healthwatch Lambeth

Views of social workers on the Initial and Review Health Assessment Process

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Healthwatch Lambeth is the independent health and social care champion for local people

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About Healthwatch Lambeth

Healthwatch Lambeth is the independent health and social care champion for local people. We work to ensure your voice counts when it comes to shaping and improving services. We address inequalities in health and care, to help ensure everyone gets the services they need. We are a charity and membership body for Lambeth residents and voluntary organisations.

There are local Healthwatch across the country as well as a national body, Healthwatch England.

Executive Summary

This project was conducted in partnership with the London Borough of Lambeth and Children's Commissioning for Looked after Children. It is aimed at determining the views of social care staff working with Looked after Children and Young People on the shortfall in referrals for Initial Health Assessment within the 20-day period as required by the Care Planning, Placement and Case Review (England) Regulations 2010.[1] An Initial Health Assessment is a comprehensive assessment of the child or young person's health which is undertaken by a doctor. Mary Sheridan Centre, part of Evelina London Hospital, has been commissioned by the London Borough of Lambeth and Clinical Commissioning Group to undertake both the initial and review assessments.

This project was aimed at the following:

a) To find out the views of social care staff on the factors affecting the referral of the child and young person for an Initial Health Assessment;
b) To understand the relationship between social workers initiating Looked After Children's Initial and Review Health Assessments and relevant health professionals in Mary Sheridan Centre; and
c) To identify where improvements can be made to meet the statutory requirement of completing the Initial Health Assessment in the 20-day period.

We conducted 11 focus group discussions attended by 61 social workers and team manager, Business Support Officers (BSOs), and Independent Reviewing Officers (IROs). Fifty-four (54 or 89%) of the 61 participants were team managers and social workers from eight teams in the three services, namely: Looked after Children (1 team); Family Support and Child Protection (5 teams); Child Assessment Team (2 teams); and FSCP team managers (1 team). One focus group was held with two Business Support Officers and two Mary Sheridan staff. Lastly, five Independent Reviewing Officers (IROs) attended the focus group discussion.

The views of the participants on the factors affecting the shortfall were:

1) A general lack of understanding amongst social workers about the IHA process;
2) Lack of clarity on the part of social workers on the role of the Business Support Officers that may lead to unrealistic expectations; and
3) Varying experience on communication and interaction between social worker teams and the health team at Mary Sheridan Centre.

To address the identified issues, the following recommendations were made:

1) Learning and Development - Address knowledge and skills gap through provision of a rolling programme of learning and development opportunities for social workers. The training programme should be mandatory and has the buy in of the directorate so that managers can release social workers to attend training courses.
2) Role Description - Revisit the capacity and roles of the Business Support Officers (BSO), social workers, and team managers. As the BSOs are managed by different managers outside of the three services (CAT, LAC and FSCP), the Business Support Unit should also understand the importance of Initial and Review Health Assessment to support the BSOs. Team Managers can be proactive with providing inductions to all their team members when they first start with the team.

[1] http://www.legislation.gov.uk/ukpga/1989/41/section/22

3) Communication - Improve the communication between social care teams, BSOs, and health team at Mary Sheridan Centre. This includes developing an efficient system of information sharing including a variety of methods to communicate (e.g. electronic communication, phone calls, meetings), and regular networking and feedbacking opportunities between social workers teams and the health team at Mary Sheridan Centre.
4) Initial and Review Health Assessment Referral forms – Undertake a review of the accessibility and user-friendliness of the different forms and where possible, simplify them.

Introduction

A child is legally defined as 'looked after' by a local authority if he or she is provided with accommodation for a continuous period for more than 24 hours, is subject to a care order; or is subject to a placement order [2]. In addition, Section 20 of the Children's Act states that every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of there being no person who has parental responsibility for him; his being lost or having been abandoned; or the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.[3]

As of 31 March 2018, the number of children looked after by local authorities in England increased by 4% from 75,420 to 72,590 in 2017, with continuing increases seen in recent years. This is equivalent to a rate of 64 per 10,000 in 2018, which is up from 62 per 10,000 in 2017 and 60 per 10,000 in 2016.[4]

All local authorities have corporate parenting responsibilities including a duty under Section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

Section 40 of the Statutory Guidance for Local authorities, clinical commissioning groups and NHS states that local authorities are responsible for making sure that a health assessment of physical, emotional and mental health needs is carried out for every child they look after, regardless of where that child lives. To implement this duty, Regulation 7 of the Care Planning, Placement and Case Review (England) Regulations, 2010 requires the local authority that looks after children and young people to arrange for a registered medical practitioner to carry out an initial assessment of the child's state of health and provide a written report of the assessment.

The Initial Health Assessment must be undertaken by a registered medical practitioner. The assessment then results to a health plan. Review Health Assessments must also be undertaken after 6 or 12 months depending on the age of the child or young person and may be carried out by a registered nurse or registered midwife. The agreed benchmark for social care generating requests for initial health assessments is 5 working days from the day the child/young person has become looked after. The agreed number of working days for the Initial Health Assessment to be completed, from the time it is conducted, to the final report being completed and provided to the relevant social worker is 20 working days.

Evelina London Children's Hospital, a part of the Guys and St Thomas' Trust (GSTT) has been commissioned to provide the Looked after Children (LAC) health service in Lambeth. The service which is based at The Mary Sheridan Centre aims to meet the health needs of children and young

[2] http://www.legislation.gov.uk/ukpga/1989/41/section/22

[3] http://www.legislation.gov.uk/ukpga/1989/41/section/20

[4] Children looked after in England (including adoption), year ending 31 March 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757922/Children_looked_after_in_England_2018_Text_revised.pdf

people in care who are looked after in Lambeth and Southwark and other providers outside the borough. The service consists of the following tasks:

- Deliver statutory initial and review health assessments
- Conduct holistic assessment of medical and emotional well-being
- Provide all care leavers with a summary of all health records
- Conduct health promotion and coordinate with other health services
- Conduct medical counselling service
- Deliver teaching and training to foster carers, social workers and Guy's and St Thomas' Trust (GSTT) staff
- Offers outreach service for Looked After Children and Young People, and care leavers in a suitable and accessible location for them.
- Complete adoption medical reports and provide medical advice on assessments of prospective adopters and foster carers health as it relates to parenting
- Provide advice to adoption and fostering panels
- Acts as a resource for Health and Social Services personnel.
- Provide health care services to unaccompanied refugee children in care of Lambeth Social Services
- Contribute to multi-agency planning and strategic programmes relating to Looked after Children.

Initial Health Assessments are usually conducted in Mary Sheridan Centre. However, depending on the availability of the doctor and the accessibility of the centre, Initial Health Assessments can also be held in other centres including Sunshine House in Southwark, Gracefield Gardens in Lambeth, or other out of borough centres as identified by the Designated and Named Doctor for Looked after Children or the triage team.

Independent Reviewing Officers (IROs) also have crucial statutory roles to ensure that Looked after Children and Young People achieve health and wellbeing. The statutory duties of the IRO are clearly set out in the Handbook for IROs [5], as follows:

- Monitor the performance by the local authority of their functions in relation to the child's case;
- Participate in any review of the child's case;
- Ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the appropriate authority; and
- Perform any other function which is prescribed in regulations.

Section 2.10 of the same handbook indicates that the primary task of the IRO is to ensure that the care plan for the child fully reflects the child's current needs and that the actions set out in the plan are consistent with the local authority's legal responsibilities towards the child. As corporate parents each local authority should act for the children they look after as a responsible and conscientious parent would act.

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/337568/iro_statutory_guidance_iros_and_las_march_2010_tagged.pdf

Project Background

Discussions with the Lead Commissioner for Looked after Children Service resulted in an agreement to conduct a training needs analysis on the assumption that the shortfall was due to knowledge and skills gaps of social workers. However, as it will become apparent in this report, there are other factors contributing to the shortfall. It was then decided to take a broader view of the issue and to explore other aspects that may contribute to the local authority's performance on the Initial and Review Health Assessment process.

This project was aimed at determining the views of social care professionals working with looked after children and young people on the Initial Health Assessment (IHA). Specifically, we explored the following:

1) Factors affecting the referral of the child and young person for Initial Health Assessment (IHA);
2) The roles of the different teams in IHA process; and
3) The relationship between social care and health professionals.

The project was undertaken in July and August 2019. It is hoped that this report would inform the plan to address the shortfall.

Rationale

Looked after children are a very vulnerable group of children whose health needs prior to being in care are often not recognised, or if recognised, often remain unmet (Burton, 2015; Simkiss 2012). The importance of early identification of their needs cannot be underestimated as it would enable supporting young people in a timely manner. Additionally, it would allow the commissioners to plan for children and young people to receive health care wherever they are placed and to review the services in place for them (Barnes and Merredew, 2015).

The importance of Initial Health Assessment (IHA) is shown in some previous studies. For example, in an audit of 648 cases from six London boroughs, it was found that 72.3% of 648 children and young people showed behavioural problems. The findings highlight the prevalence of a number of different emotional needs at the point of entry into care of children and young people with no previous history of care, that cannot be attributed to the care system itself (Sempik et al. 2008). In the London Borough of Hillingdon, a similar audit of 237 completed health assessments was conducted and it was found that 118 (49%) of all children had mental health needs whilst 67% of Children from 10 to 17 years old were assessed to be having different health needs (Hillingdon Local Authority 2017).

In Lambeth, there are 352 looked after children as of March 2019, 166 of whom were children who became looked after in that year (Evelina Hospital data 2019). Of the 166 children, 143 (86%) had their Initial Health Assessment. However, only 37% of those 143 children had their IHA completed within the 20-day period. In addition, monitoring data on Review Health Assessments

for children who have been in care for at least 6 months show that only 281 (69%) children and young people attended the Review Health Assessment (RHA).

Data show that there is a failure in fulfilling the statutory requirement but Lambeth isn't unique in this failure. Data from Southwark indicate that in 2015/2016, only 39% of referrals were received within the 5-day timeframe and this further declined to 18% in 2016/17.[6] There are no published data on the same topic in Lewisham.

Ethics and Data Protection

Healthwatch Lambeth adheres to research ethics including seeking informed consent and protecting the identity of the respondents. We follow the Research Governance Framework by Healthwatch England which includes maintaining rigour in how we design any insight gathering work, how we select respondents, collect, and share data, and how we publish the report. Healthwatch Lambeth has a Data Protection Policy which is informed by the General Data Protection Regulations (GDPR). We are required by law to publish our Privacy Statement and it can be accessed in our website.

Transcripts from the focus group discussions were saved in password-protected files that are accessible only to the researcher. They will be deleted after six months as per our Data Protection policy. No identifiable information about the respondents has been included in this report.

Methodology and Participants' Profile

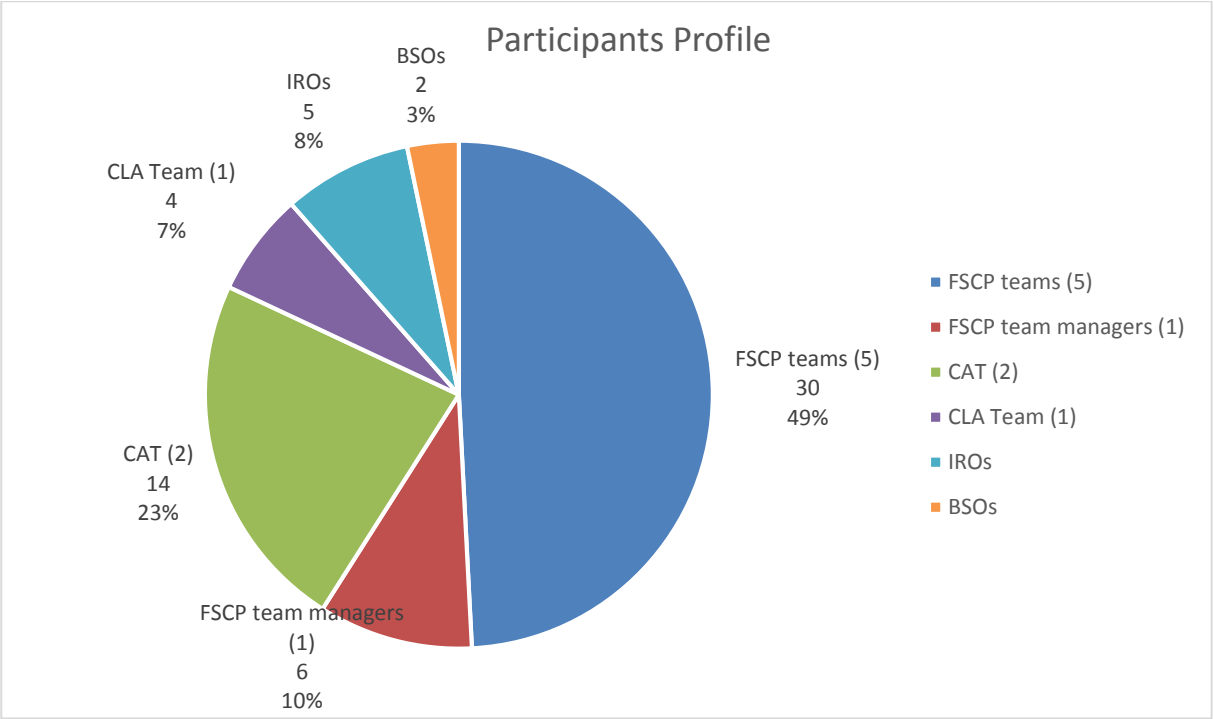
We corresponded with heads of services, manager of the Independent Reviewing Officers (IROs), and a member of the health team at Mary Sheridan Centre to access potential participants. The Director of Children Services also endorsed this project which helped in increasing the take up from social care teams. It must also be noted that the focus groups were held during the holiday period which might have prevented some teams from participating. There was also one cancellation due to social workers' unavailability. Two students via the Nuffield Research programme assisted us at the focus groups by way of taking notes and typing them up. They also acted as the second and third encoder to ensure that there was objectivity and that bias in analysis was minimised.

The project aimed for the participation of all social workers and team managers in three teams, namely Family Support and Child Protection (FSCP), Looked After Children (LAC), and Child Assessment Teams (CATs), as well as the three Business Support Officers (BSOs) from social care and all Independent Reviewing Officers (IROs). However, there were delays in correspondence from the teams and time constraint due to summer holiday.

[6] Southwark Looked After Children Health Annual Report 2016-17
http://moderngov.southwark.gov.uk/documents/s71747/Appendix%201%20Southwark%20Looked%20After%20Children%20Health%20Annual%20Report%202016-17.pdf

The two students took and typed the notes from the 11 group interviews. We used thematic analysis where emerging themes from the transcripts were identified and grouped together. The two students were the second and third encoder. This helped us in determining variations in the findings and agreeing the final themes.

A total of 61 social care staff took part. Nearly half (30; 49%) were from five (5) Family Support and Child Protection (FSCP) teams. The FSCP team managers also had one focus group where six (6) took part. Two (2) Child Assessment Teams (CAT) and one Children Looked After (CLA) team had 14 and 4 participants, respectively. Two (2) of the three Business Support Officers (BSOs) and five (5) independent Reviewing Officers (IROs) attended each focus group discussion.



Findings

There is general recognition of the value of health assessments. Senior managers, team managers, and social workers at Lambeth Children's Services also showed high regard for the welfare of children in care as demonstrated by their willingness to participate in this project. Four staff from Mary Sheridan Centre were also supportive and did assist the researcher in three focus groups.

In addition, Children's Social Care demonstrated willingness to address some issues brought to their attention by the researcher. For example, a working group to develop the flowchart/pathway has been established. This was in response to the need for social workers to understand the process whilst the training programme is being developed.

The results from the focus discussions are presented below.

1. Roles of and expectations from respective teams and officers

1.1 Role of the Business Support Officers (BSOs)

The majority of participants said that there was dissatisfaction with the current structure and role of the BSOs. They indicated that the reduction from having one BSO per team to now three BSOs across all teams had resulted to the lack support in filling out the form, lack of confirmation of receipt of the referral, and lack of clarity on who to contact when a social worker has some questions – all of which contributing to delays in the referrals. Social workers said that they were when the BSO function was re-structured, they were not formally informed or trained on the new process.

Social workers said that up until recently, the BSOs did not have a replacement which resulted to referrals not being sent to Mary Sheridan on time. Approximately 80% of all teams shared their frustration that they could not directly send the referral to Mary Sheridan. They said that incomplete or wrongly filled out forms are sent to the BSOs rather than social workers which contributed to delays. It was said by one health team staff at Mary Sheridan Centre that this was the last pathway agreed between the health team at Mary Sheridan Centre and Children Social Care. In addition, it has become apparent that 50% of participants from social worker teams did not know who the BSOs are.

Interestingly, two of the eight teams had exactly opposite experience with the BSOs. They said that they know who their BSOs are and can directly contact them once they've completed the LAC referral and IHA form. They also said that the BSOs often confirm that they have sent the forms to Mary Sheridan although they do not always inform the social worker on the follow ups received.

It has become apparent that the BSOs also felt that there are unrealistic expectations from them. They said that their role on the IHA and RHA process is only one of the many functions they perform. The fact that there are only three of them means that there is increased caseload. They also report to different managers and this contributes to inability to immediately address identified issues. They said that they value the IHA and RHA and sometimes help social workers in

filling out the forms but an increased workload and other functions with the Business Support Unit affect the support they can give.

BSOs also said that there is variation in the level of knowledge and skills amongst social workers in that some, even newly qualified social workers can correctly complete the forms whilst some social workers who have been in the council for a few years still make mistakes.

In addition, there are issues in communication between the social care teams and BSOs and IROs who said that they don't receive notification when a child or young person becomes looked after. This results to their inability to follow up the relevant social worker or offer help, where possible.

1.2 Role of social care teams

Almost all teams said that social workers have a lot of tasks to complete and this leaves limited time for filling out health assessment referrals. They said that team members were reduced from nine to six social workers which also meant an increased caseload for each social worker.

Social workers from FSCP indicated that they are faced with much more difficult family situations that need to be prioritised, in addition to the Initial Health Assessment. Interestingly, some social workers from other FSCP teams verbalised that their teams are not responsible for IHA and that it is not one of their Key Performance Indicators (KPIs).

Team managers also highlighted that social workers are required to do administrative tasks on top of their social worker duties. Apparently, this was raised within the senior managers but this has not been addressed yet.

1.3 Role of team managers

Two teams said that they have put in place processes and systems to ensure that referrals are made on time. Both managers said that they provide guidance on what to do when a child is referred to them. They said that they allocate children and young people for IHA (and other assessments) to the suitable social worker. They also manage the caseloads of each member of the team and that team members can ask help and able to support each other. One manager said that she rings Mary Sheridan if she has questions.

It appears that where managers make follow ups, social workers very rarely miss deadlines. For example, one team said that, during the 20-day period, social workers in the team need to also complete five deadlines and three other assessments and that IHA is only one of those. The child needs to also be seen every week of the first four weeks since referral. Despite this, the manager has devised a system of allocation – e.g. only one child or young person per social worker at any given time, where the child needs a referral for IHA. As a result, their team has not missed any deadlines from April 2018-March 2019.

One of the two teams said that missed deadlines are usually due to other factors such as, an unaccompanied minor where very little information can be provided. They said that Mary Sheridan would not accept the form because essential information such as the child's assigned GP is missing. That part of the form cannot be filled out until the child is assigned a GP which causes delays in the completion of the assessments. They suggested that Mary Sheridan should employ

certain flexibility in situations like this. It could be appreciated that this would be on case to case basis and that regular communication would help.

2. Learning and Development

Approximately 80% of the participants said that there was no induction to prepare them for their role including the IHA process. One commented that that there was an expectation for social workers to *"get it running on the ground"*. However, this does not resonate with some managers who said that they instruct social workers to buddy up or shadow a colleague.

In addition to induction, almost all respondents said that there is no training provision on the process or the guidance on LAC and they only learned the process by asking colleagues. One social worker said that training courses are available but those are not mandatory. She also said that there was consistently low take up from social workers. One social worker said that they "*have a lot of workload to complete and the time of the training session may not fit with their schedule.*"

Interestingly, one Mary Sheridan Centre staff said that they had developed a training programme but there is no buy-in from the Children Social Care. She also said that they had been waiting for more than a year to be linked with training department but this had not materialised. In addition, in 2018, clinicians and administrators from the Mary Sheridan delivered training sessions with the CLA teams , FSCP teams, and IROs on IHA/RHA and processes in addition to training provided to the adoption and fostering team SWs and the adoption panel and prospective adopters . They also plan to deliver a training programme with health and CSC, including all teams working with LAC. However, this has been put on hold pending the result of this training needs assessment. It should also be noted that Mary Sheridan team have been waiting for more than a year to be linked up with the training team to organise an embedded rolling programme of training.

It also appears that amongst the IROs, there is inconsistency in understanding about the IHA process. Whilst four IROs know that the IHA should still be conducted even when a medical assessment had already been done prior to the child coming into care, one said that an IHA should not be done because it is a short time frame between assessments.

Social workers said that those who haven't supported looked after children before would struggle with the referral. For example, one said that the first time a looked after child was allocated to her, she did not know about the need to fill out the forms within the first 5 days as this had not been discussed in her induction. Some also said that they did not know where to access the forms, let alone fill them out.

Some social workers and BSOs have different views about the forms. Social workers said that references and guidance on how to complete the forms are not available which make the process more difficult and time consuming as they need to ask colleagues for guidance. On the other hand, the BSOs said that there are clear instructions and references on the forms. In addition, it was said that a guidance had been produced and circulated it.

Almost all social workers and managers commented that there is no step-by-step guide or flowchart for social care teams which might be helpful, both for old team members and newly qualified social workers joining the team.

3. Communication between social workers, BSOs, IROs and Mary Sheridan based staff

Two of the eight teams across LAC, CAT and FSCP said that communication with Mary Sheridan has been satisfactory. They said that the doctors are approachable and they feel they can ask questions if they need to.

The majority of the teams (6 of 8) felt that communication can further improve. Social workers from two teams said that they knew the former LAC nurse but not the current one. The IROs said that social workers are not being informed by the BSOs if the referral had been sent and/or received by the health team at Mary Sheridan. Equally, they are not being notified when the child becomes looked after.

Some respondents said that team managers and social workers meet every week to see where they are in terms of progression and if they've completed what they needed to do. They said that they should receive monitoring data so that they can follow up or support social workers in case delays are happening.

One social worker said that there had been some progress in that there is a panel that meets once a month to review the teams' performance against the Key Performance Indicators (KPIs). They also discuss issues such as the lack of feedback from Mary Sheridan or BSOs about referrals made, confusion on who uploads the reports and delays in receiving health reports.

4. IHA Referral Process and required forms

Social workers said that the forms are long and too complicated, and that the process is unclear. One participant said that it takes up to 2-3 days to complete them from form filling, printing, and seeking consent. They said that the lack of clear process creates confusion especially when the IHA referral is done alongside the other assessments. For example, when a child becomes looked after, there are five documents to fill out but the IHA is submitted separately. On top of this, social workers said their caseloads could be up to 19 children with varying levels and urgency of needs.

They also said that there should be some flexibility on the part of Mary Sheridan. According to some social workers form six teams, referrals are sent back if certain box/boxes are left unticked or even though the social worker may not have the information to fill out certain sections.

5. Issues with consent

Social workers said that delays also happen when parents refuse to give their consent and therefore would not sign the form. Some social workers in one team said that parents are not always available. They however have identified a way to address this such as getting as much information as possible during the assessment. Some social workers from various teams said that it would be helpful if there is a pack with forms and explanation/guidance that they can bring with them as they visit the child/young person for the first time. That way, they can explain it to parents and can ask them for their consent.

Parents may not be ready or willing to talk to the social workers and this can delay the referral. Parents' hesitation may be due to their misunderstanding of the situation and believing that by signing the form they would not be getting their child back. It may also come down to the

parents' lack of understanding on the value of the IHA as they are already 'healthy'. They said that the process can be easier with children from Section 20 as the looked after child's parent has consented to their child becoming looked after instead of going into court.

Some social workers said that another issue might be due to the young person's unwillingness to take up the assessment. Due to social workers' increased caseload, some find it difficult to meet with the children. Some social workers from one team said that children have reported disappointment about not meeting with their social workers. This lack of contact may affect the children's knowledge on the value of the initial health assessment because there is no opportunity to explain it to them. However, it was also said that due to joint custody in children assessed through Section 20, some parents take their children to appointments but some rely on the social workers. Social workers said that although it is situational, there is a lack of clarity on who should go with the child for the IHA. They said that there should be clear guidance on this.

Some social workers from all teams and some IROs also said that the looked after child or young person might not want to attend their IHA or the Review Health Assessment. One IRO said that 10% of the children that they were allocated did not want to attend the assessment. One social worker said that two IHA appointments had been made for one young person and that he did not turn up on both occasions.

One staff from the health team at Mary Sheridan Centre said that they have designed three leaflets on IHA and the social care's one is still awaiting feedback from Children Social Care. In addition, there was also a plan for a 'new into care pack' but there has never been an opportunity for the health team to advise on this as they have not been asked to input.

6. Social workers' views on improvement

All respondents suggested a number of ways to address the issues. The suggestions can be categorised into three: learning and development to address knowledge gap; better communication between and amongst social care teams and Mary Sheridan Centre staff; and simple referral process to follow and simpler forms.

6.1 Learning and development

Almost all participants from LAC, CAT and FSCP teams suggested developing a training package and a rolling programme for all social workers. They said that attendance in training should be mandatory and the only way to ensure social workers can attend is by giving them protected training time so the managers can release them. The training should include the LAC Statutory Guidance, all statutory assessments including the IHA process, and how to fill out the forms. It was proposed that new social workers could go to Mary Sheridan and spend a morning shadowing the doctors and nurses who will assist them in filling out initial health assessment forms (training).

Amongst other things, these suggestions were made:

a) Develop a flowchart which can be shared with all teams and displayed so that social workers are reminded of the process. This is particularly helpful for new social workers joining the team.
b) Provide proper induction that will include the role, the process required to complete an initial health assessment, amongst other things that relate to the role of the new member of the team.
c) Members of one team also suggested that new workers should be assigned a mentor or a worker who has been working long enough to guide them and inform them of their role and what is to be expected.
d) Develop a staff handbook.
e) Develop a pack consists of forms and guidance which social workers can take with them when they visit the family. They can use it to explain the process and get parents' consent.

6.2 Better communication

Social workers said that they should be able to directly communicate with Mary Sheridan Centre in addition to communicating with the BSOs. They said that this would remove the extra layer which will make it easier for them to discuss where further work needs to be done on the form. They can also phone health staff where necessary. The BSO's should attend team meetings in order to discuss performance issues, changes, and what can be done to support each other. They can also do workshops on filling out the forms.

Participants also suggested for the BSOs and the IROs to be notified once the child becomes looked after as they may be able to support social workers as they make IHA referrals.

Two managers suggested that they should be provided with the performance data so they can discuss how to address the shortfall and support social workers where necessary. In addition, social workers would like to be notified when structural changes happen. The CAT team have explained that there is a lack of clear process with the LAC team on when and how to transfer cases. They said that the systems and procedures need to be clear.

6.3 Clarity of roles, responsibilities and line management

Almost all teams would like to know their respective BSOs and for their role to be explained so they would know what to expect from them.

BSOs suggested that the team managers should ensure that social workers complete the IHA referral on time. BSOs said that they have asked an allocated day to focus purely on the referrals that would help them catch up with back logs and communicate with social workers. This however, was not supported.

6.4 Simple forms and clear process

Almost all social workers and team managers commented that Mary Sheridan should have some flexibility in accepting the forms even some information are missing instead of sending the whole form back to the social worker. However, it should be noted that some standards and safety

cannot be compromised. One staff at Mary Sheridan Centre said that they have a minimum criteria for rejection including consent, risk profile, and contact details. In addition, social workers said that the health appointment can already be booked whilst waiting for the missing information.

Discussion

There is a general view amongst the participants on the value of the Initial Health Assessments. This stems from their understanding of the need for children and young people in their care to achieve their health outcomes. They also value holistic assessment that includes looking into their health and wellbeing. Also, there are some good practices that can be replicated.

However, it has become apparent that there are different factors resulting to the shortfall and those are interconnecting. They can be categorised into five themes: knowledge and skills; roles and expectations; communication; consent; and structural arrangements.

There is a general lack of knowledge on the Initial Health Assessment process across the social care teams and Independent Reviewing Officers.

It should be noted that the LAC Service involves not only Mary Sheridan Centre but also senior managers at Children Social Care Directorate and Children's Commissioning Service. The failure to provide a rolling training programme is a shared responsibility.

It's been found that there is a general lack of knowledge on the IHA process which could be the primary factor contributing to the shortfall. Although Mary Sheridan has a training programme, it was said that there was no buy-in from the Children Social Care Service and that Mary Sheridan had been waiting for more than a year to link with the Children Social Care training department.

In addition, the lack of induction is weakness and this might be due to non-clarity on the part of some team managers about their role in induction of their team members. It has been found that whilst the majority of the participants did not have induction, social workers from some teams said that their experience was different. The inconsistency of the practice could be due to varying understanding of the team managers about their role. It could also be due to lack of management skills. Those then would result to inconsistency in the standard of care and performance by social care teams.

There are unrealistic expectations from the Business Support Officers (BSOs) resulting from the lack of understanding about their role.

One common view shared by 80% of the participants was the lack of understanding about the role of the BSOs which resulted to some unrealistic expectations. In addition, there was also a concern on the BSOs' capacity. It is unrealistic for three BSOs to support more than 100 social workers unless changes are made to their role description – e.g. more advisory role rather than administrative.

BSOs' role is crucial in making sure that referrals are sent on time. However, they too have limitations including not being notified when a child or young person becomes looked after and their other functions outside of IHA. This can only be approached structurally. The directorate should be able to think of the effective line management agreement and revisit the role of the BSOs. The BSOs could work closely with managers and teams instead of directly with each social worker. That said, the role should fit with the needs of the whole service and any changes made should be communicated to all teams.

Ultimately, team managers have the overall responsibility in their teams' performance, not the BSOs. There may be a need to also review both the capacity and management skills of team managers. Responses from two teams showed that where managers can delegate properly and have installed systems within the team, referrals were made on time.

Communication about the Initial Health Assessment HA is generally less satisfactory.

Some actions had been introduced such as meetings between the BSOs and Mary Sheridan Centre and meetings of the performance panel. However, it appears that there are still communication issues at different levels across different teams and services. Communication – from notification of the child becoming looked after to receiving performance reports - is generally unsatisfactory for the large majority of the participants. It is a matter of knowing who to contact and by what means.

It appears that communication is not properly embedded in the Children Social Care and that there is no effective and efficient way of information sharing across the Directorate. The varying knowledge of the roles, failure to share performance reports, and the lack of knowledge of most social workers on where to access the referral forms, let alone the process for IHA referrals – all manifest that there is less satisfactory communication across all departments and officers working on the Initial Health Assessment, and communication between social workers and health team at Mary Sheridan Centre.

There is a need to improve relationship with families to enable them to understand the value of Initial Health Assessments.

It has been found that some parents/carers and children and young people refuse to give their consent. This could be attributed to a number of things such as lack of trust in the system, fear that the child/young person will be taken away from them (where appropriate, e.g. in Section 20 assessments), lack of understanding of the value of Initial Health Assessments, and unavailability and/or inaccessibility of the parent/carer or young person.

A possible reason could be failure to establish trust between the social worker and the child/young person or the parent/carer. It can be appreciated that five days is a short time to for the social worker to establish trust with the young person and/or the parents. It could also be challenging because of the processes prior to the child becoming looked after which may have (or have not) affected the relationship. Ultimately, it is down to the social workers to establish an open, honest and mutually acceptable relationship with the family. This is however dependent on the knowledge, skills, and confidence of the social worker. Again, this is linked with training opportunities and supervision, and availability of resources such as the 'new into care' pack. It's

become apparent that its development had been planned but the implementation has yet to happen.

Children may have already been placed outside the borough and therefore would necessitate more time to make the referral. However, this should not be an issue for conducting the IHA or RHA as Mary Sheridan Centre can conduct out of borough assessments. The issue is more about for social workers finding the time to engage with the parent/care of child/young person. It appears that there could be potential support from the placement team to assist in giving information to the child and the parents. Unfortunately, this aspect was not explored but is something that the Directorate may want to review later.

Some structural arrangements hinder opportunities to fulfil the statutory duty

It can be said that the role of the IROs is not being maximised and this could be attributed to the lack of notification when a child becomes looked after. This can also be attributed to the requirement that the review has to take place within the first 20 days which is also the same time period where the IHA has to be conducted, which would have been too late to determine if an IHA referral had been made. This is a lost opportunity for IROs to support the IHA process.

Equally, the role of BSOs has limitation as the line management is outside the Looked After Children Service. There are limits to the support they can give and this has to be addressed structurally.

That said, processes have to be aligned and structures have to be reviewed to ensure that the role of the BSOs and IROs add value to the IHA process.

Recommendations

It appears that the failure of the local authority in fulfilling its duty on Initial and Review Health Assessment can be attributed to a number of interconnecting factors. It is believed that progress can be made through some strategies but primarily through building a culture where the child and family are centre of all actions and decisions made. Sadly, the statistics does not reflect that this is the case.

To address the identified needs, we are recommending the following:

1. Learning and development
    - Develop and implement a robust, rolling training programme for all social workers and make attendance in the training mandatory. Children Social Care should have ownership and buy-in to the training programme and be able to facilitate it embedding in the Children's Social Care training.
    - Ensure that all new staff receive a thorough induction. Equally, enable team managers to conduct induction with their respective teams. They may need the relevant skills to do this.
    - Provide opportunities for sharing knowledge and skills through workshops and short seminars. For example, share good practice about systems and processes installed by some teams and allow better sharing of lessons and experiences in the different services.

2. Communication and Referral Forms
    - Develop a consistent approach to information sharing. It would be helpful to develop an organisational structure to show line management responsibilities and accountabilities.
    - Diversify methods of communication across all teams and services.
    - Improve interaction between Children Social Care and Mary Sheridan Centre.
    - BSOs to attend social care team meetings to discuss performance and other concerns and how to address those.
    - Appoint a health champion who will be the point of contact between social workers and the health team.
    - Upload all forms in the Mosaic system for easy access and monitoring.

3. Roles and Responsibilities
    - Revisit and redefine the role of the BSOs including line management responsibility.
    - Revisit the structure along with the role of team managers to be more accountable to performance targets and learning and development of their teams.
    - Looked After Children Service Commissioner to have a more pro-active role of monitoring the service outcomes and engage with both Mary Sheridan Centre and Children Social Care to address identified performance issues.
    - Review the commissioning specification of Mary Sheridan Centre to add more weight on their role in supporting learning and development in Children's Social Care.
    - Appoint a *health champion* in Children Social Care to be the point of contact between the them and Mary Sheridan Centre.

Conclusion

Almost all respondents verbalised their understanding of the value of the Initial Health Assessment. We have identified some good practices that can be replicated and strengthened, including: a process of allocation and systems of tracking referrals practised in some teams; regular meetings between the BSOs and Mary Sheridan team; existence of a performance panel; and satisfactory communication by some teams with Mary Sheridan Centre. Equally, we have identified some factors that might be contributing to the shortfall in IHA referrals in terms of knowledge and skills; relationship between and amongst teams and Mary Sheridan Centre; and communication between teams and Mary Sheridan and with families.

The recommendations made in the previous section can only be implemented through complete ownership of Children's Social Care Directorate, as ultimately, the local authority has the corporate responsibility for looked after children and young people. This responsibility should be translated into efficient and effective strategies that will help in achieving the outcomes for children and young people, starting from fulfilling the statutory duty in Initial Health Assessments.

In the current economic climate where Lambeth families have increasing needs from public services, it may not be possible to increase the capacity of the workforce. However, there may be ways to address the identified issues by embedding in the system a culture of learning, transparency, and accountability. Each part of the system has a role to play and this should be fulfilled.

Creating a culture where looked after children and young people are able to thrive is not an easy task but also not an impossible task. It may take a few years to see the improvement. That said, there are current opportunities that can be maximised.

First, bank on management skills of some team managers. Some teams shared good practices that can be replicated and modelled across the different teams. Second, create opportunities for better interaction and communication amongst teams and between social care and the health team at Mary Sheridan Centre. Some teams have indicated that clarity on the process, knowing who does what, and transparency help in timely referrals. Last, provide an ongoing opportunity for learning and development. There are basic things that need to be done such as induction and a rolling training programme. This is especially useful as there is fast turnover of social care staff and/or changes in team members.

One Independent Reviewing Officer quoted: *"It is our duty to ensure that the children's health needs are met in a timely manner but this will not be possible if we fail to do the assessments on time. It is more than a duty, it is about creating a culture where children's needs are prioritised"*. As the child/young person's corporate parent, the local authority should endeavour to create a culture where the child and young person is at the centre of the structure and systems, and a culture that promotes learning between and amongst teams.

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