The Royal Wolverhampton NHS Trust

CP08
Children and Young People in Care Policy

Contents

Appendices:

1.0 Policy Statement (Purpose / Objectives of the policy)

1.1 The NHS has a major role in ensuring the timely and effective delivery of health services to Looked after Children (DfE DH, 2015). This policy provides the key duties and responsibilities of professionals, and the organisation as stipulated within Children Act (1989,2004) and NICE Guidance (2021), providing guidance, support and processes involved in delivering the Children and Young People in Care service.

1.2 The term Children & Young People in Care (CYPiC) was introduced by Wolverhampton Local Authority in 2019 following consultation with the Children in Care Council echoing the wishes of the young people in care. However much of the statutory guidance refers to this group as “Looked After”.

1.3 This policy is supplemental to, and not a replacement for, the Wolverhampton Safeguarding Together policy and procedures. These policies and procedures can be accessed via the following link: www.wolverhamptonsafeguarding.org.uk

1.4 The Trust is committed to working in partnership with parents, carers and families to promote an open, transparent and non-judgmental environment. The Trust recognises the importance of listening to children and young people and ensuring that their opinions are taken into consideration. The Trust is also committed to ensuring the required statutory roles are in place to have oversight of this cohort, with the overall aim being to achieve the required improvement being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults (DfE DH 2015)in outcomes for these vulnerable children and young people, in line with statutory guidance RCPCH (2020)

1.5 Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. Children in care have a greater risk of poorer mental health as well as developmental and physical issues (RCPCH, 2020). Delays in identifying and meeting their emotional well-being and mental health needs can have far-reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults (DfE DH 2015).

1.6 This policy has been developed to promote the health and wellbeing of children and young people in care who are in the care of Wolverhampton Local Authority, wherever they are residing, and those placed in Wolverhampton by other Local Authorities who access services provided by The Royal Wolverhampton NHS Trust.

2.0 Definitions

2.1 Adoption

Adoption Is a way of providing the security, permanency and love of a new family when it is not possible for a child to remain with his/her birth parents or within the birth family. Adoption is a legal process which fully transfers “parental responsibility” (PR) from the child’s birth parents to their adoptive parents.

2.2 Children and Young People

In England, a child is defined as anyone who has not yet reached their 18th birthday. Child protection guidance points out that even if a child has reached 16 years of age and is living independently, in further education, a member of the armed forces, in hospital or in custody in the secure estate they are still legally children and should be given the same protection

and entitlements as any other child.
Children under 16 can consent to their own treatment if they are assessed to be Gillick competent. If the child is not Gillick competent, those with parental responsibility can make a decision on the child's behalf. In most situations, the care and welfare of children under the age of 16 will be dealt with under the care of the Children Act (1989). There are however parts of the Mental Capacity Act (2005), which apply to children under the age of 16 where the ill treatment or wilful neglect of a child who lacks capacity is considered a criminal offence.

Young people aged 16 or over are presumed to have capacity to make their own decisions, unless there is significant evidence to suggest otherwise, in which case formal best interests' assessments must be completed in accordance with the Mental Capacity Act (2005).

2.3 Child Exploitation

Criminal exploitation is a form of abuse where a child or young people is forced or coerced into doing things for the benefit of others. Exploitation is a gradual process and can take many forms including criminal exploitation, sexual exploitation, modern slavery, radicalisation, county lines and trafficking.

2.4 Corporate Parenting

The term corporate parenting refers to the collective responsibility of the Local Authority and partner agencies to provide the best possible care and protection for Looked after Children and to act in the same way as a birth parent would (Children Act, 1989.)

2.5 Corporate Parenting Board

The Corporate Parenting Board meets on a regular basis to consider matters which affect children and young people in care. It is also responsible for making sure that the City of Wolverhampton Council's Corporate Parenting Strategy is met.

2.6 Contextual Safeguarding

Contextual safeguarding is an approach to understand and respond to young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse (Firmin and Knowles, 2020).

2.7 Delegated Authority

Delegated authority allows foster parents to make everyday decisions about the children and young people they care for, as far as possible, just as parents do**.** A child's placement plan should record who has the authority to make particular decisions about the child and it should also record the reasons where any day-to-day decision is not delegated to the foster parent. Decisions regarding delegation of authority should take account of the child's views and consideration should be given as to whether a child is of sufficient age and understanding to make decisions themselves.

2.8 Foster Carers (also known as foster parents)

In the UK foster carers are trained, assessed and approved to look after fostered children by a fostering service, and they are referred to locally as foster parents. They are childcare experts working as part of a team of professionals providing children with the highest

standard of care.

2.9 Health Passport

The health passport is a record of information about a child or young person's health history and medical needs. The health passport is a blue booklet that should be issued to children and young people at their initial health assessment and should remain with them during their journey in care. The principle is the same as a parent held record whereby young people, parents and foster parents should be encouraged to fill in the details of any health appointments. This is not a statutory document.

2.10 Leaving Care Health Summary

This is a summary of the young person's health history which is compiled for them as they approach 18 years of age. This is a statutory document.

2.11 Looked After

The term was introduced by the Children Act 1989 and refers to children and young people who are under the age of 18, those who live away from their parents or family and are supervised by a social worker from the Local Authority Children's Services.

The different sections of the Children Act under which the child could be in care are given below:

Section 20 – This is a voluntary agreement with their parent who holds parental responsibility.
Section 31 – A Care Order is created by court placing a child or young person in the care of the local authority, with parental responsibility being shared between parents and the local authority.
Section 38 – An interim care order gives the local authority shared parental responsibility and allows them to make decisions about where the child lives and the welfare of the child.
Section 44 & 46 – Are Emergency Orders for the protection of children where the police have reasonable cause to believe the child would otherwise be likely to suffer significant harm.
Section 21 - When the child or young person is under remand to local authority care or subject to a criminal justice supervision order with a residence requirement.

2.12 Multiagency Child Exploitation (MACE)

MACE meetings are held when a child/young person is deemed to be at medium or high risk of exploitation following a risk assessment. The aim of the meeting is to prevent children and young people being exploited by working together to gather, share and understand important information and intelligence to identify potential risks and for agencies to use their resources to protect the child and young person.

2.13 Mental Capacity Act 2005

The Mental Capacity Act (2005) is a piece of legislation enacted in 2007. Its purpose to empower and protect the rights of individuals' who may not have the ability to make a specific decision. The act is applicable to those aged 16 years or older residing in England or Wales. The legislation provides professionals with a statutory framework to support patients with decision making or to plan if loss of capacity it anticipated. The overarching aims of the Act are to promote patient autonomy and protect vulnerable people from harm.

See CP19 Mental Capacity Act (2005) Policy and CP06 Consent to Treatment and Investigation Policy. For further advice or support contact the Safeguarding Team.

2.14 Deprivation of Liberty Safeguards (DoLS)

The process of independent assessment to safeguard people whose care involves restrictions and, or restraint in their best interests, to which they cannot validly consent. he safeguards documented in this policy cannot apply to people while they are detained in hospital under the Mental Health Act 1983. They also only apply to people aged 18 and over. DoLS can be used for patients aged 16 and 17, however, if the issue of depriving a person of their liberty under the age of 18 arises, other safeguards must also be considered such as the existing powers of the court, particularly those under section 25 of the Children Act 1989, or use of the Mental Health Act 1983. Advice must be sought in these circumstances from the Children's Safeguarding Team and the RWT Legal Team.
See CP02 Deprivation of Liberty Safeguards Policy. For further advice or support contact the Safeguarding Team.

2.15 Parental Responsibility

Parental Responsibility is defined in The Children Act 1989 as all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property. A person with parental responsibility means someone with the rights and responsibilities that parents have in law for their child including the right to consent to medical treatment for them, up to the age of 16 years.

2.16 Social Workers

Social workers exercise the local authority's parental responsibility. This includes making sure that the child's needs are met, that their welfare is safeguarded, and they are encouraged to develop to their full potential. Social workers have a legal duty to make sure that the child or young person's physical and emotional needs are cared for appropriately.

2.17 Special Guardianship Order (SGO)

This is an order appointing one or more individuals to be a child's special guardian. It is a private law order made under the Children Act 1989 and is intended for those children who cannot live with their birth parents and would benefit from a legally secure placement. The child or young person does not have "looked after" status when they have an SGO in place.

2.18 Statutory Health Assessment

This is the legal health assessment of a child / young person who is a CYPiC. This includes both initial and review statutory health assessments.

2.19 Statutory Initial Health Assessment (IHA)

This is the first health assessment undertaken within 20 working days of a child/young person entering care.

2.20 Statutory Review Health Assessment (RHA)

These are the subsequent assessments which continues for as long as a child holds CYPiC status and ceases when they leave care. A child under 5 years of age receives a statutory review health assessment at least every 6 months. A child /young person over 5 years of

age receive a statutory review health assessment at least every 12 months.

2.21 Unaccompanied Asylum-Seeking Children (UASC)

These are children and young people who are seeking asylum in the UK but who have been separated from their parents and carers. While their claim is processed, they are cared for by a Local Authority.

3.0 Accountabilities

3.1 Integrated Care Boards (ICB's)

Integrated Care Boards have replaced previous CCG's (Clinical Commissioning Groups. The ICB has a duty to comply with requests from the local authority to help them provide support and services to children in need. ICB commissioners need to ensure the services they commission meet the needs of CYPiC (Department for Education and Department of Health and Social Care 2015).

The NHS contributes to meeting the needs of CYPiC by commissioning effective services to be delivered through provider organisations alongside individual practitioners providing coordinated care for each child, young person and carer.

Where a Local Authority arranges accommodation for a CYPiC in the area of another ICB, the originating ICB and CYPIC team remains responsible for the services required that are commissioned by ICB's.

3.2 Royal Wolverhampton Trust (RWT)

As the provider of services to children and young people in care the CYPiC Service within RWT is responsible for completing initial and review health assessments for those children and young people who are placed in Wolverhampton and within a 50-mile radius of Wolverhampton. The CYPiC service have a responsibility to offer CYPIC training to all staff undertaking review health assessments within the trust and provide professional advice regarding children and young people in care in line with local procedures and national guidance. The CYPiC service provide a quarterly and annual report alongside regular assurance through the Dashboard to the ICB.

3.3 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are policies in place not only to protect children from abuse but also to ensure that those children and young people looked after by the Local Authority receive health care in line with the Trusts role as a corporate parent to these children as agreed by the Corporate Parenting Board.

3.4 Head of Safeguarding

The Head of Safeguarding provides expert leadership on all aspects of the safeguarding agenda. Responsibilities also include ensuring that the Trust has robust systems and processes in place for the protection and ongoing support of adults and children and supporting the work generated by the Wolverhampton Safeguarding Children and Adult Board.

3.5 Matron for Children and Young People in Care

The Matron for CYPiC manages the CYPiC team and provides expert leadership on all aspects of the safeguarding agenda. Responsibilities also include strategic management of the service, ensuring robust systems and processes are in place, working in partnership with Black County ICB and Wolverhampton Safeguarding Partnership to ensure a multiagency approach and providing effective support and acting as a resource to providing accessible, accurate and relevant information Trust-wide.

3.6 Designated Professionals

The roles of the Designated Nurse and Designated Doctor are to undertake the statutory responsibilities outlined in “Promoting the Health and Well-being of Looked after Children” (DfE DH&SC 2015). These posts are ICB roles intended to be strategic and separate from any responsibilities for individual CYPiC. This includes assisting health providers and other commissioners of health services in fulfilling their responsibilities to improve the health of CYPiC.

3.7 Named Professionals

The term Named Doctor/Nurse are statutory roles and denotes identified Doctor(s) or Nurse(s) with additional knowledge, skill and experience in working with CYPiC. They are responsible for promoting good professional practice within their organisation; providing supervision, advice and expertise for fellow professionals and ensuring that training is in place as per Intercollegiate Document (RCPCH 2020).

The Named Doctor is responsible for contributing to monitoring the quality and effectiveness of services, including monitoring performance against indicators and standards, including implementation of effective systems of audit and developing CYPiC related guidelines. The Named Doctor also attends all key Directorate and Trust meetings, and the Trust Safeguarding Operational Group (TSOG). This enables the team to raise the profile of CYPiC within RWT and escalate concerns.

The Named Nurse’s responsibilities include co-ordinating and monitoring RHA’s of CYPiC placed and quality assurance of all health assessments via clinical audit. The Named Nurse is also responsible for contributing to the dissemination and implementation of organisational policies and procedures as well as contributing to monitoring the quality and effectiveness of services, including monitoring performance against indicators and standards.

3.8 Specialist Nurse for CYPIC

Specialist Nurses’ responsibilities include supporting the Named Nurse and Doctor to ensure that the organisation meets its responsibilities for CYPiC, undertaking health assessments and providing written reports, and ensuring advice and support is available to multi-agency professionals, CYPiC and their foster parents.

3.9 Community Paediatricians

Community Paediatricians’ responsibilities include completing IHA’s for CYPiC, treating and monitoring identified health needs, ensuring necessary referrals for investigation and treatment of conditions is identified at clinical assessment. In addition, they work collaboratively with children, young people and their foster parents and colleagues in Health and Social Care to ensure that the health needs of CYPiC are met.

3.10 Medical Advisor (MA) for Adoption

The Named Doctor and Designated Doctor for CYPiC fulfil the role of Medical Advisors for the Regional Adoption Agency. They are Consultant Community Paediatricians who undertake statutory health assessments for CYPiC.
Based on statutory guidance, their role is embedded within the multiagency system, the aim of which is to provide an integrated service to CYPiC with a care plan for adoption and ideally their job description is jointly agreed by the Health Trust with relevant Health Board and Adoption Agency.

See Appendix 1 for the Adoption Process.

3.11 The Named Health Professional

Each CYPIC is to have a 'named' community practitioner (Health Visitor/School Nurse/Partnering Families Nurse/ Named Nurse CYPIC/ Specialist Nurse CYPIC), who is responsible for ensuring that the health needs of CYPiC are identified and addressed by undertaking holistic health assessments and developing a health recommendations care plan. The named practitioner is expected to monitor the progress of the health plan, documenting appropriately in line with Trust policy and to liaise with the Named Nurse and any other relevant professionals if any concerns are highlighted.

3.12 CYPiC Administrators

The CYPiC Administrators are responsible for:

- Coordinating the initial and review health assessments for all Wolverhampton CYPiC wherever they are placed in line with the agreed service specification.
- Liaising with health and multi-agency colleagues to ensure accurate information required for comprehensive, timely health assessments is requested and received.

3.13 Maternity Services (including neonatal)

- CYPiC may be seen in maternity services either as a mother in receipt of maternity care or as a new-born infant.
- It is anticipated that a mother who is in care would have been identified by her community midwife prior to delivery in hospital and that this information would be recorded clearly in the mother's hand-held maternity records. The information should be checked for by the midwife caring for any young woman under the age of 18. The maternity records should document clearly who can accompany the young person and who should be contacted in the event of the birth as outlined in the birth plan.
- Infants who are voluntarily accommodated under Section 20 of the Children Act 1989 or made subject to a legal order in the immediate post-natal period should have a copy of their post-natal safeguarding plan in the obstetric and medical records. It is important that the foster parent addresses are not disclosed given potential associated risks.
- Any neonate requiring medical follow up should be referred to the appropriate medical team.

4.0 Policy Detail

4.1 Team Structure

See Appendix 2 for CYPiC team structure.

4.2 Referrals

It is the statutory responsibility of the allocated social worker for each CYPiC to make all referrals for a health assessment to be undertaken as soon as a child enters care. The allocated social worker will ensure that the appropriate BAAF (British Association of Adoption & Fostering) form with the correct consent and foster parent details are forwarded to the CYPiC administration team within 5 working days of a child/young person entering care for an IHA and a minimum of 8 weeks' notice for RHA's

4.3 Initial Health Assessments (IHA) – timing and management (Appendix 3)

The purpose of the IHA is to identify and record existing medical conditions from the time the child is first looked after, to provide a comprehensive and holistic health assessment and to formulate a Health Recommendation Care Plan. The IHA provides the opportunity to offer age-appropriate health promotion for both the child and foster parent and allows the child's wishes and feelings regarding their health to be recorded. A health passport is issued at the IHA which allows the foster parents/young person to document health information.

In accordance with statutory guidance, all IHA's will be carried out by a Registered Medical Practitioner. The IHA will be undertaken as soon as is practicable after a child becomes looked after. The IHA should be holistic and include physical health, emotional/mental health and health promotion. A typed report of the IHA and a health recommendation care plan is to be prepared for each child. The report from the IHA should be with the social worker within 20 working days of a child entering care. Interpreters will be booked for all health assessments for unaccompanied asylum-seeking children. Assessments will not take place if the interpreter is not present. As far as possible, face to face interpreters will be booked for the consultation and if unavailable, they will be booked to be present virtually via a video link on MS Teams.

Where appropriate, the health professionals should ascertain from the child's social worker which adult or adults (e.g. foster parent and/or birth parent and social worker) need to be present with the child/young person for the IHA.

The Named Doctor for CYPiC is responsible for the quality assurance of IHA's in accordance with the agreed audit tool -see Annex H (Appendix 11).

BAAF (form IHA C (child aged 0-10 years old) or YP (Young people aged 10 years or over), is the assessment tool that is used by RWT (Appendix 3a).

4.4 Detail of Review Health Assessment (RHA) Procedure
See Appendix 4 for information regarding the process upon an RHA request being received.

4.5 RHA – timing and management (Appendix 4a)

The purpose of the RHA is to provide a holistic review of the health, wellbeing and development of CYPiC, to review the existing care plan and identify any new health concerns, providing an updated care plan. This should be done by engaging the child/young person in their own health care, reflecting their voice throughout the assessment. The RHA provides the opportunity to offer age-appropriate health promotion as well as assisting young people preparing to leave care.

RHA requests that are due to be booked in with the CYPiC Team will be reviewed at a weekly allocation meeting held between the CYPiC administration and nursing team.

The CYPIC Nurses will review I.T systems including Clinical Web Portal (CWP), health and local authority Eclipse, GP summary, previous health assessment and will liaise with the allocated social worker as required prior to arranging the health assessment which should be arranged to meet the needs of the child/young person i.e. in clinic/at home/at another agreed appropriate setting. Virtual and telephone methods can be used if circumstances require this method or engagement and if this is the most effective method of engaging with them.

Following the completion of the IHA, the timetable for the statutory review health assessment is as follows:

Children birth to 5 years of age – at least every six months
Children/young people five years to 18 years of age at least every twelve months.

Where appropriate the health professional should ascertain from either the child's social worker which adult/adults (e.g. foster parent and/or birth parent) need to be present with the child for the RHA. The accompanying adult should have sufficient knowledge of the child's health needs and be able to provide information to support an effective assessment.

Contact must always be made with a foster parent prior to seeing a young person. Where a foster parent/ young person does not attend the appointment the professional responsible should follow OP101 Children & Young People Did Not Attend//Failed To Be Brought To Acute Or Community Appointments Or For Acute Admissions/No Access Gained At Pre-Arranged Home Appointments Policy and inform the named social worker and the CYPiC health team.

See Appendix 4b for information on the RHA forms.

If you have any concerns regarding a CYPIC please refer to Appendix 5 in conjunction with the Safeguarding Children's Policy and Escalation policy .

4.6 Health Information and Documentation

- It is imperative the child/young person is present at their assessment and where age permits, if they choose to attend independently, the practitioner must also liaise with foster parent and social worker.
- Before commencing the assessment, it is essential to gain consent from the young person or from the child, if they have sufficient capacity and maturity or from the adult with parental responsibility. It is important to consider and assess that the child/young person may have capacity to consent. A young person over 16 years is generally deemed competent to consent for themselves. Where capacity is questionable refer to the Mental Capacity Act 2005/2019. See Consent policy .
- For children/ young people in care the person with parental responsibility may be a birth parent or the local authority. Where in doubt contact their social worker for advice.
- It is the social worker's responsibility to obtain consent for statutory health assessments, routine screening and immunisations when a child is taken into care.
- It is the assessor's responsibility to review details of any previous health assessments, and other relevant information to inform the assessment. This must clearly be documented in the assessment paperwork.
- For children under the age of 5 years an age-appropriate assessment tool should be used to assess development and social emotional development.
- When the completing practitioner documents on relevant paperwork it is essential that the voice of the child is identified, regardless of their age or ability to communicate.

- The voice of the child can be obtained via direct observation, discussions with foster parents and direct engagement with the child/young person offering them the opportunity to be seen alone if appropriate.
- Where available the child/young person's health passport and personal child health record (red book) should also be updated. These should remain with the child throughout their journey, including those placed for adoption.
- At the point a child is adopted a new red book can be offered to accommodate the child's new details, however the original red book should still remain with the child.
- Practitioners completing assessments must ensure they adhere to local and national requirements in relation to consent, documentation and record keeping. For record keeping standards see Structure and use of a health record.
- Notifications – when receiving hospital discharge or A&E notifications the practitioner must review them, upload to electronic records or print and add them to the CYPiC records; they must also contact the social worker to inform them of attendance and document actions on Clinical Web Portal or 0-19. When receiving out of area local authority A&E attendances they should be forwarded by the admin team to the local authority the child or young person is looked after by.

4.7 Consent and Information Sharing

Information sharing is essential for effective safeguarding and promoting the welfare of children and young people (Department for Education, 2018b). Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe (Department for Education, 2018a). Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children and young people, which must always be the paramount concern.

If you have any concerns regarding a CYPIC please refer to Appendix 5 in conjunction with the Safeguarding Children's Policy and Escalation policy .

Where appropriate, concerns should be discussed with the parent or foster parent unless seeking agreement is likely to:

- Place the child/young person at risk of significant harm through delay or the parent's actions or reactions.
- Lead to the risk of loss of evidential material for example in circumstances where there are concerns or suspicions of a serious crime or induced illness.
- The allocated social worker must also be consulted as part of this, ensuring information is shared.

Information may be shared between professionals and local agencies without consent if it is to promote the welfare and protect the safety of children. This must be clearly documented in the patient's records. For further guidance on information sharing please see OP85 Information Sharing Policy.

4.8 Special Educational Needs and Disabilities (SEND)

Children and young people in care start with the disadvantage of their pre-care experiences and, often, have special educational needs (Department for Education, 2018). Health professionals working with CYPiC should ensure that the Education, Health and Care Plan (EHCP) works in harmony with their care plan to tell a comprehensive story about how the child or young person's health needs in relation to accessing education are being met (DfE DH&SC, 2015). All health professionals undertaking health assessments should ensure that health action plans align with the outcomes in the EHCP's to ensure that, taken together,

they meet the child's needs. The CYPiC team captures information obtained from the IHA's/RHA's in relation to which children and young people have SEND and EHCP's.

For further information on how health professionals can support CYPiC who have special educational needs please refer to 0-25 SEND Code of Practice.

0 to 25 SEND code of practice: a guide for health professionals (publishing.service.gov.uk)

4.9 Regularity of Contact with CYPiC

Health Visiting Service/Partnering Families Team

All pre-school aged CYPiC are to receive a minimum of a face-to-face contact and have a review of their health recommendation care plan by their named health visitor every 3 months regardless of change of placement or change of health visitor. More frequent contact with the child and carer should be undertaken according to need and professional judgement of the health visitor.

School Nursing Service

All school-aged CYPiC in a Wolverhampton school are to be reviewed by their named school nurse within the timescale agreed with the young person when completing their RHA, and the frequency of review should be recorded in the health care plan. Professional judgement of the school nurse, in conjunction with the child/young person's wishes, and their foster parent/guardian if appropriate should be applied when agreeing contact details. This may be a face-to-face contact, telephone contact or any other means agreed. Any child or young person who attends a school which is not covered by the school nursing service, such as an independent school, will be allocated to the CYPiC nursing team.

This is an opportunity to support and monitor the health care plan, which should be reviewed at least 6 months after completion of the health assessment to ensure the care plan actions are being undertaken and health needs are being met.

RHAs for school-aged children / young people are to be offered at a suitable time and venue for the child. Under no circumstances should the RHA take place without an awareness of the appointment by the foster parent/guardian.

4.10 Non- attendances for Health Appointments

The practitioner must document any non-attendance of statutory health assessment appointments in the health record in accordance with the OP101 Children & Young People Did Not Attend//Failed To Be Brought To Acute Or Community Appointments Or For Acute Admissions/No Access Gained At Pre-Arranged Home Appointments Policy. The named social worker is to be contacted and informed of **all** non-attended statutory health appointments on the same working day.

See Appendix 6 for the Was Not Brought/ not attended appointments pathway for RHA's.

See Appendix 6a for the Was Not Brought/ not attended appointments pathway for IHA's.

Lateral checks are to be completed to confirm correct details, engagement with other services and ensuring the CYP is not outstanding other health appointments they may have – this should raise concern and be escalated further in line with the Trust Escalation Policy.

Three appointments will be offered, a letter will then be sent to the named social worker and the social worker's line manager informing them that no further appointments will be offered unless specifically requested and arranged for by the social worker in conjunction with the Named Nurse/ Specialist Nurse for CYPIC. All correspondence will be copied to the child or young person's GP. For CYPiC placed in Wolverhampton if the child/young person does not attend/is not brought the placing area health team will be informed and two appointments in total will be offered before the request is returned to the placing area health team detailing all of the information in relation to the non-attendance.

NB: For any additional health appointments that CYPiC are not brought to it is expected that the health professional involved will follow the OP101 policy, ensuring the allocated social worker is fully informed. It is not sufficient to liaise with the foster parents alone as they do not hold Parental Responsibility.

See Appendix 5 for the was not brought/ not attended appointments pathway.

4.11 Transition

The transition from childhood to adulthood means leaving school, entering work or higher education, leaving home and becoming more independent. CYPiC are an extremely vulnerable group of young people and transition can be made harder when professionals fail to plan or manage the process of handover from one service to another. This can have an impact on the health & wellbeing of CYPiC. The school nurse should handover to the CYPiC Nurses so that the health needs of CYPiC continue to be met. Plans should be included within the final RHA in regard to referring and liaising with other services.

4.12 Leaving Care Health Summaries (LCHS)

The allocated social worker is responsible for requesting a LCHS from CYPiC health team, by sending a signed consent form from the young person for the summary to be completed. A LCHS provides young people with health information from birth to 18 years. It can include information about birth details, diagnoses, medications, ED attendances, immunisations, development, allergies, (appropriate) birth family health information, dental, vision, and details of local health support services.

LCHS will be discussed with all CYPIC placed in Wolverhampton at their RHA once they turn 16 and written consent will be gained via the social worker. If the young person refuses the LCHS this must be clearly documented in their records, and they should be informed of how they can access their health information in the future should they wish to. LCHS will be completed by the CYPIC nurses and contact will be made with the young person to arrange for them to be issued. With the young person's consent, the LCHS will be forwarded to the local authority for saving to the local authority system, should the young person require another copy in the future. See Appendix 6 for the LCHS pathway.

4.13 Multi-Agency Child Exploitation (MACE)

MACE is a multi-agency professional meeting which is held in order to risk assess, plan and ultimately safeguard children and young people who are at risk of harm through a vulnerability.
Vulnerabilities can (however this is not exhaustive) include:

- Child Sexual Exploitation (CSE);
- Child Criminal Exploitation (CCE) including county lines;
- Missing from Home (MFH);
- Modern Slavery & Human Trafficking;

- Harmful Sexual Behaviour (HSB);
- Online Child Exploitation;
- Wider Contextual Safeguarding.

If you have any concerns regarding a CYPiC open to MACE regular screening is to be undertaken. To access the screening tool please refer to: Wolverhampton Exploitation Screening Tool 0 to 25 Years .

Concerns are to be reported to the social worker and information is to be shared with the CYPiC nurses. CYPiC who are known to MACE will have support from appropriate professionals in accordance with MACE pathway (see Appendix 7).

4.13 Youth Justice Service/Exclusion

CYPiC who are open to other services from health, such as the Youth Justice Service (YJS) or are excluded from education will follow the YJS//Pupil Referral Unit (PRU) pathway (Appendix 9).

4.14 Sexual Health

Embrace provide free and confidential sexual health services in Wolverhampton. Everyone is welcome and the young person doesn't need to see a GP first. Please refer to: https://www.embracewolverhampton.nhs.uk/ for further information.

CYPIC who have involvement from the sexual health service will follow the Sexual Health Pathway (Appendix 10).

4.15 Training and Supervision

CYPiC training is provided as per Intercollegiate Document (RCPCH 2020) which underpins the levels of training required for the specific staff groups. Please refer to; Looked After Children: Roles and Competencies of Healthcare Staff for further information.

All practitioners undertaking health assessments for CYPiC must complete Level 3 mandatory CYPiC training in line with the RCPCH Intercollegiate Document (2020). Staff must receive refresher training every three years as a minimum. Non-compliance of CYPiC training will be escalated to their managers. Training, support and guidance is provided by the CYPiC Team, and group supervision is currently provided to practitioners along with individual supervision being available as required.

4.16 Continuity of Service Provision

Any transfer of care to other health colleagues both in and out of city is to follow the OP97 Confidentiality Code of Conduct for Staff.

In all cases, the principles of confidentiality and data protection apply, in order to make sure personal identifiable information is not disclosed inappropriately. Safe haven procedures must be in place where staff are likely to receive personal information from other sites or if they wish to send personal information to other sites. When sending personal identifiable information by email or electronic transfer, personal and identifiable information must be encrypted. When sending paper notes which contain person identifiable information, make sure 'confidential' is marked prominently on the front of the envelope.

Refer also to OP12 IT Security Policy and OP07 Health Records Policy.

GDPR

If any of the CYPiC files have school records merged with them and they have left care, the school records are archived with the CYPIC files with a destruction date of 25 years (when they reach their 26th birthday).

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	N/A

6.0 Equality Impact Assessment

The Equality Impact Assessment has been completed and it indicates there is no adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

This policy will be reviewed every three years or earlier if warranted by a change in standards or if changes are deemed necessary from internal sources.

8.0 Communication and Training

This policy will be made available to staff via the Trust intranet page, and it will be communicated at the level 3 CYPiC Training.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Application of procedural detail to practice.	CYPiC Health Personnel	Production of monthly activity reports, quarterly reports including exceptions and annual reports.	Monthly Quarterly Annually	CYPiC Health Steering Group CQRM

Quality assurance of IHA's and RHA's	Named Doctor Named Nurse	Quality Assurance Tool used to quality assure all health assessments	Daily	Trust Safeguarding Group
Training Compliance	IMTG/CYPiC Team	Internal training monitoring	Monthly	Trust Safeguarding Group

10.0 References

Children Act 1989 Available at www.legislation.gov.uk

Children Act 2004 Available at www.legislation.gov.uk

Department for Education and Department of Health & Social Care (2015) *Promoting the Health and Wellbeing of Looked after Children*. London: HM Government. Promoting the health and well-being of looked-after children - update note added to start in August 2022 (publishing.service.gov.uk)

Department for Education (DFE) (2018a) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: HM Government.

Department for Education (DFE) (2018b) *Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers.* London: HM Government.

Firmin, C. and Knowles, R (2020). *The legal and policy framework for Contextual Safeguarding approaches*. The legal and policy framework for Contextual Safeguarding approaches

Mental Capacity Act 2005 Available at www.legislation.gov.uk

NICE (2021) *Looked-after children and young people*. Looked-after children and young people (nice.org.uk)

Royal College of Paediatrics and Child Health (2020) *Looked After Children: roles and competencies of health care staff. Intercollegiate Document*. London: Royal College of Nursing.

Part A - Document Control

Policy number and Policy version: CP08 Version 2.0	**Policy Title** **Children and Young People in Care Policy**	**Status:** Final		**Author:** Matron for Children & Young People in Care Named Nurse Children & Young People in Care Named Doctor Children & Young People in Care **Chief Officer Sponsor:** Chief Nursing Officer
Version / Amendment History	Version	Date	Author	Reason
	V1	July 2021	NN CYPiC ND CYPiC	New policy.
	V1.1	July 2023	NN CYPiC ND CYPiC	Inclusion of Appendices 13 and 14
	V2.0	December 2024	M CYPiC NN CYPiC ND CYPiC	Review of procedures in line with 3 yearly reviews of policy
Intended Recipients: Health Visiting Service, School Nursing Service, Named Nurses CYPiC, Specialists Nurses CYPIC, Paediatric Advanced Nurse Practitioners (PANPs), Paediatricians, Community Children's Nurses (CCN), Partnering Families Team (PFT).				
Consultation Group / Role Titles and Date: Named Nurses CYPiC, Specialist Nurses CYPIC and safeguarding professionals RWT, Designated CYPiC and Safeguarding professionals ICB; Related service groups - Health Visiting, School Nursing, Community Children's Nurses (CCN), Partnering Families Team (PFT), Advanced Paediatric Nurse Practitioners (PANPs), Nurses and Paediatricians, Local Authority				
Name and date of Trust level group where reviewed	Trust Safeguarding Group Trust Policy Group – December 2024			
Name and date of final approval committee	Trust Management Committee – January 2025			
Date of Policy issue	January 2025			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	December 2027 - 3 yearly review.			
Training and Dissemination: Awareness-raising of / distribution to the related service groups, Trust brief, Matrons meeting, Trust Safeguarding group.				
Publishing Requirements: Can this document be published on the Trust's public page: **Yes** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.				

To be read in conjunction with:

Promoting the Health and Well-being of Looked After Children (DOH, 2015)

https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

QS31 Quality Standard for the Health and Wellbeing of Looked After Children and Young People (NICE, 2013).

https://www.nice.org.uk/Guidance/QS31

The Children Act 1989

https://www.legislation.gov.uk/ukpga/1989/41/contents?view=plain

The Children Act 2004

https://www.legislation.gov.uk/ukpga/2004/31/contents

RCPCH Looked After Children: knowledge, skills and competence of health care staff (Intercollegiate Document 2020).

https://www.rcpch.ac.uk/resources/looked-after-children-lac

The Mental Capacity Act 2005

https://www.legislation.gov.uk/ukpga/2005/9/contents

The Health and Social Care Act 2012

https://www.legislation.gov.uk/ukpga/2012/7/contents

The Care Act 2014

https://www.legislation.gov.uk/ukpga/2014/23/contents

The Children and Families Act 2014.

https://www.legislation.gov.uk/ukpga/2014/6/contents

General Data Protection Regulation (GDPR) 2018.

https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation

Care Matters: Time for Change 2020.

https://www.gov.uk/government/publications/care-matters-time-for-change

Court orders & pre proceedings April 2014

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306282/Statutory_guidance_on_court_orders_and_pre-proceedings.pdf

Care Leaver Strategy 2013

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/266484/Care_Leaver_Strategy.pdf
Initial Equality Impact Assessment (all policies): Completed Yes **Full Equality Impact assessment (as required): Completed No** If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904

Monitoring arrangements and Committee	Production of activity reports by Named Professionals for CYPIC Activity reports presented to the Trust Safeguarding operational Group (TSOG) Internal audits. Quality Assurance processes Quarterly reports CCG Dashboard CQRM report

Document summary/key issues covered.

This policy provides guidance and support in relation to Children and Young People in care aimed at practitioners trust wide. It provides support for practitioners in completing statutory health assessments, outlines roles and responsibilities of the team, organisation and individuals working for the trust ensuring safe and effective standards of care are delivered for Children and Young People in Care.

Key words for intranet searching purposes	
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk, it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**No** If Yes include the following sentence and relevant information in the Intended Recipients section above – In the event that this is policy is made available to the public the following information should be redacted:

Appendix 1

Adoption reports

All adoption medicals (approx. 98%) are done from the IHA or RHA.

On receipt of request for adoption medical, details of the request are saved on the W drive under “Adoption Medicals” and updated throughout the process of the report including keeping record of any urgent e-mails for reports being chased up.

Adoption secretary also attends monthly meetings with Local Authority administrative teams Court Team and Area Team managers), to ensure list of children going through the adoption process is updated along with required RHA requests.

Initial Adoption report:
Social Worker requests an initial health assessment appointment, requesting an initial adoption medical if this is also required. This is then flagged to the doctor who is seeing the child so that a report can be dictated at the same time.

Review Adoption Reports
Review adoption medical reports are done every 6 or 12 months.

If child is under 5 they have a review health assessment completed every 6 months; on receipt of the request need to check when last RHA was completed/is due and then put forward request to Consultant to dictate review adoption medical. (A report can only be completed from the RHA if it is less than 4 months old).

If the child is over 5 they will have a review health assessment completed every 12 months. On receipt of the request, practitioners need to check when the last RHA was completed/is due and then put forward request to the Consultant to dictate review adoption medical. (A report can only be completed from the RHA if it is less than 4 months old).

The adoption report is typed in Dragon adding two signatures to go through the QA process (Adoption reports will be checked by the Consultant Paediatrician/Designated doctor and Consultant Paediatrician/Named doctor. These reports are quality assured by either of the two Medical Advisors, who share this work equally.
Once the report has been QA’d, it is sent by secure email to the Local Authority administrative team

Update LAC database (adoption tab) with as much information as possible.

Adult Health (AH) reports for prospective adopters and foster carers
The forms received are AH forms (first report) and AH2 (update report, usually every two years) for fostering, adoption or special guardianship. These forms are received from the Fostering Team at Priory Green or the Adoption Team, Adoption at Heart.

On receipt of form, scan and save on the W drive under “AH FORMS”

The Fostering and Adoption Database updated with initial request and throughout the process of the report including keeping record of any urgent e-mails for reports being chased up.

The medical report is dictated, and the doctor will complete the Medical Adviser section. This Medical Advisor section is scanned and saved on the W drive.

The report is typed in Dragon adding two signatures to go through the QA process (the report will be checked by the Consultant Paediatrician/Designated doctor and Consultant Paediatrician/Named doctor. These reports are quality assured by either of the two Medical Advisors, who share this work equally.

Once the report has been QA'd, it is sent by secure e mail to the fostering admin team or Adoption At Heart administrative team.

From 1 April 2020, following confirmation with Local Authority teams, both the fostering team and Adoption at Heart team request the medical reports to be sent electronically and the AH request form to be shredded by RWT, as the AH request forms are managed by the Local Authority.

Setting up prospective adopter clinics are via telephone consultation with Adoption Medical Advisors (Designated and Named doctor for Children and Young People in care), Social Worker and Prospective Adopters.

A request is received via e mail from a social worker for prospective adopter's telephone consultation. Ensure correct telephone contact numbers of the prospective adopter and adoption social worker and family finding social worker are provided to enable them to be contacted as required, on day of appointment.

An appointment is arranged which is always the last appointment slot in the clinic and is 1 hour appointment slot for the Medical Advisors (Consultant Paediatrician/ Designated Doctor and Consultant Paediatrician/ Named Doctor). If there are two or more siblings, then this needs to be discussed with Consultant as the clinic may run over into other commitments.

The secretary will create and set up a clinic date on PAS, make the appointment on PAS, ensuring no appointment letters are sent out.

Inform the social worker of the date and time of the appointment by e mail taking into account the adoption panel date.

Obtain LAC notes and print off clinic list sheet and put altogether for the clinic.

Once the clinic has taken place the clinic needs to be cashed up on PAS.

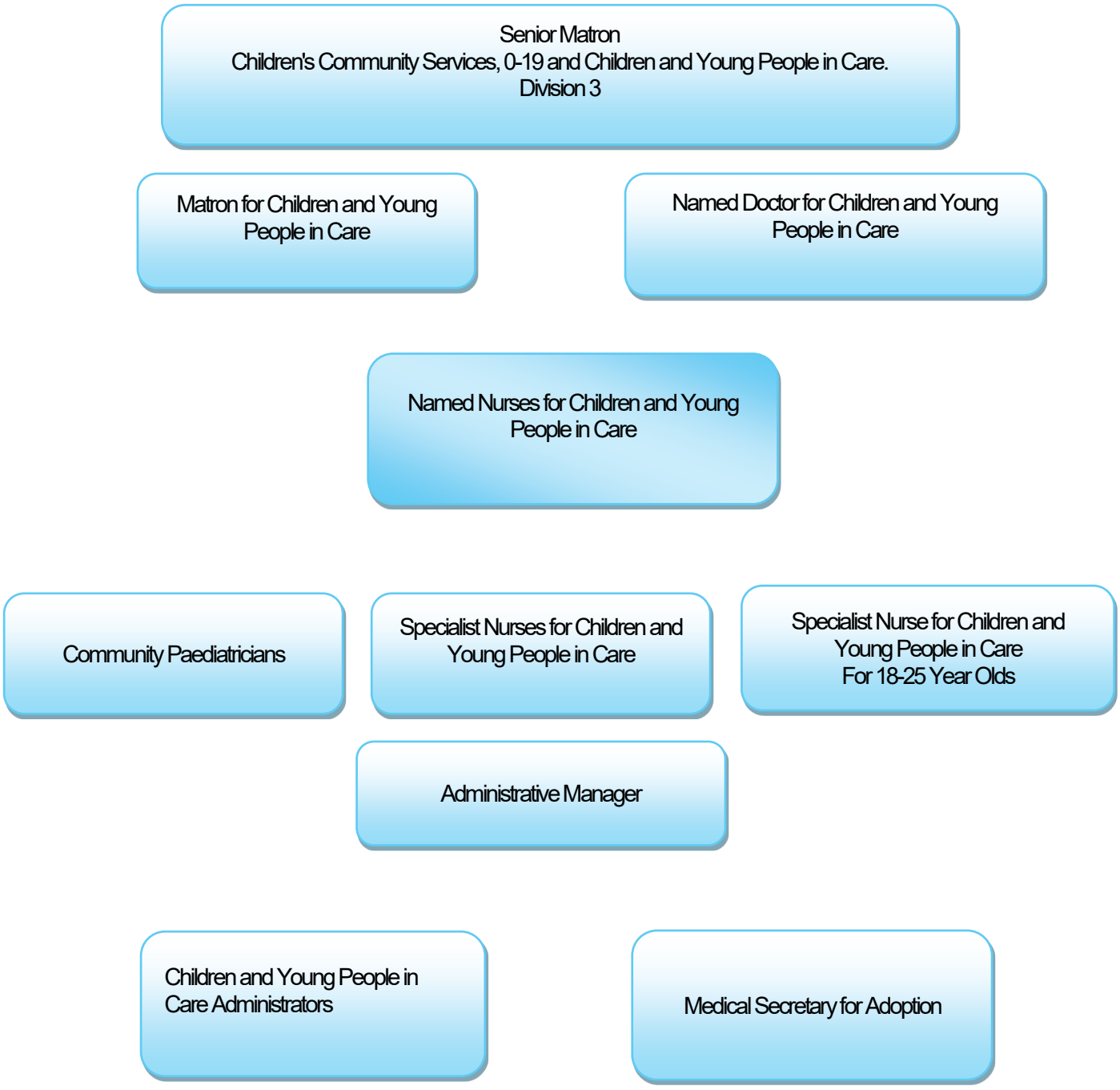
The medical secretary will type the report in Dragon, adding two signatures for the other Consultant Paediatrician/Medical Advisor to QA.

Once the QA process is complete then the report is e mailed via secure e mail to the requesting social worker admin team.

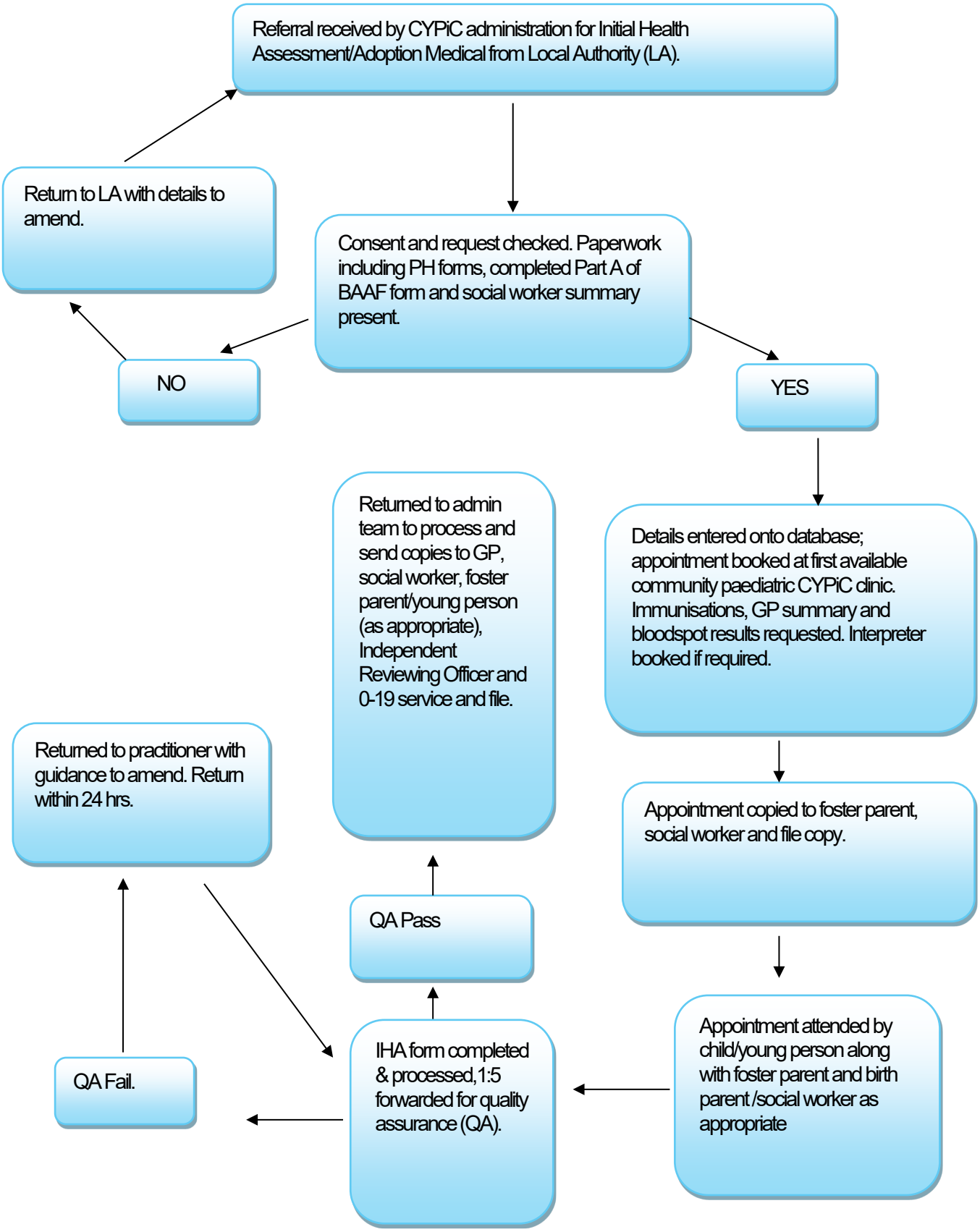
The prospective adopters report is then uploaded to portal and saved on the W drive under "completed medicals (year)".

Appendix 2

CYPiC Team Structure



Appendix 3
Flowchart for Statutory IHA.



Appendix 3a
IHA Assessment Forms

Part A (of BAAF form)	Part A is completed by the Social Worker and provides basic background information on the child, including their legal status, placement details and the reason they became looked after. It also includes consent to undertake the assessment.
Part B (of BAAF form)	Part B of the IHA is a holistic assessment of the child's health and must be completed by the assessing Doctor. It is recommended that the child's social worker, foster parent and birth parents (if appropriate) attend the assessment, if possible, to ensure a comprehensive assessment. In case they are unable to attend, accurate contact details should be provided by the child's social worker to enable the assessing clinician to contact them via telephone as necessary.
Part C (of BAAF form)	Part C is to be completed by the assessing Paediatrician. It comprises of a summary report and health recommendation plan which will then form part of the child's holistic care plan. **This is the only information from the BAAF form that is shared with the social worker /foster parent.** The assessing practitioner should ensure that all relevant information from Part B is summarized in Part C and that it is typed and completed in full. Where health needs are identified the required recommendations should be specific, measurable, attainable, relevant and timely (SMART). The person responsible for ensuring the need is met must be clearly identified. The name, title and contact details of the professional undertaking the assessment and the date it was completed must be provided at the end of Part C. Copies of Part C will be sent to the Local Authority administration team, foster parent, Public Health Practitioner to be filed in the health records for the child/young person and young person where appropriate by the administrator. A full copy of the assessment will be forwarded to the GP.

Appendix 4
RHA Process

Social worker for each CYPiC to forward a completed BAAF Part A form via the local authority Business Support Team three months (and a minimum of 8 weeks) prior to RHA due date, along with a completed social worker summary and a completed SDQ to the CYPiC administrators.

Request is recorded on the CYPiC database and a GP summary and immunisation status will be requested.

An interpreter will also be booked as required as per Trust Policy.

The BAAF form along with any available GP, immunisation, CAMHS summary and SDQ, will be forwarded to the named professional for that child/young person. For the 0-19 Service it will be sent via the Single Point of Access (SPOA) Hub. For requests for children and young people placed over 50 miles from Wolverhampton the request will be forwarded to the Out of Area Team.

RHA's will be requested to be completed within 6 weeks of receipt of the request.

RHA undertaken by:

- Health Visitor,
- School Nurse,
- Partnering Families Nurse
- CYPiC Nurse
- Out of Area Team practitioner

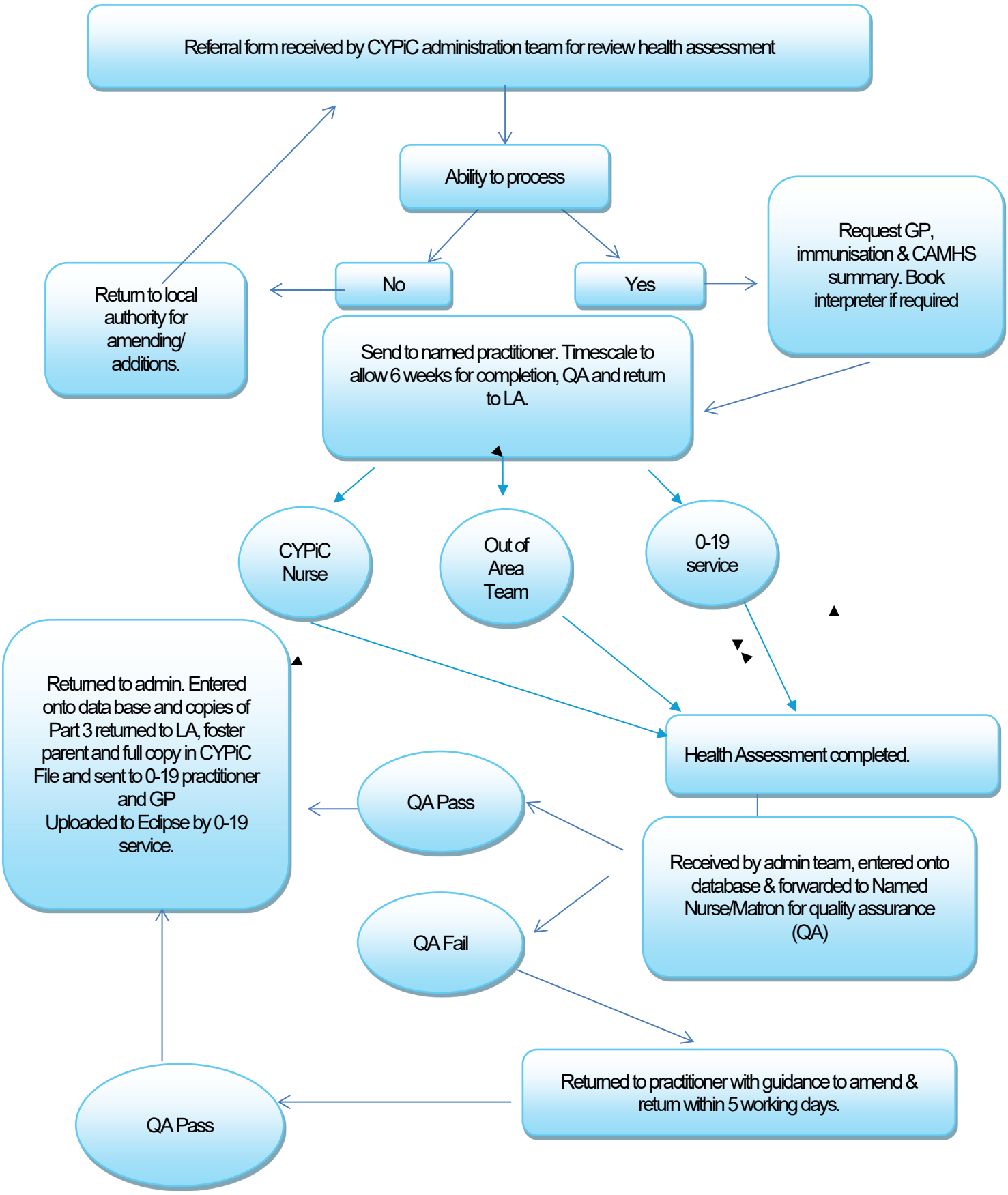
Band 6 school nurses, or above, can undertake a statutory RHA for CYPiC aged 5 –18 years. Band 5 school nurses can undertake RHA for children who are of primary school age.

Health Visitors practising at Band 6 or above can undertake RHA for all pre-school children.

Health information should be reviewed prior to carrying out the RHA using IT systems such as local authority eclipse, health eclipse, care plus, clinical web portal, GP summary and the previous health assessment.

Appendix 4a

Flowchart for Statutory RHA.

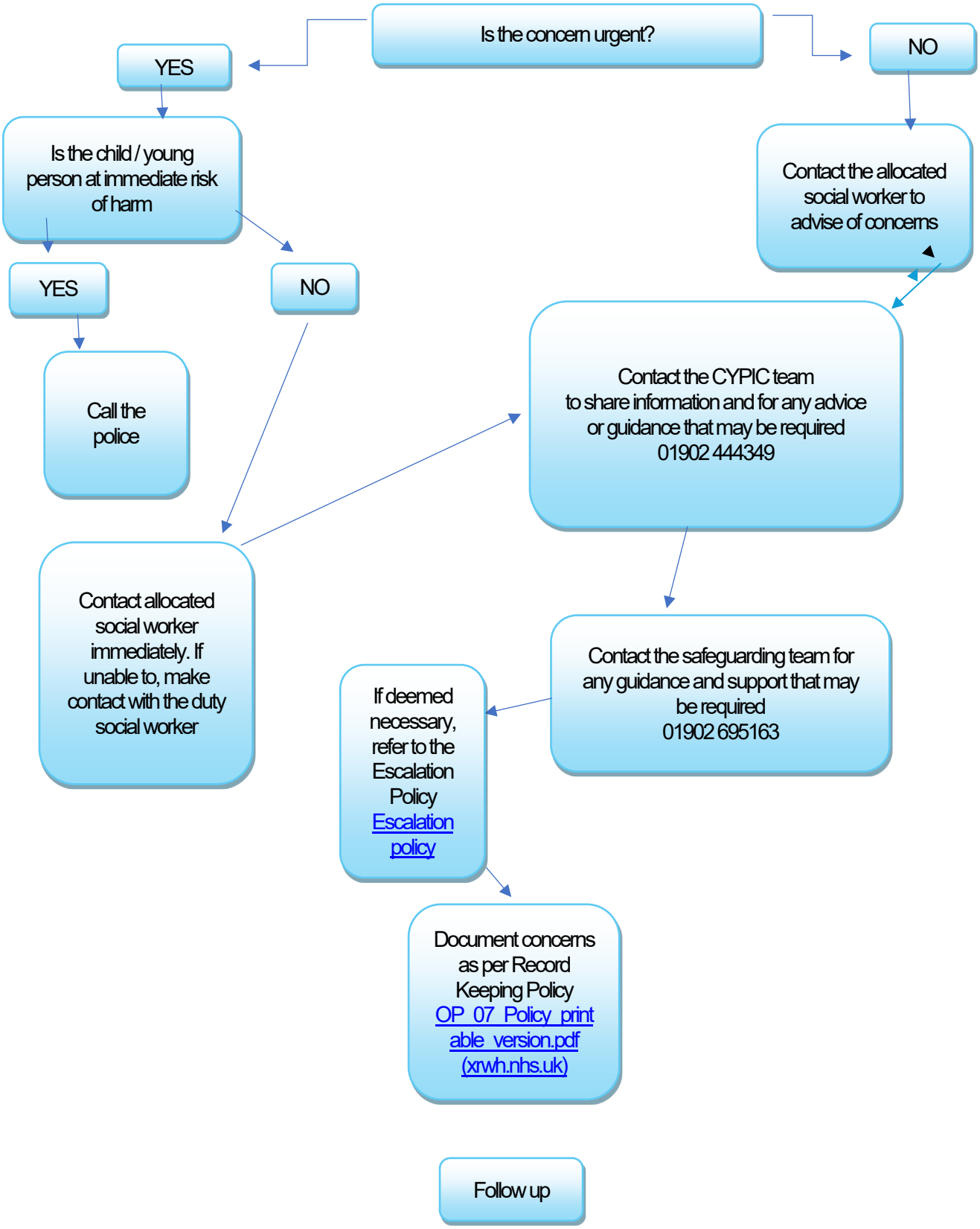


Appendix 4b
RHA Forms

Part A of BAAF form RHA-C/YP	Is completed by the Social Worker and provides basic information on the child, their legal status and placement details. It includes consent to undertake the assessment; assessments will not take place without consent.
Part 2/B (of chosen assessment form)	Is a guide and prompt only; some questions may not be appropriate for the child/young person. If this is the case it should be documented clearly on the form so that all sections are completed. If the named professional identifies other issues that need addressing that are not included on the form, supplementary pages must be added. The Strengths and Difficulties Questionnaire Score (SDQ), for Children in Care aged 4-16 years will be provided by the social worker and discussed with the child/young person and foster parent and integrated into the RHA to ensure that emotional needs are considered and addressed. Any referrals to allied agencies should be offered where appropriate and documented in the appropriate section. The name, title and work base address of the health professional undertaking the RHA and date it was completed must be provided at the end of Part 2/B. **Part 2/B contains personal and possibly sensitive information about the child/young person. It should therefore be retained in the child's health record and treated with the utmost care and respect to confidentiality.**

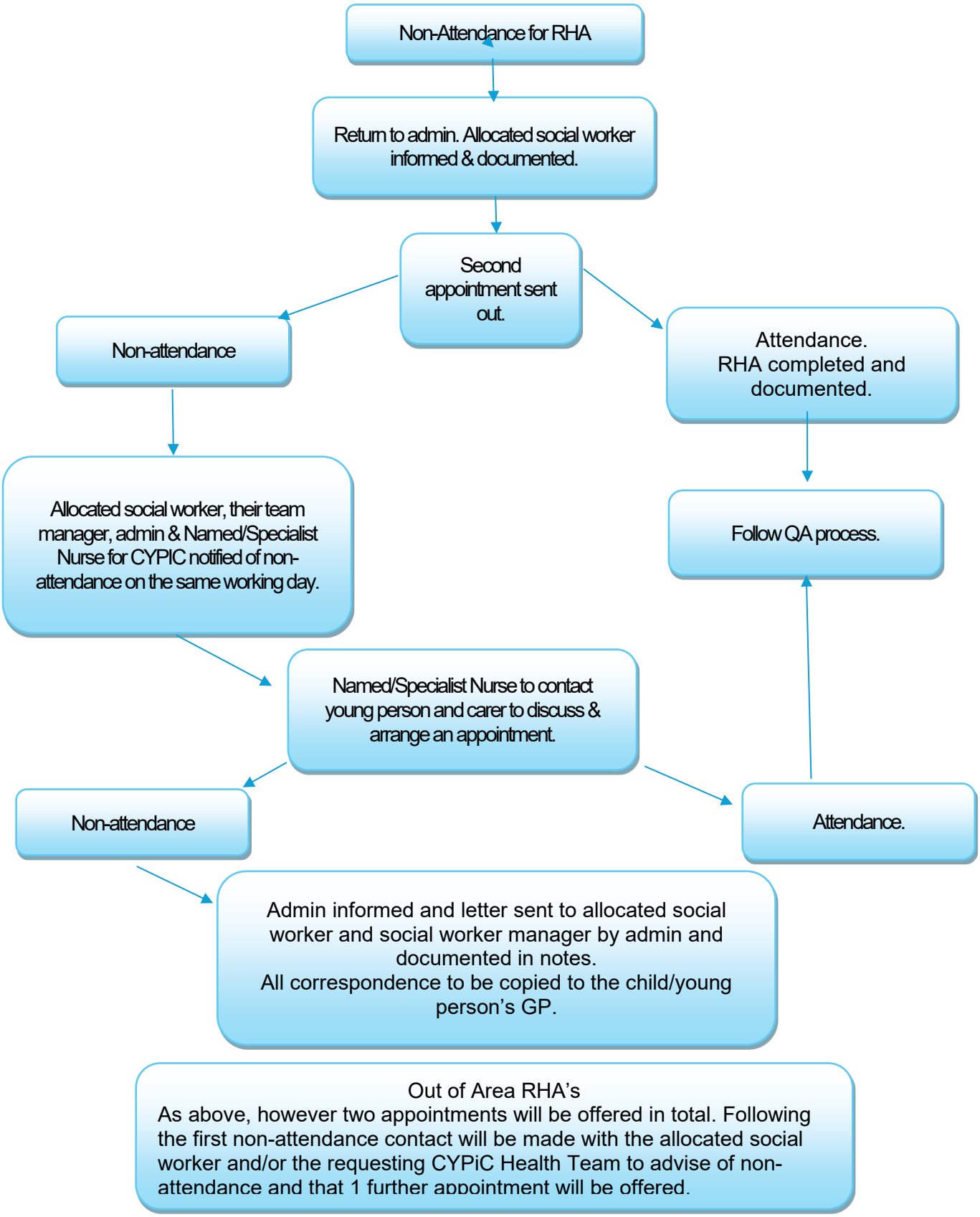
Part 3A & 3B/C	It is the responsibility of the assessing named professional to complete Part 3/C A&B. Part 3/C comprises of a summary report and the health recommendations which forms part of the child/young person's holistic care plan. This is the only information from the assessment forms that is shared with the social worker/foster parent. Ensure that all relevant information from Part 2/B is summarised in Part 3A/C. Part 3A/C should be completed in full, if there are no unmet health needs identified please state ***'no unmet health needs'*** in the plan. **The issues raised in the summary report must be discussed with the young person and great care must be taken to respect confidentiality.** Where health needs are identified the required recommendations should be specific, measurable, attainable, relevant and timely (SMART). The name, title and work base address of the health professional undertaking the RHA, and date it was completed, must be provided at the end of both parts. Copies of Part 3A&B/C will be sent to the Local Authority administration team, young person/ foster parent. A full copy of the assessment will be forwarded to the GP. If the assessment has been completed by a member of the 0-19 service, once quality assured it will be uploaded to Eclipse by the professional undertaking the RHA to the form previously created 'Generic Contact-LAC Medical'. If completed by any other professional a copy will be forwarded to the health practitioner. It is the responsibility of the practitioner carrying out the RHA to follow up referrals to other services and review health actions.

Appendix 5
Do you have a concern regarding a CYPiC



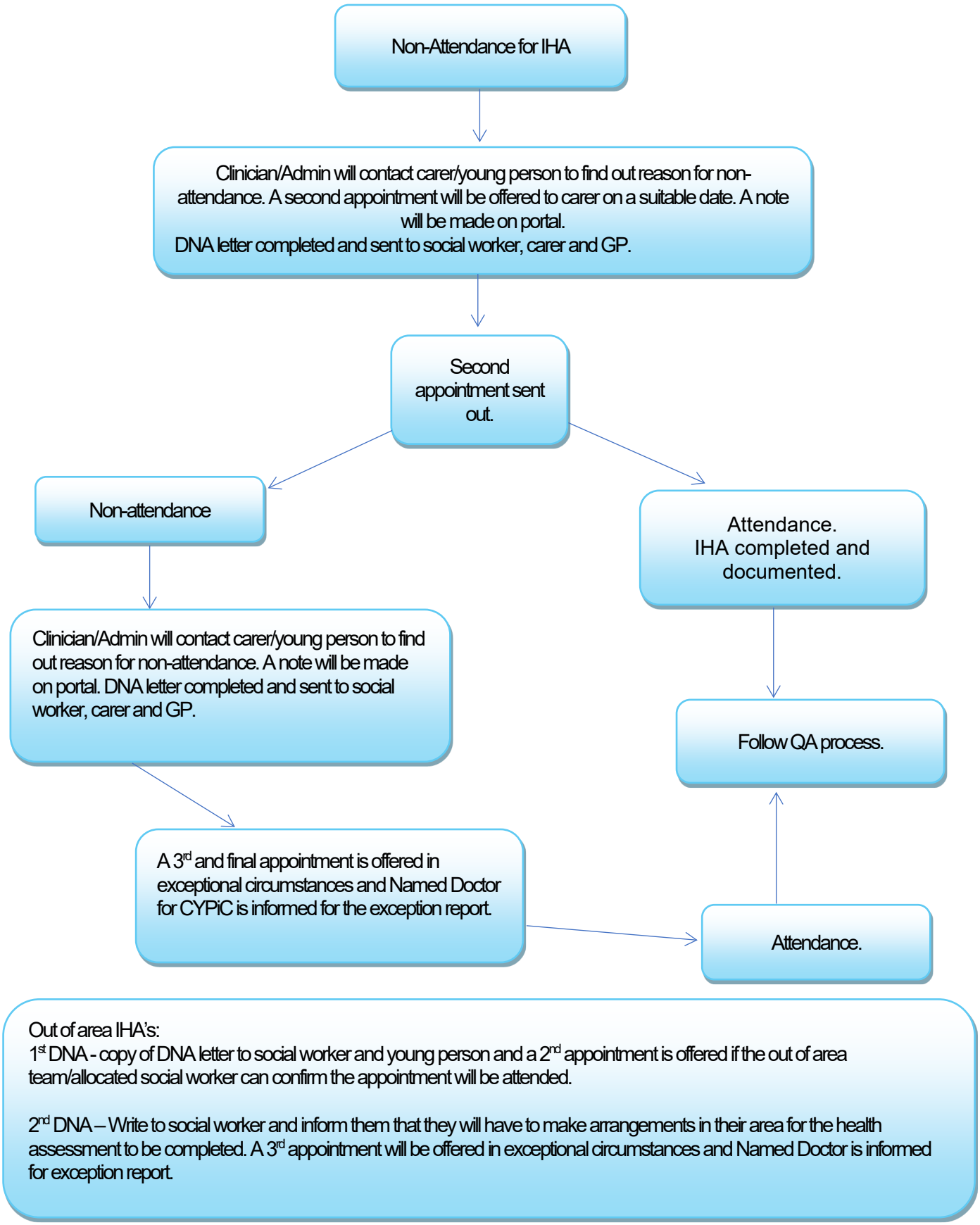
Appendix 6

Child/Young Person Was Not Brought/Not Attended Pathway RHA's



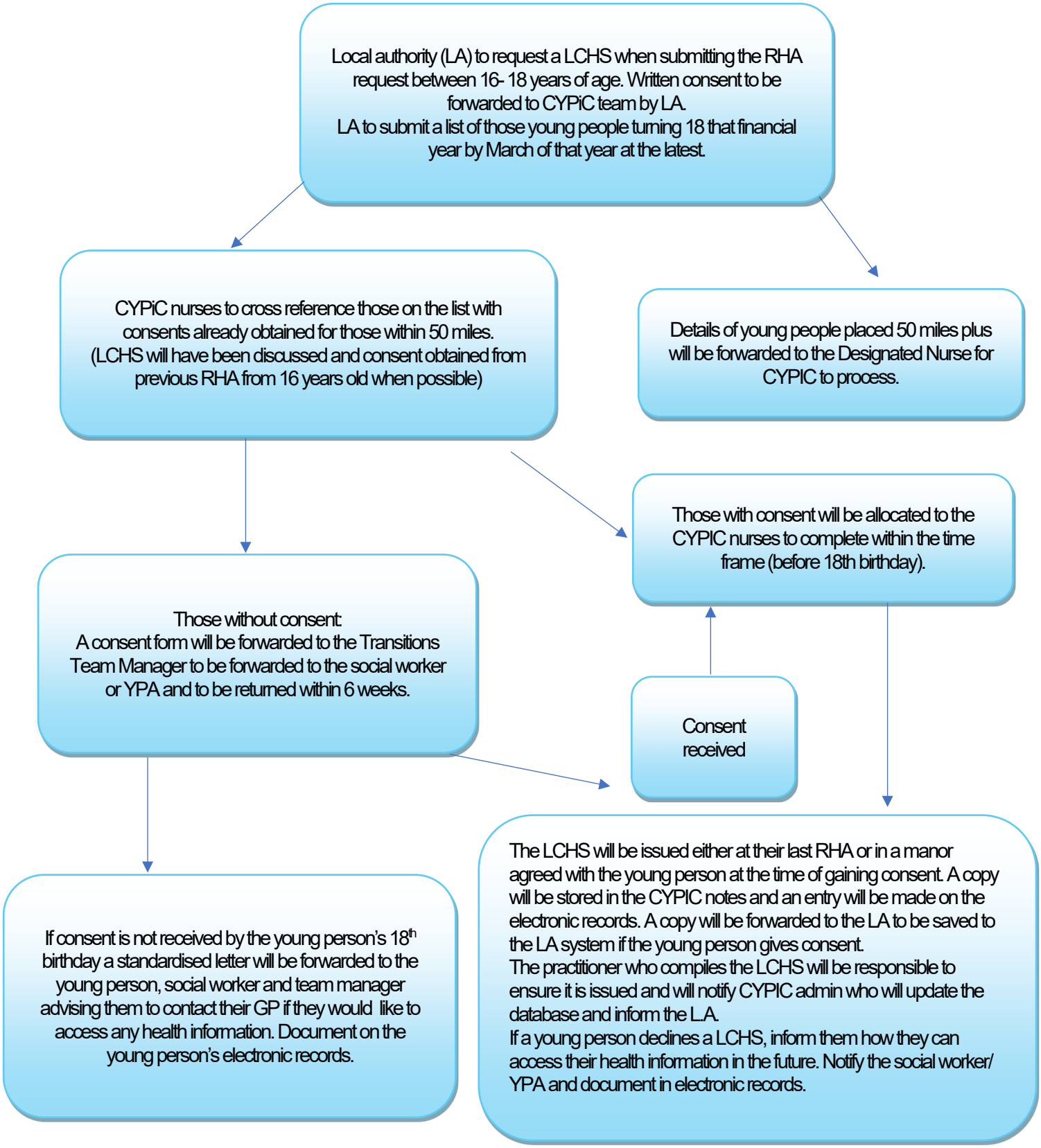
Appendix 6a

Child/Young Person Was Not Brought/Not Attended Pathway IHA's

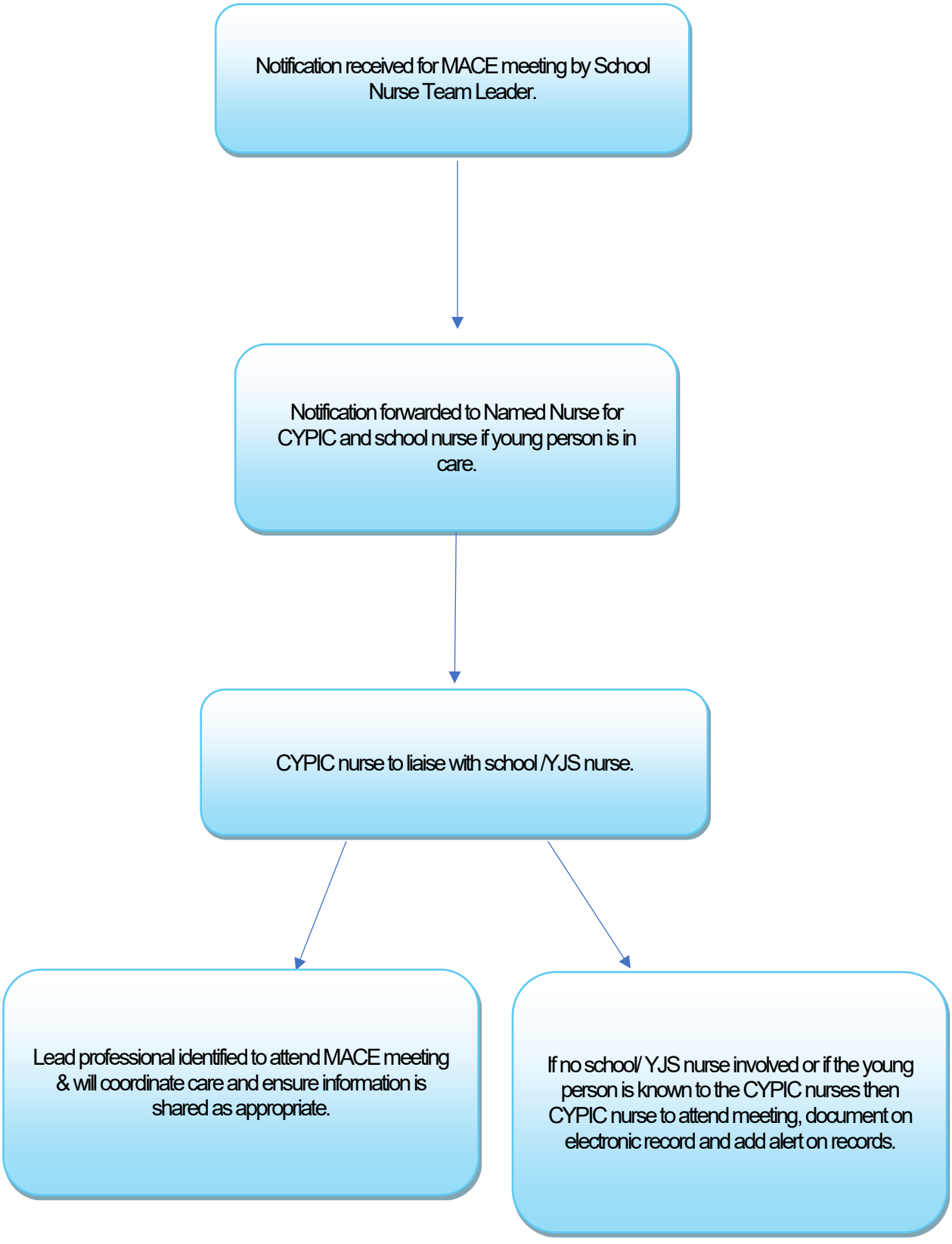


Appendix 7

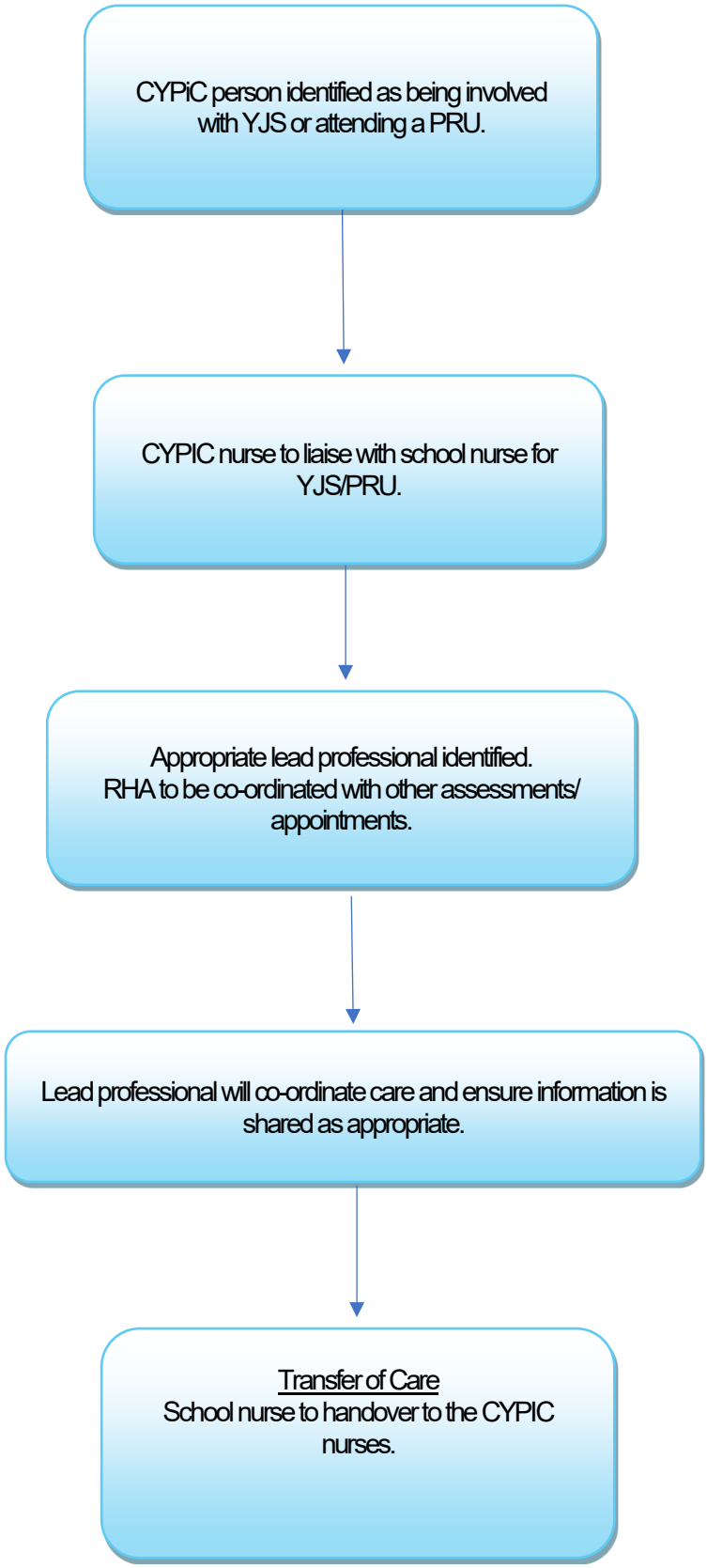
Leaving Care Health Summaries Pathway



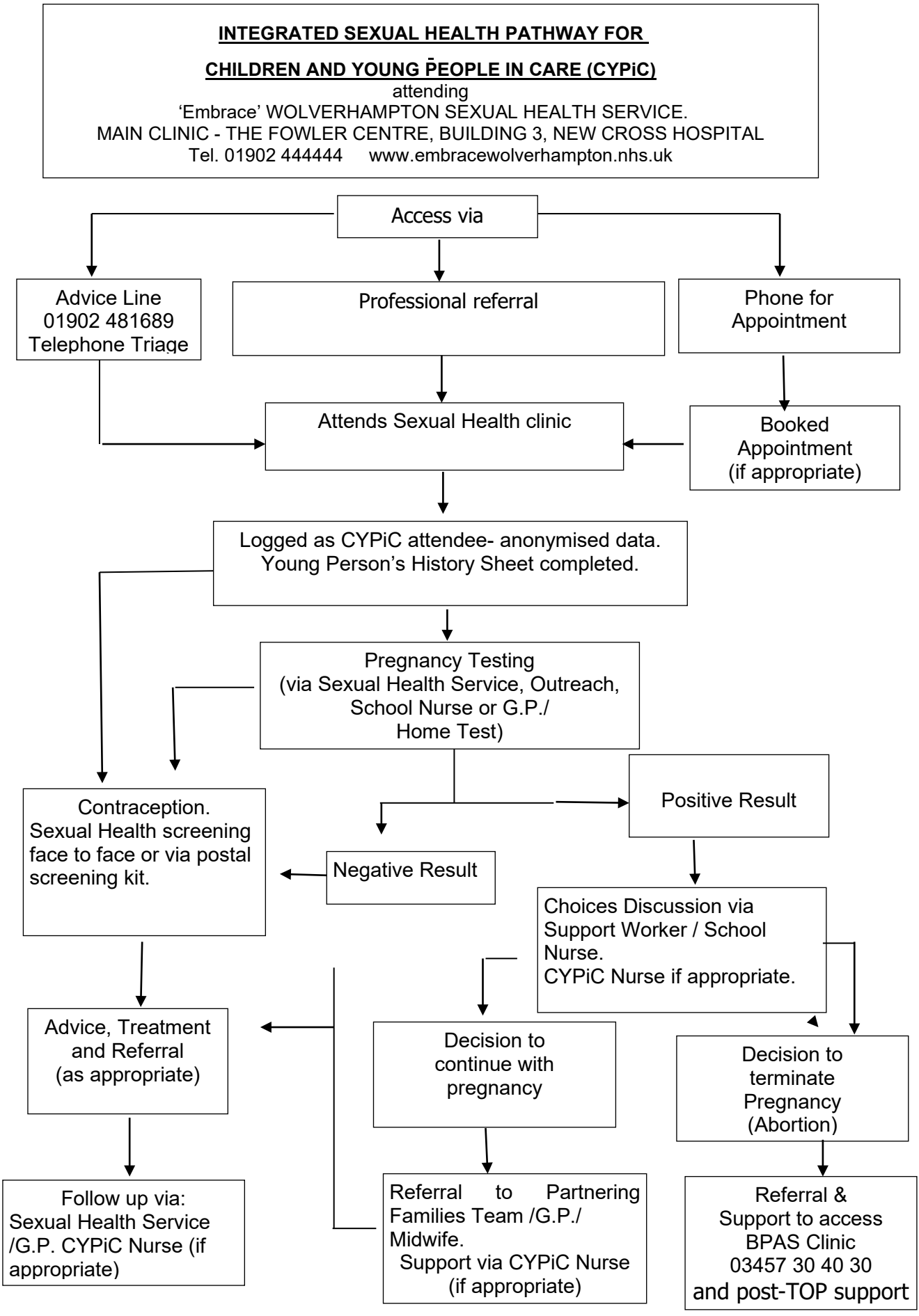
Appendix 8
Children & Young People in Care MACE Pathway



Appendix 9
Children & Young People in Care Youth Justice Service/ Pupil Referral Unit Pathway



Appendix 10: Integrated Sexual Health Pathway for CYPiC



Document Status: Update Sept. 2024	Version number Four	Review Date: Sept. 2027	Author: Victoria McKenzie

Appendix 11: Annex H: Health Assessment for Looked after children checklist tool

Annex H: Health Assessment for Looked after children checklist tool

This should be completed by the health assessor and sent to the **responsible commissioner / designated professional.** The checklist will be reviewed by the **responsible commissioner / designated professional** to support payment against the agreed quality.

For additional guidance on roles, competences of healthcare staff please see: Looked after children, Knowledge, skills and competence of health care staff. Intercollegiate role framework, Published by the Royal College of Nursing and the Royal College of Paediatrics and Child Health - May 2012

http://www.rcpch.ac.uk/system/files/protected/page/RCPCH_RCN_LAC_2012.pdf

Child's Name			
NHS Number			
Date of Health Assessment[168]			
Date of request for Health Assessment			
Assessment completed by: .			
Qualification: Nurse, Midwife, Doctor			
Competent to level 3 of the Intercollegiate Competency Framework	Yes	No	Please delete as appropriate
Section 2			
The Summary Report and Recommendations should be typed and include: • Pre-exisiting health issues • Any newly identified health issues			
• Recommendations with clear time scales and identified responsible person			
• Evidence that referrals to appropriate services have been made.			
• A chronology or medical history including identified risk factors.			
• An up to date Immunisation summary			
• Summary of Child Health Screening			
• Any outstanding Health Appointments			
Section 3			
Child or Young Person's Consent for Assessment (where appropriate)			
Where the Young Person is over 16years written consent has been obtained for release of GP summary records, including immunisations and screening to a third party.			
Evidence that the child or young person was offered the opportunity to be seen alone.			
Evidence that child or young person's concerns/comments have been sought and			

[168] This should be within 28 days of the request.

Appendix 12 Coram Baaf RWT Pathway

Local Authority Admin Team to send Form M & Form B to Maternity Admin Team (of hospital where child is born) within 5 days of child or young person entering care.
rwh-tr.rwhcorambaafs@nhs.net
(Requests should be sent for all children and young people, excluding Unaccompanied Asylum-Seeking Children)

Form M

Wolverhampton child born in Wolverhampton

Form M completed by Safeguarding Midwife. Within 10 working days.

Completed Form returned to referrer courtteamsecure@secure.wolverhampton.gov.uk & Gem Centre rwh-tr.lookedafterchildren@nhs.net

Wolverhampton child born out of area

Local Authority Admin Team to send Form M and B to relevant Maternity Admin Team of local hospital.

Local hospital to return completed forms to Local Authority. courtteamsecure@secure.wolverhampton.gov.uk

Local Authority to send completed Form to Gem Centre rwh-tr.lookedafterchildren@nhs.net

Child looked after by other Local Authority born in Wolverhampton

Placing Local Authority send Form M to Wolverhampton Maternity Admin Team to complete.

Maternity admin team to send completed form to referrer.

Escalation

In the event the forms are not completed within 28 days, please escalate to:
the Matron for Community Midwives, Antenatal Clinic and Foetal Assessment Unit
***Turnaround time could increase to more than 28 days to allow for periods of annual leave.**

CYPIC Health Admin – Inform Medical Advisors when completed Form M and Form B are received to enable completion of relevant IHA and Adoption Medical updates within 14 days.

Form B

Wolverhampton child born in Wolverhampton

Local Authority Admin Team to send Form B to Wolverhampton Maternity Admin Team within 5 days of child or young person entering care.
rwh-tr.rwhcorambaafs@nhs.net
(Requests should be sent for all children and young people, excluding Unaccompanied Asylum Seeking Children)

Neonatal Unit Admission at New Cross Hospital. Maternity admin to send form to Neonatal Unit Neonatal Consultant to complete form within 10 working days.
Any baby that does not require a neonatal unit admission will not need Form B to be completed.
Form B to be returned to Maternity admin.

Completed Form returned to referrer
courtteamsecure@secure.wolverhampton.gov.uk
and Gem Centre
rwh-tr.lookedafterchildren@nhs.net

Wolverhampton Child born out of area

Local Authority Admin Team to send Form B to relevant Maternity Admin Team of local hospital.

Local hospital to return forms to Wolverhampton Local Authority within 10 working days.
courtteamsecure@secure.wolverhampton.gov.uk
Local Authority to forward completed forms to Gem Centre.
rwh-tr.lookedafterchildren@nhs.net

Child looked after by other Local Authority born in Wolverhampton

Placing Local Authority send Form B to Wolverhampton Maternity Admin Team to complete.

Neonatal Unit Admission at New Cross Hospital. Maternity admin to send form to Neonatal Unit Neonatal Consultant to complete form within 10 working days.
Safeguarding Midwife to complete Form B where there is no Neonatal admission.
Form B to be returned to Maternity admin.

Completed Form returned to referrer.

Escalation

In the event the forms are not completed within 28 days, please escalate to:
the Matron for Community Midwives, Antenatal Clinic and Foetal Assessment Unit
***Turnaround time could increase to more than 28 days to allow for periods of annual leave.**