CHILDREN IN CARE (LOOKED AFTER CHILDREN) & CARE LEAVERS POLICY

Policy Type	Clinical
Directorate	Corporate Nursing
Policy Owner	Chief Nurse including Midwifery and Allied Health Professionals
Policy Author	Named Nurse for Looked after Children Children in Care Team
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Approving Body	(insert name of approving committee/group and date of meeting where approved)
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'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
10 Nov 2020	0.1		Chief Nurse including Midwifery and Allied Health Professionals	*New policy draft for consultation and approval*	
				Draft agreed with policy Lead Director	
	0.2			*Amended following consultation*	
				Policy contents agreed at subject specialist meeting	***Safeguarding Looked after Children***
01 Jul 2021	0.2	12/8/21	Chief Nurse including Midwifery and Allied Health Professionals	*For approval and approval*	*Joint Safeguarding steering group*

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1 Executive Summary

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. For example, almost half the children in care have diagnosable mental health disorder and two-thirds have special educational needs. 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 (DOH/DOE March 2015).

This policy applies to all members of staff working within The Isle of Wight NHS Trust who are involved in any aspect of care of Children in Care and Care Leavers (CiC&CLs). In particular it relates to staff working in Paediatrics, the Emergency Department (ED), Walk in Centres, ENT and Orthopaedics. It applies to CiC&CLs in all settings, inpatient and outpatient and given that CiC&CLs includes YP up to the age of 25years it is likely that CiC&CLs will also be seen in Surgery, Medicine, Gynaecology and Maternity. They may also be inpatients on the MAU or be assessed by the Crisis Team.

2 Introduction

Children in Care and Care Leavers from 0-25 years are known to have health inequalities when compared with the non-looked after population (DOH 2015). CiC specifically is also a population for whom there are specific issues regarding consent and communication.

Children in Care (CIC), Looked After Children (LAC) or Children Looked After (CLA) are all terms which refer to Children and Young people in the Care of their Local authority. For the purpose of this document the term Children in Care & Care Leavers (CIC & CLs) will be used.

In England and Wales the term ‘looked after children’ is defined in law under the Children Act 1989. A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by said authority.

Children in Care fall into four main groups:

• Children who are accommodated under voluntary agreement with their parents (section 20)

• Children who are the subject of a care order (section 31) or interim care order (section 38)

• Children who are the subject of emergency orders for their protection (section 44 and 46)

• Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

The term ‘looked after children’ includes unaccompanied asylum seeking children, children in regulated friends and family placements and those children where the agency has authority to place the child for adoption. It does not include children who have been

permanently adopted, subject to a Special Guardianship Order (SGO) or are privately fostered.

Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts; whether of full blood, half blood or marriage/affinity *(*ref. Coram-BAAF -http://corambaaf.org.uk/info/kinship-care-and-special-guardianship*)*

Children and young people in care share many of the same health risks as their peers, often however, to a greater degree. Poor health prior to entering the care system and past experiences of poverty, abuse and neglect can be to blame but too often these greater needs can remain unmet, with many children and young people continuing to experience significant health inequalities. Leaving care does not signify an end to these difficulties and sadly poor health, education and social development may be a lifelong issue.

Research and guidance relating to Children in Care emphasise the importance of assessing their emotional health and Well-Being. Almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. 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 the chances of reaching their potential and leading happy and healthy lives as adults (DOH 2015).

Professionals should work collaboratively with partner agencies to address any health inequalities and promote high quality care to ensure that children and young people achieve their full potential. Partner agencies as Corporate Parents need to have high aspirations for these children and young people.

3 Definitions

3.1 Children in Care and Care Leavers (LAC/CLs):

Children in Care: Those children and young people who are subject to a legal order by which the local authority has gained shared parental responsibility (e.g. Interim care order, full care order ,placement order) or who have been voluntarily accommodated by the local authority under section 20 of the Children Act (2002).
Care Leavers: **"Any adult who spent time in care as a child** (i.e. under the age of 18). Such care could be in foster care, residential care (mainly children's homes), or other arrangements outside the immediate or extended family.

3.2 Parental responsibility:

Parental responsibility is defined in Section 3(1) 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". Whilst the law does not define the details of parental responsibility a key role is agreeing to the child's medical treatment. **(Appendix 3)**

3.3 Corporate Parenting:

Corporate Parenting refers to the duty and responsibility held by the local authority to collectively act as good parents in the best interests of the Looked After Child and Care Leaver. The Corporate Parenting role extends from strategic commissioning at senior levels to the actions of all local authority workers and workers in the local authority's partner agencies (health, education, housing, police etc).

4 Scope

This policy applies to all members of staff working within The Isle of Wight NHS Trust who are involved in any aspect of care of children in care and care leavers (CiC&CLs). In particular it relates to staff working in Paediatrics, the Emergency Department (ED), Walk in Centres, ENT and Orthopaedics. It applies to CiC&CLs in all settings, inpatient and outpatient and given that CiC&CLs includes YP up to the age of 25years it is likely that CiC&CLs will also be seen in Surgery, Medicine, Gynaecology and Maternity. They may also be inpatients on the MAU or be assessed by the Crisis Team.

As these are Isle of Wight CiC&CLs there is an expectation that this policy is applicable to providers of secondary/tertiary services to whom CiC&CLs are referred by staff working within The Isle of Wight NHS Trust. This can be achieved by identifying them in referrals as CiC/CLs and copying the referral to the CiC health team and the social worker.

There are many children residing on the Isle of Wight with foster carers or in independent agency placements who are the responsibility of other Local Authorities (Out of Borough placements). These children under national health commissioning arrangements will access health services from The Isle of Wight NHS Trust. If these children are identified the general principles of this policy apply and the Isle of Wight CiC Health Team can help to identify the originating local authority and those with parental responsibility. They will also assist in disseminating information as appropriate.

5 Purpose

5.1 To provide a system for identification of CiC&CLs through The Isle of Wight NHS Trust

5.2 To explain who may be able to provide valid consent for a CiC requiring clinical care and how to seek consent if required.

5.3 To ensure that information is distributed appropriately while maintaining the young person's confidentiality and safety.

5.4 To provide guidance on professional involvement with CiC/CLs and the standards of care required

6 Roles and Responsibilities

The Chief Executive has ultimate responsibility for governance; including ensuring processes are in place to support the implementation of policies which instruct practice.

The Trust Board has overall responsibility for ensuring that the organisation complies with all legal, statutory and good practice requirements by the provision of up to date, evidence based policies.

Human Resources Team will provide guidance and support to managers who have staff experiencing DA, either as victim or perpetrator

Line Managers/Service Leads must familiarise themselves with this Policy and supporting procedures, and ensure that the contents of the documents are brought to the attention of employees under their supervision.

Designated Doctor CiC

To be the operational lead within the trust for CiC

To attend/Chair CiC Health meetings, Corporate Parenting Board alongside the Designated Nurse for CiC, to ensure that developments relevant to the Trust care of CiC are fed into the Safeguarding Operational Group (SOG) and Joint Safeguarding Strategy Group (JSSG)

To be accessible to frontline staff for advice and guidance

To develop and update policies and procedures for corporate parenting of CiC

To be the central point of contact within the trust for all medical CiC enquiries

To maintain close liaison with the named Professionals for Safeguarding to ensure CiC receive the same protection from abuse and neglect and to highlight the vulnerabilities of CiC leaving care to the adult safeguarding Team.

Associate Directors, Service line Managers, Senior Nurses, Ward and Department Managers

- To adhere to and implement the CiC & CLs policy ensuring that staff are able to identify CiC/CLs appropriately and recognise their vulnerabilities
- To ensure that the CiC Health team are contacted for advice or receive notification of a child attending their department for health care
- To ensure that appropriate consent is sought for any clinical procedure undertaken
- To ensure that staff are aware of the need to check with the carer or Social worker who has parental responsibility and whether the child's placement is protected. If so to ensure that under no circumstances should the carers address be revealed to family members. Advice should be sought before notifying family of a child's attendance at the hospital.
- To warn staff that CiC even given their status in care remain more vulnerable to abuse and neglect and if concerns are identified Safeguarding procedures should be followed.

Paediatric and nursing staff/ Staff in acute settings

- Should maintain their skills in the recognition of abuse and neglect and be familiar with the reasons why some of these children may be admitted into the care of the local authority
- Be able to clearly identify those children who are CiC by means of sensitive questioning of the parent, carer or child.
- Be able to identify the particular vulnerabilities of this group of young people and ensure they receive appropriate care.
- Seek training to ensure they have a basic knowledge of key issues which may impact on how a looked after child /CL may present in the health care setting e.g. attachment difficulties, FASD, history of abuse.
- Document as part of their assessment "the voice of the child" which may be missing in these circumstances and may reflect the child's feelings regarding their current situation
- Ensure all information relating to consent and confidentiality is gathered and that there is a balance between the services need to protect the YP in care and their need for confidentiality.
- Inform the child's social worker and the CiC health team of the child's attendance although the carer will usually inform the social worker if the child is in foster care

All Staff

- To follow this policy and attend mandatory training where the vulnerabilities of this group of children will be highlighted

- To identify to their manager if they become aware of a CiC/CLs to ensure that appropriate actions are taken.
- To maintain the child and carers confidentiality by only informing those who need to know to ensure safe practice is followed within the trust

Records department

- To assist CiC health team in identifying and labelling records of children in long term foster care thus avoiding the records being archived
- To ensure processes are followed to protect carers addresses when records are copied for legal proceedings
- To establish new sets of records for children when adoption orders are made and the child continues to reside in borough under a new name and with a new NHS number. This will be done following liaison with the adoption agency on the Isle of Wight NHS Trust Hospital system PARIS, once a CiC turns 18 they automatically have a CLs alert put on to acknowledge they may need additional support. This alert is actioned by the administrator within the CiC Health Team.

7 Policy detail/Course of Action

7.1 Health needs of Children in Care and Care Leavers

Nationally and locally it is known that children and young people who are looked after by the local authority have more health needs and worse health and wellbeing outcomes than their non-looked after peers(DOH 2015) Reviews of the health issues identified at the point of coming into care on the Isle of Wight showed that poor dental hygiene, incomplete immunisations, lack of a permanent general practitioner, concern about emotional wellbeing and problems with vision and hearing were commonly highlighted (Health Assessments 2016-2019).

When CiC present to health services they may do so with incomplete information about their own personal health history. When any practitioner is involved in assessing the health of a CiC they should try to do so with an awareness of this background population profile of increased health needs and knowledge that there may be missing information which could have relevance to the presenting problem.

All Children looked after by the Isle of Wight are required to have an Initial health assessment (IHA) carried out by the Designated Dr/CiC Health Team within a month of coming into care. This cannot be carried out until the local Authority social worker has obtained consent to carry out the health assessment and shared the information on a need to know basis. The assessment is then documented on an IHA form which is filed within the clinical records section of the hospital notes. A summary of the assessment and the child's health care plan is typed and filed in the correspondence section. Review health assessments (RHA) are completed by CiC nurses within the CiC & CLs Health Team.

The child's health care plan on the final page of these forms identifies key professionals involved in the child's care.

Children under 5 years of age have six monthly reviews of their health and those over 5 years of age have annual reviews. The health care plan is updated at each review and its accuracy depends on the CiC health team being informed of changing health needs by all those involved in providing health care to the child.

It has been identified nationally that 70% of CiC & CLs have emotional or mental health needs which may impact on their presentation within the health setting. This should be a key consideration in all clinical contacts and liaison with the health team may assist staff in identifying whether mental health services are involved and what pathways of care can be accessed. CiC are considered a priority group in CYPS services as are adopted children and adolescents.

Identification of the CiC/CL in the health care setting is key to ensuring that their health needs are addressed whilst paying careful attention to confidentiality; that valid consent (for CiC) is sought and that information is shared appropriately and safely with those who hold parental responsibility and are in a position to ensure actions are undertaken of settings. The following sections also highlight particular aspects of continuing care that arise in different departments.

7.2 Emergency Department (ED)

CiC&CLs presenting to the ED should have their status identified by the triage nurse making an initial assessment of their condition **(see Appendix 1).** At present the ED admission documentation allows for recording the identification of CiC. Please note that young people in particular do not always like to be asked directly if they are “in care” or “looked after” and if they have been in long term foster care for a number of years they may not consider themselves as such and may see their long term foster carers as parents. If the sections “accompanied by”, “Next of Kin” and “Relationship” are completed correctly by the reception staff the replies should identify those patients who are looked after and this should enable the triage nurse to sensitively seek further information to establish who holds parental responsibility. This should then be highlighted on the admission sheet and the information handed on to the doctor making the initial assessment of the child or young person.

A CiC in who there are safeguarding concerns referred by social services are usually seen on arrangement with the consultant paediatrician on call in the paediatric outpatients. However on occasions children may be sent directly up to the children’s ward, 16years may be assessed by Emergency care staff at the request of the Police and their CiC status and the safeguarding concerns subsequently identified.. As part of the discussions with social workers they may indicate that the child/YP is going into care. Thereafter guidance within this policy should be followed. It is essential that the Designated Doctor for CiC is copied into the Safeguarding assessment report to avoid duplication of medical assessments when arranging the IHA..

It is important to recognise that even when looked after, children may have contact with their birth family and may fall ill and have accidents in their care and be brought to hospital by them. It is essential that the foster carers are informed of any incidents that occur. Their addresses may be protected and not known to the family. The health team can ensure that appropriate information is shared with those who need to know. On the electronic record of attendance and discharge from ED there is provision for highlighting the CiC health status. Copying in the CiC health team will enable the appropriate social worker to be informed and ensure the health care plan is updated and acted upon. On occasions after attendance at the ED the child may move placement..

Notification of the team in these circumstances is essential. The team also use these reports to monitor training needs of both professionals and Foster carers and to ensure children, YP and carers receive health promotion advice.

7.3 Out Patient departments (Paediatric, ENT, Orthopaedic, Gynaecology, Maternity, Adult medical and surgical etc.)

CiC&CLs seen in any out patients setting should have their looked-after/care leaver status identified by the doctor seeing them in clinic and this should be recorded in the notes **(see Appendix 1).** Often if the child is an Isle of Wight child this is flagged by the CiC administrator within the CiC Health Team. Ideally there should be reference to their status in the referral letter and if a child is accompanied, the status of the accompanying adult should routinely be sought and documented. Foster carers are advised to identify themselves as such when attending health appointments. Alternatively the doctor/health worker may see IHA/ RHA forms in the correspondence section and make sensitive enquiries.

As YP may be "looked after" up to the age of 18 they may well be seen in adult Clinics, care leavers maintain their care leaver status up until the age of 25. Particular care needs to be given to consent and confidentiality issues for CiC whilst recognising their additional vulnerability. They have the right to be seen alone without the foster carer present and indeed may not want any aspect of their care shared with the carer or social worker and this should be recorded along with the professionals assessment as to whether the YP has the capacity to consent or whether it is safe to withhold information from the carer. Those with parental responsibility for the child may not be present in clinic.

In certain circumstances where a looked after child is already well known and under follow up by a paediatrician, that doctor may be asked to complete the initial health assessment or one of the Specialist CiC nurses who complete the review health assessments (above 5 years of age, under 5s are completed by the child's HV). It is essential that these are completed within timescales and that the quality of the assessment and health care planning meets agreed standards. This request will be made by the CiC health team and aims to both reduce duplication of medicals and professionals involved in the child's care and ensure continuity of care.

In the case of "was not brought" appointments CiC should be treated as those in other special circumstances and should not be discharged automatically. Contact with the health team will establish whether there has been a change of placement or whether the child has returned home. In the latter circumstances the risks that brought the child into care in the first instance may be recurring and every effort should be made to ensure the child's health needs are being met

7.4 Inpatients (Paediatric short stay unit, MAU, surgical unit)

CiC admitted to the Paediatric unit should have had their status identified and recorded by the admitting nurse making an initial assessment of their condition. It is important that a CiC should have a detailed social and family history recorded. The initial health assessment in the records is a valuable source of information on the child (immunisations, past medical history) which the foster carer may not be as familiar with especially if the child has changed placement since the initial health assessment.

Given that the local authority has a responsibility as Corporate Parents to CiC up to the age of 18 (and above in certain special circumstances) it is anticipated that some CiC will be admitted to adult wards or MAU. The possibility of a young person being looked-after should be considered and clarified through specific questioning whenever they present to a hospital inpatient setting. Their status should be clearly recorded as it has implications for the carers' ability to consent for treatment.. The carer can provide the social workers name and should be aware who holds parental responsibility and whether they have delegated authority. The

health team may hold information which enables an assessment of the YP's capacity.. Often these YP will require consideration as vulnerable adults under the appropriate safeguarding policies.

Day case surgery. If children are to have surgical procedures these should be planned in advance as the consent issues may be complex and there may be no one present on the day who can give consent. For children in the full care of the local authority or where parents cannot be contacted a senior manager in Children Social Care services will be required to sign consent.

7.5 Maternity Services (including SCBU)

Children in Care and Care Leavers may be seen in maternity services either as a mother in receipt of maternity care or as a new-born infant. It would be anticipated that a mother who is looked after would have been identified as such by her community midwife prior to delivery in hospital and that this information would be recorded clearly in the mothers hand-held maternity records. This information should be checked for by the midwife caring for any young woman under the age of 18 **(see Appendix 1).** The maternity records should document clearly who can accompany the YP and who should be contacted in the event of the birth.

Infants may be born who are subject to an ante-natal child protection plan which indicates that they will be voluntarily be accommodated under Section 20 of the Children Act or made subject to a legal order in the immediate post-natal period.. These infants are already identified by the current Safeguarding alert system and the details of the post-natal safeguarding plan will be in the obstetric record and in the alert folder held within SCUBU as well as help within the electronic safeguarding file. It is essential that the foster carer's addresses are not disclosed as these are often high risk cases. Follow up from SCBU for these babies can be provided by the CiC Designated doctor with the agreement of the acute Paediatrician. Specific directions for follow up and a copy of the discharge letter should be forwarded to the team. Every effort should be made to avoid duplication of appointments as this may place the baby at increased risk.

Occasionally babies may be placed with carers who are specifically assessed as Foster to adopt carers if the plan for adoption is relatively secure. In these situations safety of the placement is paramount.

7.6 Records Department

A significant number of children on the Isle of Wight are in long-term foster care. It is important that these children's records are not archived to avoid further loss of past health information for the child. If there is a change of placement the new foster carer may have difficulty providing past health histories. If and when the child or young person leaves care they may themselves have limited information on their past health history and it is therefore helpful to have files reflecting their full past medical history. Records of these children/YP in long term foster care should be labelled "DO NOT ARCHIVE".

The CiC health team hold electronic files on all looked-after children including information from mental health providers and community services. They can on request and within the restrictions posed by confidentiality provide information that may be missing from hospital records.

When a child is placed for adoption the child's birth name should be used in all correspondence and in clinics. When the child is formally adopted the NHS number changes and the new name applies. To date if the placement is not considered to be "at risk" the old records are retained and used for those children placed on the Isle of Wight. If it is considered to be a risky placement ie one where birth family may seek to find out where the child is placed a new set of hospital records should be made up The old records are archived and a clear link should be maintained through the hospital number.. An anonymised report summarising past medical history is prepared and placed in the new record and further detailed past health information can be obtained on a need to know basis the CiC health team.

Every effort should be made to avoid the child's old name, new name, new address and adopters names appearing in the same set of hospital records especially if the placement is considered high risk. The previous address is identified as the Local Authority adoption Team.

When a child is placed for adoption in another district and is not going to use services provided by the Isle of Wight NHS Trust hospital records should be archived as soon as the adoption order is made. Prior to the order being made the child remains looked after and the health team continue to be responsible for ensuring the child's health needs are addressed. The address on the records in the interim period will be the LA adoption team. No correspondence in the records should carry the adopter's names or address. The Adopters address should not be visible while the child is known by the birth name and carries the original NHS number.

7.7 Consent issues for Children in Care and Young People

When seeking consent for a CiC it is important to both consider general principles regarding consent in children and young people (see GMC Guidance 0-18 years) and also the special circumstance of being looked-after and how this and any legal orders pertaining to the child or young person may affect who can give valid consent on their behalf (See **Appendix 2).**

Firstly, remember that you can provide emergency treatment **without** consent to save a young person's life or to prevent a serious deterioration to their health.

Secondly, remember that a child or young person may have the capacity to consent for themselves and that this should always be considered and assessed when seeking consent. In general it can be assumed that a young person over the age of 16 can consent for themselves. If you are concerned about the capacity of a young person over the age of 16 then refer to the Mental Capacity Act 2005 and The Isle of Wight NHS Trust Policy (Consent to Examination or Treatment policy).

If a child or young person aged 16 or under does not have capacity to consent to treatment then consent should be sought from an individual with parental responsibility for the child or young person. For a CiC this may (but not necessarily) be the child's birth mother, birth father, local authority or another individual who holds a relevant legal order. **(Appendix 2)**

If in doubt about who can give consent for a CiC then contact their social worker during office hours or the Emergency Duty Social Worker outside of this time for further advice. If doubt remains or there is a difference in views between individuals who hold parental responsibility then discuss with a senior colleague and consider seeking legal advice.

It is the duty of social workers on admission of a child into care to obtain consent for statutory health assessments, routine screenings and immunisations. The CiC health team holds copies of these signed consents and can advise whether the consent covers the

proposed treatment. In addition certain aspects of care may be covered by the carers delegated responsibility.

Information is often requested on the child or young person's neonatal and early health history, or the birth parents health including obstetric health. Under certain orders social services can give qualified consent for the release of the child's information **(Appendix 2)** but cannot give consent for disclosure of parental health information or indeed for the child to be tested for conditions which will reveal maternal health i.e. Blood borne virus testing and genetic testing. If this is clinically indicated for the child these tests can be undertaken but if the information is required for permanency planning consent from the courts would be required prior to testing to establish the balance of need for the information. If there are safeguarding concerns then this too may justify information sharing but legal advice should be sought if information sharing reveals confidential health information of the mother e.g. for adoption purposes.

7.8 Confidentiality and Information Sharing: CiC

Children in Care have the same right to confidentiality as any other child or young person of the same age and capacity although this right should be set against the background of vulnerability and health-inequalities that persist for this population. Evidence indicates that accurate and up to date personal health information has significant implications for the immediate and future well-being 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 or inaccurate record keeping can lead to wrong decisions by professionals and adversely affect the child or young person.

In general, it is important for information to be shared with those involved with a child's direct care and those with parental responsibility, however there may be circumstances where information sharing is not appropriate It would be anticipated that, for CIC (12 years and younger), information regarding health should be shared with all relevant parties unless there is a clear risk of significant harm to the child if this were to happen e.g. revealing a foster carers address to parents who may pose a risk to the placement.

CIC aged 13 years and older may seek health services independently and may wish this to remain confidential, or for some of the information regarding a particular aspect of their care to remain confidential e.g. sexually transmitted infection screening or emergency contraception. It can be useful to have a discussion regarding confidentiality and its limits with a young person at the start of any consultation. In considering if information should be shared it is important to have a discussion with the young person to determine whether there would be a significant risk of harm to them or a third party if information was shared or not.

If it is judged that information needs to be shared against the child's consent then this should be done so having first explained why this is necessary; this discussion should be carefully recorded.

It may not be necessary to share all information with everyone involved in the care of a child or young person. Limited information sharing should be considered carefully but may be appropriate in some circumstances

The completion of health assessments requires the engagement and cooperation of the individual child however, should this not be forthcoming, it is the responsibility of the assessing health practitioner to consider how effective care planning will be in the absence

of crucial health information *Refer to the 'Guide to BAAF - Review Health Assessments for Children in Care' (appendix 2)*

8 Consultation

This policy will be disseminated for consultation in line with the organisations Procedural Document Control Policy.

9 raining

Evidence suggests that the experiences and needs of children in care and young people are not well understood by all professionals who come into contact with them.

Specific training on the needs of children in care, identification and confidentiality and information sharing is covered by the CiC Health Team through Level 2 training workshops, and Level 3 training package through the IOW LSCP. Safeguarding Children training (L3) further provides an awareness of CiC and their vulnerabilities all of which is mandatory training for all staff in roles that have the associated responsibilities outlined in this policy.

The Intercollegiate Role Framework document: Looked after children: Knowledge, Skills and competencies of health care staff (March 2015) highlights the training needs of different staff groups.

10 Monitoring Compliance and Effectiveness

Compliance to this policy will be monitored via the following routes:

Compliance with this Policy will be monitored both internally via the Joint Safeguarding Strategic Group and externally via the IOW Local Safeguarding Children Partnership (LSCP).

IOW NHS Trust
Compliance with Looked after Children processes across secondary care services that deliver daily care to Looked after Children and Care Leavers will be monitored daily by the Looked after Childrens Team ensuring processes and expectations are met.

Quarterly Looked after Children reports, including performance data, will be submitted to the Joint Safeguarding Strategic Group to include any identified gaps and actions required to address these.

All internal audit outcomes will be reported to the Joint Safeguarding Steering Group with an action plan against any identified actions. Members of the Joint Safeguarding Steering Group will represent their specific areas for any actions required.

A quarterly Looked after Childrens summary report will be submitted to the Director of Nursing (Head of Safeguarding).

The Trust Board will receive an annual Looked after Children report.

11 Links to other Organisational Documents

IOWNHST Safeguarding Policies

Guidelines for the completion of IHA's and RHA's. (Paediatric Guidelines)

12 References

Promoting the health and well-being of looked-after children. Department of Health and Department of Education (2015)

Information sharing guidance for practitioners and managers-HM Government 2008

Children's Act 1989: Guidance and regulations. Volume 2 Care planning, placement and case review HM Government 2010

Looked after children: Knowledge, skills and competences of health care staff. INTERCOLLEGIATE ROLE FRAMEWORK 2020

"Who Pays" Determining responsibility of payment to providers. NHS England 2013

Health and Social Care Act 2012 The Stationary Office

13 Appendices

Appendix 1

CiC may be sensitive about their status. Some CiC will have been in placement for a long-time and will view their foster carers as parents whilst others will be in foster care placements with extended family members therefore questions have to be both sensitive to the situation but specific enough to identify those who are Looked After.

It is suggested that CiC could be identified by ensuring that the relationship between a child/young person and any accompanying adult is clarified as well as asking the screening questions

"Is there a social worker involved with X or their/your family?"

"Is X in the care of the local authority at all?"

"Is X subject to any legal orders that you know of?"

Appendix 2

Children and young people -

People aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances.

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

Otherwise, someone with parental responsibility can consent for them.
This could be:

- the child's mother or father
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

Parental responsibility

A person with parental responsibility must have the capacity to give consent.

If a parent refuses to give consent to a particular treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.

By law, healthcare professionals only need 1 person with parental responsibility to give consent for them to provide treatment.

In cases where 1 parent disagrees with the treatment, doctors are often unwilling to go against their wishes and will try to gain agreement.

If agreement about a particular treatment or what's in the child's best interests cannot be reached, the courts can make a decision.

In an emergency, where treatment is vital and waiting for parental consent would place the child at risk, treatment can proceed without consent.

When consent can be overruled

If a young person refuses treatment, which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection.

This is the legal body that oversees the operation of the Mental Capacity Act (2005).

The parents of a young person who has refused treatment may consent for them, but it's usually thought best to go through the courts in this situation.

Appendix 3

Parental Responsibility

A mother automatically has parental responsibility for her child from birth.
In England and Wales a father has parental responsibility if he:

- is married to the mother at the time of the birth
- has jointly adopted a child
- has jointly registered the birth of the child with the mother from 1 December 2003)

- has a parental responsibility agreement with the mother
- has a parental responsibility order, made by a court

The law regarding parental responsibility for fathers is slightly different for children who were born in Northern Ireland or Scotland.

If a child is born overseas and then comes to live in the UK, the parental responsibility rules apply for the UK country in which they live.

Legal Orders

If the child or young person is subject to a

- Care Order then the relevant local authority gains shared parental responsibility (Section 33 Children Act 1989).

- Residence Order/Child Arrangement Order (2014) then the person who the order is granted to gains shared parental responsibility (Section 12 Children Act 1989).

- Special Guardianship order then the special guardian gains shared parental responsibility (Section 14 Children Act 1989).

- Placement order and is placed with prospective adoptive parents then the prospective adoptive parents gain shared parental responsibility (Section 21 Adoption and Children Act 2002) though the degree to which parental responsibility is gained can be varied.

- Adoption Order then the adoptive parents gain parental responsibility and the parental responsibility which any person other than the adopters or adopter has for the adopted child immediately before the making of the order is extinguished (Section 46 Adoption and Children Act 2002).

If the child or young person is **accommodated** by the local authority the local authority do not gain parental responsibility; who holds parental responsibility remains unchanged (Section 20 Children Act 2002).

Delegated Responsibility

People without parental responsibility, but who have care of a child, may do what is reasonable in all the circumstances of the case to safeguard or promote the child's welfare. This may include step-parents, grandparents and foster carers. In some circumstances responsibility can be delegated to them by Social Services or the parents. You can rely on their consent if they are authorised by the parents or local authority.

However you should endeavour to make sure that their decisions are in line with those of the parents, particularly in relation to contentious or important decisions.

It is usually sufficient to have consent from one individual with parental responsibility. If parents cannot agree and disputes cannot be resolved informally, or if the best interests of the child are not being acted upon, you should seek legal advice about whether you should apply to the court.

Appendix 4

Health team structure:

Designated Nurse for CiC
Designated Doctor for CiC
Medical Advisor for Adoption & Fostering
Named Nurse for CiC & CLs
Specialist Nurse for CiC
Team Administrator for CiC, Adoption & Fostering

Financial and Resourcing Impact Assessment on Policy Implementation

Document title	Children in Care & Care Leavers Policy

As stated within the Intercollegiate document for Looked after Children 2020 it is within the roles and responsibilities for the Named and Specialist nurses for LAC to deliver and ensure training is maintained and upto date within the Isle of Wight NHS Trust.

The Royal Colleges recognise the importance of education and training to prepare practitioners for the roles and responsibilities entailed in working with looked after children and care leavers. Recognising work previously undertaken in Scotland,[10] the review of the intercollegiate safeguarding competences framework[11] continued to highlight that whilst many children and young people move in and out of the looked after children system there is a need for a separate, specific framework to be developed for looked after children, outlining key roles, and the knowledge and skills required.

In England, the term named doctor/nurse denotes an identified doctor or nurse with additional knowledge, skill and experience in working with looked after children who is responsible for promoting good professional practice within their organisation, providing supervision, advice and expertise for fellow professionals, and ensuring that looked after children awareness training is in place.

Totals	WTE	Recurring £	Non Recurring £
Manpower Costs	N/A		
Training Staff			
Equipment & Provision of resources			

Manpower	WTE	Recurring £	Non-Recurring £

Operational running costs	0		
Totals:	0		

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals:	0	

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed	0	
Building alterations (extensions/new)	**0**	
IT Hardware / software / licences	**0**	
Medical equipment	**0**	
Stationery / publicity	**0**	
Travel costs	**0**	
Utilities e.g. telephones	**0**	
Process change	**0**	
Rolling replacement of equipment	**0**	
Equipment maintenance	**0**	
Marketing – booklets/posters/handouts, etc	**0**	
Totals:	**0**	

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	**N/A**
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix 5

NHS Isle of Wight NHS Trust

Equality Impact Assessment (EIA) Screening Tool

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework,

Document Title:	Children in Care (Looked After Children) & Care Leavers Policy
Purpose of document	This policy applies to all members of staff working within The Isle of Wight NHS Trust who are involved in any aspect of care of children in care and care leavers (CiC&CLs). In particular it relates to staff working in Paediatrics, the Emergency Department (ED), Walk in Centres, ENT and Orthopaedics.
Target Audience	All members of staff working within The Isle of Wight NHS Trust who are involved in any aspect of care of children in care and care leavers (CiC&CLs).
Person or Committee undertaken the Equality Impact Assessment	*Kim Cook (Named Nurse for CiC & CLs)*

Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	*x*		
	Women	*x*		
Race	Asian or Asian British People	*x*		
	Black or Black British People	*x*		
	Chinese people	*x*		
	People of Mixed Race	*x*		
	White people (including Irish people)	*x*		
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	*x*		

Sexual Orientation	Transgender	*x*		
	Lesbian, Gay men and bisexual	*x*		
Age	Children	*x*		
	Older People (60+)	*N.A*		
	Younger People (17 to 25 yrs)	*x*		
Faith Group		*x*		
Pregnancy & Maternity		*x*		
Equal Opportunities and/or improved relations		*x*		

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact: NA			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:	
NA	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
NA	
Scheduled for Full Impact Assessment	Date: 12/8/21
Name of persons/group completing the full assessment.	Kim Cook (Interim named nurse for CiC & CLs)
Date Initial Screening completed	12/8/21