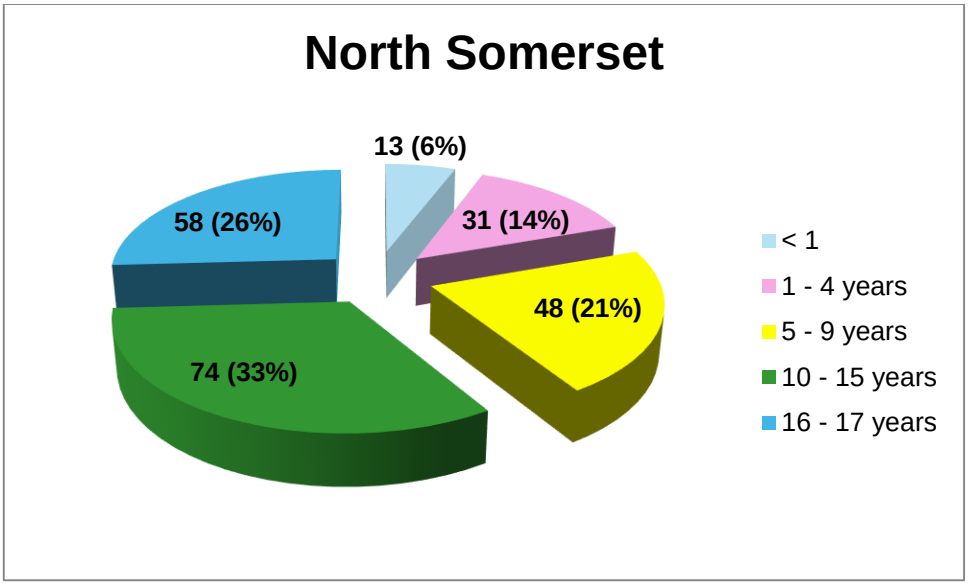


Fig 3: Age demographics of Children Looked After in North Somerset (October 2018)



Ethnicity of looked after children

Looked After Children remain of predominantly white ethnic origin in England. 75% of CLA at 31 March 2017 were white, 9% were of mixed ethnicity, 7% were black or Black British, 5% were Asian or Asian British and 3% were other ethnic groups. Non-white children were slightly over-represented in the CLA population, in particular children of mixed and black ethnicity. Children of Asian ethnicity are slightly under represented. This national picture is mirrored in Bristol with 65% of CLA being white, being reflective of the diverse population, rising to 86% in North Somerset. Demographic data for Children Looked After Children in South Gloucestershire are not currently available.

An unaccompanied asylum-seeking child (UASC) is an individual, who is under 18, who has applied for asylum in his/her own right, is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so. Although the numbers of UASC increased in England in 2017 for BNSSG localities the numbers remain small with 2 UASC accommodated in each of the 3 BNSSG localities in Q1.

2. Data - discussion and analysis

Performance Data Q1

The following charts outline the picture for Children Looked After in BNSSG in terms of numbers accommodated, numbers of health assessments carried out within the statutory timeframe and exception reporting from the provider. It is not expected that any actions taken to improve performance in Bristol and South Gloucestershire will be demonstrated until Q3 as increased staffing levels were not in place until late in Q2.

Chart 1

Total number of children and young people (0 – 18) accommodated in Q1 by area

	Total	Number placed within locality	Number placed out of area
North Somerset	17	16	1
Bristol	45	42	3
South Glos.	22	12	10

Chart 2

Chart 2 below indicates the trend in completion of health assessments across the last 3 quarters. North Somerset have improved over this period and both Bristol and South Gloucestershire's performance has declined. Since the appointment of a Designated Doctor for Children Looked After (locum) in North Somerset the numbers of IHAs carried out within timescale has dramatically increased.

Comparison chart quarters 3, 4 and 1 BNSSG IHAs and RHAs completed within timescales

	North Somerset	Bristol	South Gloucestershire
Q1 (2018-19)			
IHAs	16/17 (94%)	1/22 (2%)	7/19 (36%)
RHAs	45/48 (94%)	48/129 (37%)	16/30 (53%)
Q4 (2017-18)			
IHAs	50%	5%	59%
RHAs	85.7%	55%	78%
Q3 (2017-18)			
IHAs	14/33 (42%)	2/37 (5%)	11/22 (50%)
RHAs	42/48 (87.5%)	64/116 (55%)	36/42 (85%)

Chart 3
Total number of children and young people (0-18) requiring Initial Health Assessments (IHA)

	Number of IHAs required 0-4 years	Number of IHAs required 5-18 years	Number completed within 28 day timeframe	Number of IHAs requested by other LAs
North Somerset	8	9	16 (94%)	1
Bristol	22	22	1 (2%)	1
South Glos.	4	15	7 (36%)	7

Chart 4
Exception report (IHAs):

	Late notification from LA	Refused by young person	First appointment not taken up / unable to contact carer
South Gloucestershire	9 (47%)	1	3 (see narrative below)
Bristol	33 (75%)	6	See narrative below

3.1 South Gloucestershire:

Late notifications:

Demographic information and consent for an IHA had not been received by the Children Looked After (CLAN) team in 2 cases and a further 7 were received out of timescale (notifications in South Glos should be received by the CLAN team within 48 hours in order for assessments to be completed). In consideration of the low percentage of IHAs being completed on time 1 assessment in South Gloucestershire equates to just over 5% per child therefore if 2 assessments are not completed that is a reduction of 11% overall. In March 2018 South Gloucestershire Local Authority (LA) transferred their electronic recording system from Liquid Logic Children's System (LCS) to another system, Mosaic which has caused delays in notifying the health team that a child has come into care. Had notifications been received within the agreed 48 hours 68% of children and young people would have received their initial health assessments on time.

An interim recovery plan is now in place to mitigate this issue within the LA so that until updates to the Mosaic system are available (expected March 2019) notifications will be made manually to the CLAN team by the LA placement team. This will be under regular review by the Designated Doctor and Nurse to ensure improvement is established and sustained by Q3 as this action will be instigated from October 1st 2018.

Delays also occur if a child or young person is placed outside of South Gloucestershire as the IHA will be completed locally under the national tariff system and which is dependent on the local team conducting the assessment. In addition there are some discrepancies between LA and Health data which are likely to be children who have been moved out of care and health teams have not been notified.

Refusal by young person:

This requires further analysis to ascertain reasons and enable the young person to complete a refusal questionnaire with a social worker. If an IHA is refused one of the CLAN team will offer a review which can be undertaken in the young person's home or placement. This does not take the place of an IHA but gives the young person the opportunity to discuss their reasons for refusing the health assessment and for a review of current physical and emotional health issues.

Difficulties with appointments:

There were difficulties contacting the carer in 2 cases and 1 young person moved placements around the time the assessment was due so time was allowed for the young people to settle into their new placement. Reasons for the remaining children and young people who did not receive assessments in South Gloucestershire within timescale were difficulties with availability of young people. Further detail around this has been requested from the provider from Q2. Some actions have however been identified following discussion with the Designated Doctor and Named Nurse in Bristol and this will form part of the attached action plan.

3.2 Bristol:

Late notifications:

Work is continuing to build relationships between the LA and Health and progress has been made in the past year enabling more effective working relationships. This has not however resulted in improvements in numbers of notifications being received by the provider in a timely manner. This has now been raised at the Corporate Parenting Panel in September and will be raised at subsequent meetings of the CPP and the Health Sub-group of the CPP. It is essential that reporting from the LA is a true representation of the numbers of IHAs and Review Health Assessments (RHAs) being completed and in order to ensure this these data should be reported separately.

Refusal by young person:

6 young people refused their health assessment in Bristol in this period and the LA has reintroduced the health questionnaire to enable young people to give their reasons for refusing health assessments. This is a further expectation for reporting in the Q2 report.

No exception reporting around the remaining 25% of IHAs not being completed with timescale has been given by the provider and has been requested for Q2. A dataset has been requested monthly for the Children's Community Children's Health Partnership (CCHP) ICQPM with immediate notification for July and August. This will be escalated again at the ICQPM on October 9th if this has not been received by October 5th.

The provider has initiated a Project Plan for a centralised booking system for initial health assessments in Bristol and South Gloucestershire with a planned completion date of

January 2019. This will facilitate more efficient use of the Community Paediatric and CLAN teams' health assessment and adoption medical slots for paediatricians.

3.3 North Somerset – no exception report required for Q1 as they had completed both IHAs and RHAs within timescales.

Chart 4

Review Health Assessments

Total number of children and young people (0-18) requiring Review Health Assessments (accommodated for 12 months or more) in Q1

	Total no of RHAs required	Number of RHAs required (0-4)	Number of RHAs required (5-18)	Number of RHAs completed within timeframes	Number of RHAs requested by other LAs
North Somerset	48	13	32	45 (94%)	13 (all completed)
Bristol	129	19	110	48 (37%)	6
South Glos.	30	7	23	16 (53%)	9

3.4 Exception report (RHAs)

The poor performance regarding RHAs in both Bristol and South Gloucestershire has been raised with the provider but they are unable to provide detail around these figures with the current capacity of the nursing team. This information has been requested for Q2 and discussion around collection of data by administrative staff will take place at the monthly meeting between the provider and the DNCLA.

In order to mitigate this issue he Specialist Nurse for Children Looked After will undertake 4 of the RHAs in South Gloucestershire from 1st October which has been made possible by the

expansion of the team across Bristol and South Gloucestershire. Improvements should be seen by the end of Q3 as a result of this change.

The CLAN team have been asked to provide a rationale for undertaking review health assessments out of the timeframe. Discussion has taken place with the DNCLA regarding timely bookings to ensure that any cancellations do not impact on the performance of the team.

No exception report required for North Somerset for Q1 as the target of 90% was reached for completing both IHAs and RHAs.

Chart 5

Unaccompanied Asylum Seeking Children (UASC) accommodated in Q1

North Somerset	2
Bristol	2
South Glos.	2

Chart 6

Strengths and Difficulties questionnaires (SDQ) completed

North Somerset	2
Bristol	35 / 388 (91% of children due to complete an SDQ) have an up to date SDQ

South Glos.	13

3. Actions

a. A half-day workshop attended by multi-agency professionals was hosted by the CCG on 3rd September to address the issues of poor performance. The workshop was attended by professionals from CLAN teams, social care and the DNCLA and Associate Director of Quality from the CCG. There was good representation from across all 3 localities.

b. Work focussed on aspirational and creative ways of working towards the target of 50% of health assessments being completed within the timeframe by the end of Q3. Participants were asked to consider ways of making improvements within the existing resource using 15% solutions.

c. The workshop participants demonstrated flexibility in their approach to resolving the issues of poor performance. Ideas ranged from working more closely together as a BNSSG CLAN team, using existing processes where they are working well, for example in North Somerset, in the other 2 areas. Better partnership working and collaboration was a theme that emerged strongly from the workshop.

d. Risk stratification was another area for consideration to address the lack of capacity as well as addressing the areas which were not working well but which were statutory. One of the suggested projects was working with the Department for Education to assess the feasibility of a pilot project for undertaking fewer health assessments in well older children who are in stable placements.

e. Stakeholders agreed to attend a second workshop to progress the action plan and to encourage wider participation from colleagues in mental health, Public Health, the Virtual School team, the Fostering Association and area managers in social care who are responsible for ensuring that timely notifications are made to the CLAN team. It is expected that consultation with children and young people will take place early in 2019

f. The plan attached to this document sets out the actions around performance improvement in more detail. Some of these actions have already been completed but it was not expected that performance would progress until the end of Q3 when new ways of working had been implemented for a reasonable period of time.

g. The provider in Bristol and South Gloucestershire is undertaking a review of doctors performing RHAs where this has been done historically because of a lack of capacity within the nursing team. Doctors will only complete RHAs where there is a clinical need and this will be monitored by the Service Manager.

h. The CLAN team had trialled nurse-led clinics for RHAs to take place in central Bristol which was unsuccessful. A full analysis of this pilot has been requested from the provider and a further pilot planned as seeing children and young people in clinics rather than in their homes where possible would enable the team to complete more timely assessments. However this would need to be fully supported by an admin team and there is a risk that young people are less likely to attend a clinic thereby losing a slot as well as the young person missing their assessment.

4. Summary

The numbers of health assessments being completed within the statutory timescale remain below the target of 90% in both Bristol and South Gloucestershire. An action plan was created following a workshop hosted by the CCG to address this issue and is attached to this report. The DNCLA is working with providers and the Local Authority to resolve this issue and is engaged in monthly performance meetings to monitor progress.

Immediate actions are:

- Performance raised at Corporate Parenting Panels and at ICQPM with request for monthly reporting.
- DNCLA is working with Principal Social Worker in Bristol to commence three month pilot for LA to initiate notification and supply paperwork within 10 days of a child coming into care which will facilitate earlier appointment for IHA. This will commence by the end of November.
- In South Gloucestershire, monitoring of improvement following re-instigation of manual notification to health team of a child coming into care from October.
- Monthly meetings with CLAN team to monitor improvements in timeliness of RHAs following reassignment of assessments between Bristol and South Gloucestershire CLAN nurses.
- Evaluation of services conducted by DNCLA and CLAN teams to identify possible gaps across BNSSG benchmarking against statutory guidance. To be completed by end of December.

- Improvements are not expected to be demonstrated until Q3 to allow changes in provider service to bed-in.

5. Financial resource implications

a. There are no direct financial or resource implications in the immediate term, however following the completion of the needs-led evaluation being completed in December 2018 a review of the allocated resource for CLAN may be necessary.

b. The action plan attached to this report addresses the issues around capacity and the most efficient use of the available resource which may result in financial implications for the CCG in the longer term.

c. The health needs of care leavers in Bristol and South Gloucestershire are not currently being commissioned. This requires a needs assessment to be completed which is likely to result in the need for further resource. This work should reflect the work required for transitions of young people to adult services.

6. Legal implications

There are no identified legal implications in this report.

7. Risk implications

a. If children and young people in care do not have their health needs assessed there is a risk that they will continue to have unfavourable outcomes compared to their peers and will therefore be more vulnerable to chronic physical and mental impairment and disadvantage. Evidence shows that the CLA population are four times more likely to have a mental health condition than are their peers (about 60% of children in care).

b. There is a risk of reputational damage to BNSSG CCG if adequate service provision is not delivered. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies as well as the NHS Constitution for England make clear the responsibilities of CCGs to Looked After Children and also to

care leavers. This may become apparent following the current Inspection of Local Authority Services for Children (ILAC) inspection in Bristol.

8. Implications for health inequalities

Children and young people in care are among the most socially excluded in children in England. There are significant inequalities in health and social outcomes compared with all children and these contribute to poor health and social exclusion of care leavers later in life.

The main reason for children and young people entering care in the year up to April 2012 was abuse or neglect (reported in 62% of cases). Children who are Looked After are likely to have suffered health inequalities prior to coming into care, it is therefore imperative that health assessments are carried out within appropriate timeframes in order to prevent poor health outcomes for this vulnerable group.

9. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

There are no identified inequalities for children and young people with protected characteristics.

10. Consultation and Communication including Public Involvement

Children in care are consulted through Children in Care Councils on the development of services relating to their health and wellbeing. In Bristol foster carers also support the work of the Corporate Parenting Panel where their views are heard. The Children in Care Council has close links with the Corporate Parenting Panel so that young people's views can be incorporated into the CLA agenda. There are similar arrangements in North Somerset and South Gloucestershire for the voices and views of children and young people to be heard. Information included in this report includes that produced by the Report of the Children and Young People's Health Outcomes Forum.

11. Recommendations

a. The Governing Body is asked to note:

- the contents of this report.
- the possible financial implications implicated in this report.
- the action plan to improve performance attached to this report.
- agree to receive quarterly progress reports on the action plan.

Report Author: Julie Henderson, Designated Nurse for Children Looked After
Report Sponsor: Anne Morris, Director of Nursing and Quality

Glossary of terms and abbreviations

Children Looked After (CLA)	The definition of children looked after (children in care) is found in the Children Act 1989. A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.
Designated Professional for CLA	Assists planning and advise CCGs in fulfilling their commissioning responsibilities to improve the health of looked after children. Leads and supports all activities necessary to ensure that organisations within the health community meet their responsibilities for LAC. Advises and supports all specialist LAC professionals across the health community. Are members of the Corporate Parenting Board, health and Wellbeing / Children's Trust Board and LSCBs. Provides health advice on policy and individual cases to partners.
Annual Child Looked After Return (SSDA903)	The aim of the SSDA903 return is to collect information about children who are looked after by local authorities during the year end and for those who have recently left care. For children who were looked after during the year, the information relates to their placement, legal status and adoption from care. For those who have recently left care, the information required relates to their current activity and accommodation. The purpose of the SSDA903 is to provide the government with the necessary information to evaluate the outcome of policy initiatives and to monitor objectives on looked after children, both during their time in care and on reaching adulthood. The data collected is used in the provision of information for research and statistical information in response to parliamentary questions.

Strengths and Difficulties Questionnaire (SDQ)	The Strengths and Difficulties Questionnaire (SDQ) is a short behavioural screening questionnaire used for 3-16 year olds and is available in over 40 different languages. It is used within research, evaluating treatment outcome and as part of clinical assessment in order to examine a child's mental well-being.
Children Looked After Nurse Team (CLAN)	The CLAN team carry out health assessments and safeguard the health of children and young people in care, focussing on staying well and healthy and also signposting to other services as necessary.
Corporate Parenting Panel (CPP) **Corporate Parenting Steering Group (CPSG)** **Children's Champion Group**	A corporate parent is an organisation or person in power who has special responsibilities to care experienced and **looked after** children and young people, a group that includes: • those in residential care • those in foster care • those in kinship care, who live with a family member other than a parent • those who are **looked after at home.** In simple terms, a corporate parent is intended to carry out many of the roles a parent would. They may not be able to provide everything a loving parent can, but they should still be able to provide the children and young people they're responsible for with the best possible support and care. The concept is intended to encourage people and organisations to do as much as they can to make sure children and young people feel in control of their lives and able to overcome the barriers they face. Members of these groups include local authority service managers, local councillors and the Designated Nurse for CLA amongst others.
Liquid Logic Children's System (LCS) **Mosaic**	Local authorities use electronic records for the children in their care and LCS and Mosaic are two different types of system.
ICQPM	Integrated Contract and Quality and Performance Meeting

Action Plan: To address poor performance around timeliness of initial and review health assessments in South Gloucestershire and Bristol

Date Created **05/09/2018**

Plan Owner :	Julie Henderson, Designated Nurse for Looked After Children	**Date last updated : (and version no)**	25/09/2018
Core implementation Group :	BNSSG CCG Quality Committee	**Next review due by - Group / Committee : Date :**	**23/10/2018 / Quality Committee**

Driver **Specific** Issue / gap / objective requiring action	**Monitoring/ Measurable** How we know we have succeeded	**Actions** **Specific, Achievable** Stated clearly, communicated widely	**Resource demand / constraints** ***Comments*** **Realistic**	**Person Responsible**	**Time-Frame To Achieve Timebound**	**Progress**	**Status**
Poor performance in timing of Initial and Review Health Assessments in South Gloucestershire and Bristol.	Monthly monitoring of performance data with provider. This is a strategic and operational health of Children Looked After (CLA) meeting with stakeholders across BNSSG to share good practice and hosted by the CCG.	Undertake an evaluation of the current service resourced. Initial scoping exercise completed but further work needs to identify specifics around pathways to health assessments being carried out.	This exercise may indicate there is insufficient resource in the system. Managing expectations around this will inform the wider action plan. This work should also expose discrepancies in data management between the health provider and the LA in Bristol.	DNCLA / NNLAC	December 2018	Working with PMO team to devise plan for evaluation (09/10/18).	**B**
		Work with Principal Social Worker and (Children Looked After Nurse) CLAN team to undertake pilot of notifications for IHAs being received by CLAN team without full paperwork with paperwork to be received within 10 days.	This will require changes of practice for both CLAN teams and children's social care in order to prioritise the booking of health appointments as soon as a child is known to be entering care.	DNCLA / PSW	November 2018	Discussions with Sirona service lead in initial stages. Discussions with children's social care complete (09/10/10).	**B**

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Driver **S**pecific Issue / gap / objective requiring action	Monitoring/ **M**easurable How we know we have succeeded	Actions **S**pecific, **A**chievable Stated clearly, communicated widely	Resource demand / constraints *Comments* **R**ealistic	Person Responsible	Time-Frame To Achieve **T**imebound	Progress	Status
		Monitor notifications' recovery plan in Placement Team for South Gloucestershire.	South Gloucestershire locality.	DDCLA / DNLAC	Monthly	Due to commence in October (10/10/18).	B
		Draft letter from Chief Executive to LA partners re poor performance if Q3 reports show no improvement.	Bristol and South Gloucestershire localities.	DNCLA / Deputy Director of Nursing and Quality	On receipt of Q3 report	(10/10/18)	B
		Raise poor performance in Bristol and South Gloucestershire Corporate Parenting Panel (CPP)l / Steering Group (CPSG). Raise at each meeting until recovery plan shows improvement.	Bi-monthly meetings in Bristol.	DNCLA / DDLAC		Raised at September CPP and CPSG	C
		Raise issue at CCHP ICQPM. Performance data relating to timeliness of IHAs and RHAs requested monthly.	Monthly meetings.	DNCLA / Commissioning Manager for CCHP		Raised at ICQPM in September and October (09/10/18).	C
		Develop risk stratification approach to improving performance. Proposal to Department for Education to pilot biennial Review Health Assessments for healthy children in stable placements. This proposal would increase capacity within the CLAN team to undertake timely RHAs with children and young people who are in less stable	Time constraints – project management will need to be in place.	DNCLA / Designated Doctors for LAC	May 2019	On plan with Project Management Office (PMO) team (10/10/18).	B

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints *Comments* Realistic	Person Responsible	Time-Frame To Achieve Timebound	Progress	Status
		placements or who have health issues.					
		Review reporting template / dashboard for CLA to include more specific data around exception reporting, outcomes data etc.	This will require discussion with Quality team in order to ensure any new scorecard meets the requirements of the whole CCG.	DNCLA / Associate Director of Quality	March 2019	On Plan (10/10/18)	B
		Collate information from 1st workshop and disseminate to participants to share resulting action plan.			05/09/2018		C
		Organise 2nd workshop to include wider stakeholders – Public Health, Barnardo's, Mental Health teams, Through Care Teams, Area Managers (Social Care), Virtual School Rep, Ambassadors (Care Leavers in Bristol).	This will enable practitioners to address barriers to achieving poor performance and encourage better partnership working and communication. This will include addressing any actions arising from the September ILAC inspection in Bristol. It will also give stakeholders ownership of the action plan.	DNCLA	January 2019	Notification of intention to hold workshop and purpose to be sent w/c 15/10/18.	B
No electronic patient record (EPR) in CLAN service. Having EPR in the	Quarterly reporting from provider.	Establish timeline for roll-out of EPR and funding stream.	The roll-out of EMIS access to CCHP staff has been delayed and is unlikely to be available to Children Looked After teams before 2019 / 20.	DNCLA / Head of Service, Sirona	14/09/2018	Funding is available for EMIS EPR roll out for Health Visitors only. Provider has	B

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints *Comments* Realistic	Person Responsible	Time-Frame To Achieve Timebound	Progress	Status
CLAN team would enable more efficient and timely recording of health assessments.						submitted a bid for funding from NHSE and NHS Digital in “Wave 4” – outcome is expected in November. Looked After Children Nurse team is either linked with the school nurse roll out or Community Paeds, whichever staff group is first. If the bid is successful and money is received in March 2019 it will be 6 months until the system goes live. The CLAN team have begun to scan health assessments to an internal drive from October 1st so they have an easily accessible record this time next year to ensure continuity	

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints *Comments* Realistic	Person Responsible	Time-Frame To Achieve Timebound	Progress	Status
						of care once EMIS is rolled out. (09/10/18)	
Lack of capacity in nursing team for RHAs.		Undertake analysis of nurse-led clinic in Bristol to conduct RHAs to understand feasibility of establishing a nurse-led clinic in the future.	This would require additional administrative support for the provider.	DNCLA / Head of Service, Sirona	April 2019	On plan (09/10/18).	**B**

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R