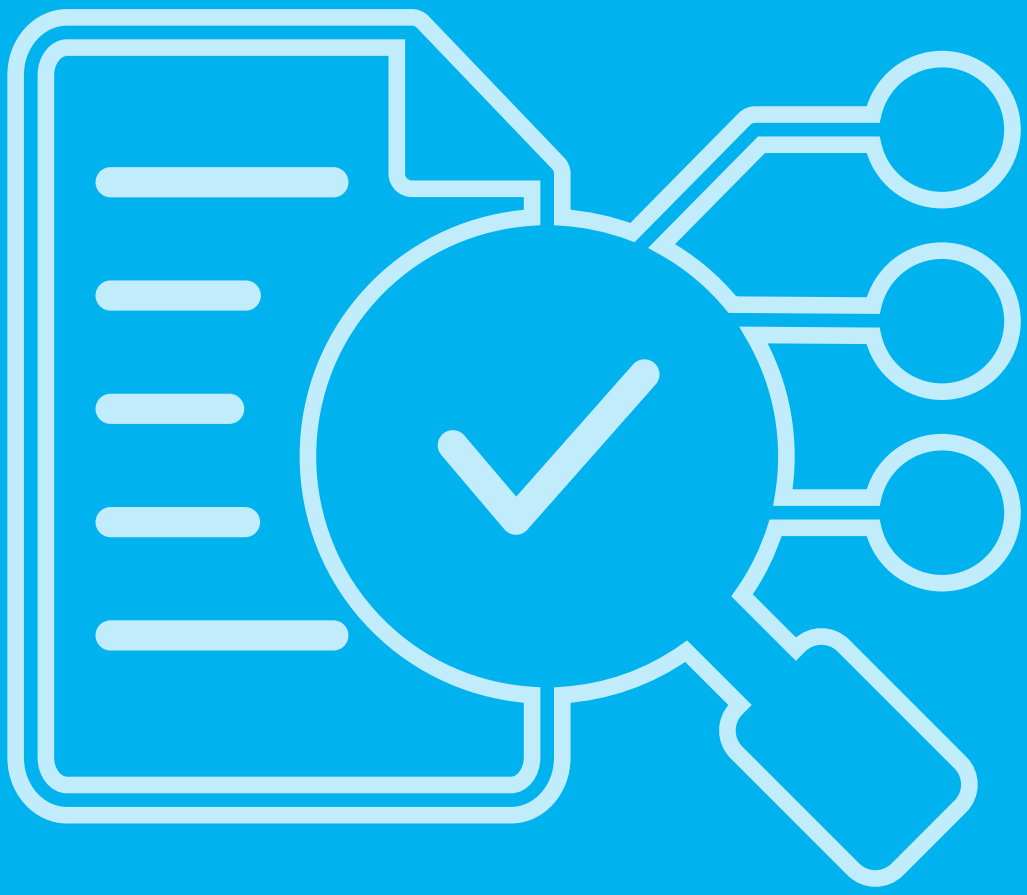
Initial health assessment delivery standards



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Contents

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Members of the RCPCH Child Protection Standing Committee also provided essential guidance in the production of these standards.

CoramBAAF conducted a literature review to investigate children and young people's views on IHAs. The findings were central to this work.

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Language note and glossary

The language we use to talk about children and young people in care is important. This document refers to 'children and young people in care' because this is the person-first term. Other organisations, areas, role titles and documents may use terms such as 'care-experienced children', 'looked after children' or 'children looked after'.

Other important terms that are used in this document are defined as follows:

- **Care Planning process:** The IHA is an important part of planning care for children. Its findings inform a health plan which is a core component of the child's care plan. A Review Health Assessment (RHA) tracks progress against the health plan at regular intervals. Social care has legal duties to develop, maintain and support children's care plans.

- **Children and young people seeking asylum and refugees (CYPSAR):** The term for individuals under the age of 18 years old who have left their country and are seeking protection from persecution and serious human rights violations. They are 'seeking asylum' if they are waiting to receive a decision on their asylum claim. They are a refugee if their claim has been granted.

    - CYPSAR may be unaccompanied (CYPSAR-U). They are under the care of the local authority and are entitled to an IHA.
    - CYPSAR is the person-first term and RCPCH encourages its use compared to other terms like unaccompanied asylum seeking child (UASC). More information and guidance is available from the RCPCH website.

- **Clinicians:** The individual conducting the IHA is referred to as a 'clinician' throughout this document. Legislation dictates which professional should be undertaking IHAs.

- **Emotional wellbeing:** Encompasses an individual's mental wellbeing including resilience, regulation, outlook and mental health diagnoses.

- **IHA: Initial Health Assessment.** A comprehensive health assessment that encompasses physical, emotional and developmental wellbeing. An IHA is typically conducted when a child enters care and statutory guidance sets out timescales for IHA delivery.

- **Level 4 competency roles/Named Doctors for Children and Young People in Care:** Professionals with a statutory service leadership role and additional responsibility have level 4 competences. These competences are set out in the Intercollegiate Document (see 'Standards and guidance'). In England they are called Named Doctors and Nurses but similar important roles exist in all four UK nations.

- **Level 5 competency roles/Designated Doctors for Children and Young People in Care:** Senior professionals with statutory strategic and health system responsibility have level 5 competences. These competences are set out in the Intercollegiate Document (see 'Standards and guidance'). In England they are called Designated Doctors and Nurses but similar important roles exist in all four UK nations.

- **Statutory guidance:** Statutory guidance is published by the Government of each nation in the UK. It provides a framework for how to comply with the law and should be followed by relevant agencies, organisations and individuals.

- **Supervision:** Clinical supervision allows a practitioner to receive professional supervision in the workplace from a skilled supervisor. It allows practitioners to develop their skills and knowledge and helps them to improve patient care. Restorative supervision focuses on the emotional wellbeing of health professionals. It is delivered in a structured and supportive way by experienced supervisors.

- **Unconscious bias:** Unintentional preferences or prejudices that are held on the basis of characteristics such as gender, race and social background.

- **Universal Personal Child Health Record (PCHR):** Also known as the 'Red Book'. A health record held by parents or carers used in the UK to record a child's health and development.

Introduction

The Initial Health Assessment (IHA) Delivery Standards aim to improve children and young people's experiences of IHAs, their outcomes and their health and wellbeing.

The standards apply to all children and young people in care regardless of where they live, including those placed out of area, children and young people seeking asylum and refuge, children in secure settings and children with disabilities receiving prolonged respite care. Sometimes groups need special consideration and this is noted throughout the document.

It is always better for a child or young person to have an IHA compared to not having an IHA at all. This principle underpins these standards. Older competent young people can decline an IHA but every effort should be made to engage them, and a notes summary and healthcare information should be offered.

The standards aim to set a benchmark for the delivery of IHAs in the UK. They can inform discussions between healthcare professionals, social care, provider organisations and service planners.

IHAs are discussed throughout this document at an individual, clinician, provider and system level. The standards emphasise the importance of statutory roles and multi-agency working, with a focus on child-centred care. They apply to IHAs but may be helpful to inform practice in respect of other processes, for example Review Health Assessments (RHAs).

These standards are not prescriptive. They do not specify the time that an IHA should take or the exact content of an IHA report, for example. Guidance on these aspects of the IHA may be found in other publications that are listed at the beginning of the 'Standards and guidance' chapter of this document.

The standards have been designed to empower clinicians across the four UK nations, allowing them to identify excellence and to recognise how practice might be improved. Some standards may seem unattainable, so the guidance accompanying each standard has been written to help foster improvement.

While some standards may be attainable by individual clinicians or services, others will require action at different levels of local and/or national health and social care systems. It is also important to note that this document is published in 2025, in the context of a rapidly changing landscape for health services in England. Nonetheless, the standards should guide expectations and improvements to the delivery of IHAs in the UK.

Overall, these standards have been developed to contribute to the improvement of outcomes for children and young people in care, and to a reduction in the longer-term health disparities experienced by children and young people in care compared to their peers.

How these standards were developed

Outcomes workshops

These standards are based on eight child-led outcomes. The eight outcomes are described as child-led because they centre the perspectives of children and young people while addressing the IHA at the individual, clinician, service and system level.

These outcomes were developed in workshops with a multi-agency group of paediatricians, social workers, GPs, nurses and researchers. They were then developed according to the findings of the literature review, to ensure that the outcomes reflected the perspectives of children and young people.

Literature review

A literature review was commissioned from CoramBAAF to investigate children and young people's views on health assessments. The review included research that focused on IHAs and other similar assessments, such as RHAs.

Alternative options were considered to gather children and young people's perspectives; for example, a one-off focus group with children and young people who have had an IHA. It was decided that the focus group approach was likely to duplicate already published work, however, and that a literature review would better inform the development of the standards.

The review focused on two research questions:

1. What are the barriers and facilitators to a positive experience of initial health assessments from the perspective of children and young people?

2. How can initial health assessments be improved to better meet the needs and expectations of children and young people?

The review found several themes that were prevalent in the literature and relevant to IHAs:

- The importance of children understanding the purpose and value of IHAs.
- Stigma and children and young people not wanting to stand out by having an assessment.
- The importance of building relationships/trust with health care professionals.
- The needs of particular groups of children and young people who have IHAs, such as CYPSAR, those that decline IHAs and young people aged 16-18 years old. These groups might be encouraged to attend their IHA by adapting processes, developing new pathways and making other practical adjustments to services.
- Training for clinicians who conduct assessments is essential; for example, providing trauma informed care or meeting mental health needs.
- The IHA should be seen as a unique opportunity to build children and young people's trust in the healthcare system, and to identify and resolve their health needs.

The eight child-led outcomes were assessed to ensure concordance with the findings of the literature review. The findings were also incorporated into the standards.

In addition to the themes listed above, the literature review concluded that more research with children and young people is needed regarding their experience of IHAs. These findings may therefore be a useful starting point for clinicians and researchers to use in designing their own projects with children and young people.

We acknowledge that the research in the literature review did not always include the views of those with disability, neurodiversity or additional learning needs. This was considered in the writing groups and is captured in the standards. We believe that the views and needs of all children should be embedded in all healthcare settings and services, which includes services used by and for children in care.

More information on the literature review is available in a short report on the RCPCH website, prepared by CoramBAAF.

Standards writing groups

The standards were informed by the views of health and social care professionals. Four writing groups were convened to develop standards against each of the eight child led outcomes. There were approximately 40 attendees in total across all four groups, from throughout the UK nations and with expertise in a range of fields. This includes paediatrics, general practice, social care, research and nursing.

Each group focused on two child-led outcomes and met twice. In the first meeting, they discussed the outcomes in relation to their own experiences and expertise. Draft standards were developed based on their insight, before the groups re-convened one month later to discuss and refine the draft standards.

These standards were further refined by the clinical leads, who utilised the findings of the literature review. Finally, prior to publication the standards document was subject to consultation by the RCPCH Child Protection Standing Committee and the project steering group, including paediatricians, social workers and researchers.

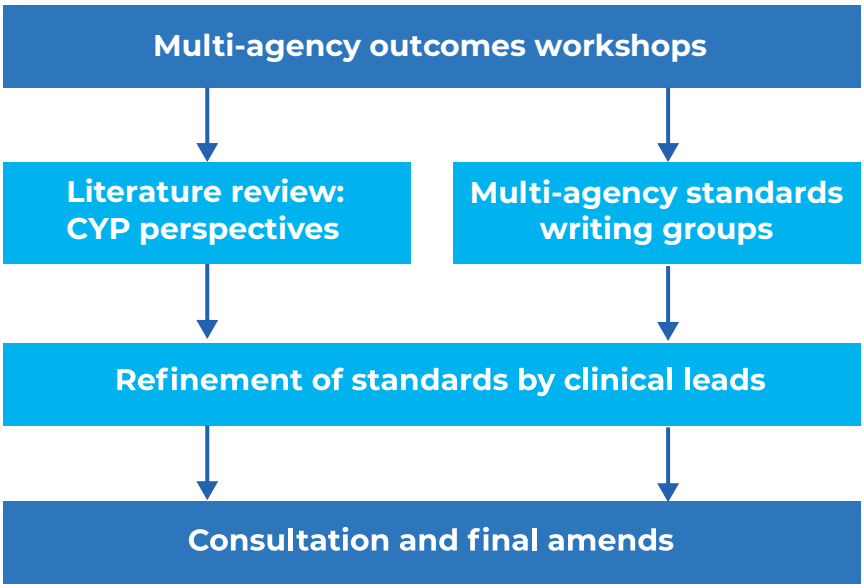


Figure 1. Standards development process

Standards and guidance

A set of standards has been developed to meet each IHA outcome.

Each standard is accompanied by guidance to provide more information. They are also complemented by indicators as suggestions to measure current practice and identify potential areas for improvement or excellence.

The standards should be viewed in line with the applicable guidance and legislation from each UK nation regarding children in care and health. The most relevant documents for each nation at the time of publishing are as follows.

- **England:**
  - Care Planning, Placement and Case Review (England) Regulations 2010
  - Promoting the Health and Wellbeing of Looked-After Children statutory guidance 2022
  - Working Together to Safeguard Children statutory guidance 2023
- **Wales:**
  - Care Planning, Placement and Case Review (Wales) Regulations 2015
  - NHS Wales Looked After Children Health Assessment Framework 2020
- **Scotland:**
  - Looked After Children (Scotland) Regulations 2009
  - Guidance on Health Assessments for Looked After Children and Young People in Scotland 2014
- **Northern Ireland:**
  - The Review of Children's Cases Regulations (Northern Ireland) 1996

The standards are also complemented by related documents. These include:

- CoramBAAF, 2017. 'Undertaking a health assessment guidance.' is available from the CoramBAAF website. The contents page and introduction can be accessed free of charge. The CoramBAAF practice notes may also be helpful on specific topics, such as Blood Borne virus testing, and CoramBAAF publish quick reference guides on child care law in each of the UK nations. A summary of each of the guides is available on page 8 of their social worker catalogues for England, Scotland, Wales and Northern Ireland.
- CoramBAAF IHA forms contain guidance notes, and details of use can be accessed on their website.
- Department for Education (England only), 2015 'Information sharing advice for practitioners providing safeguarding services.' This guidance may be helpful for individuals who are directly involved in safeguarding children, as well as individuals and organisations that work with children, parents, carers and families.
- Intercollegiate document, 2025. 'Safeguarding children and young people and children and young people in care: Competencies for Health Care Staff.' https://child-health-safeguarding.rcpch.ac.uk.
- International Child Health Group (ICHG), 'Standards for Healthcare Delivery to Children and Young People Seeking Asylum and Refugees (CYPSAR).' https://www.internationalchildhealthgroup.org/cypsar-standards-of-care
- National Institute for Health and Care Excellence (NICE), 2021. 'Guidance on looked-after children and young people.' https://www.nice.org.uk/guidance/ng205. Covers a range of topics related to children and young people in care.
- NHS England, 2025. 'Who Pays?'. Guidance, which outlines the framework for establishing which NHS commissioner will be responsible for commissioning and paying for an individual's NHS care.

- NHS guidance is available from the NHSE website on accessible communication, tone of voice in written communication and the NHS England Accessible Information Standard. These are NHS England resources but may be helpful in other nations.
- Public Health Wales has an 'Accessible Information Standard' on their website.
- RCPCH 'Being Me' resources were developed with children and young people in care. They are designed to help children and young people share their feelings, talk about their experiences and improve health outcomes.
- RCPCH has a number of resources relevant to IHAs. The 'Looked After Children resources and guidance' and the 'Guidance for paediatricians regarding children and young people seeking asylum and refugees (CYPSAR)' are publicly available, while the Child Protection Companion requires access.
- UK Government, 2023. 'You're Welcome: establishing youth-friendly health and care services' Standards', aim to centre young people's voices to improve access and reduce inequalities.

Outcome 1:
I feel positive about interacting with the healthcare system and am empowered to do so. I am listened to, respected and provided with opportunities to share what matters to me.

Standard 1.1: Children and young people, their caregivers and social workers should be given information about the IHA prior to the assessment.

Guidance:

This should include information about the purpose of the IHA and the questions that will be asked as part of the assessment. Information about the staff who conduct IHAs, the location of the clinic and other relevant details could also be included.

Indicators:

Availability of leaflets, videos and other resources for children and young people in age and stage appropriate language; evidence that the purpose of the IHA has been communicated to the child or young person in an age and stage appropriate way; established process in place to share resource(s) with children and young people, caregivers and social workers before the IHA; involvement of children and young people in the development of resources.

Standard 1.2: Attendance should be encouraged and supported from adult(s) best placed to advocate for children and young people's needs.

Guidance:

The adult(s) may be the birth parent(s), a family member or other individual who knows the child or young person well.

Children and young people should determine whether these adult(s) attend the entire IHA assessment or certain parts of the assessment. Children should be actively supported to make this decision.
It is best practice for the social worker to attend the IHA appointment, though the child or young

person may prefer that the social worker is not present for the IHA consultation. Nonetheless, if possible, the social worker should wait outside the room while the consultation takes place so that the clinician can speak with them separately as needed.

Children and young people should also be able to choose if they would like a trusted adult to be present for the entirety or certain parts of the assessment. If the trusted adult does attend, the clinician should consider speaking with them separately from the child or young person to gain further information. Sometimes it may not be possible for their chosen trusted adult to attend; for example, for reasons of safety and security. This should be explained to the child or young person.

If geographical distance is a barrier to the participation of the social worker or trusted adult, then they should be supported to engage and communicate in an alternative way. For example, they may able to attend the IHA virtually or share information with the clinician prior to the IHA.

Indicators:

Audit of attendees at the IHA appointment; content of IHA invitation letter; documentation of communication between social worker and child or young person regarding IHA attendance.

Standard 1.3: Communication should be adapted to meet the needs of children and young people.

Guidance:

Every child and young person's IHA should be conducted in an empathetic and compassionate way. The clinician's approach should be informed by their knowledge and experience regarding children and young people in care. For more information regarding clinicians' skills and knowledge, see Standard 6.1.

The IHA should take the child or young person's life experiences into account to meet their individual needs. For more information regarding the sharing of information prior to the IHA, see Standard 3.1. The clinician should be a skilled communicator who is aware of their personal unconscious bias and its potential impact. They should understand how to interact with children and young people of all ages, build trust and demonstrate flexibility.

Communication may need to be adapted to suit children and young people who are pre-verbal, have a learning disability, require an interpreter or have another communication need.

If an interpreter is required, they should attend in person rather than remotely, unless in person attendance is not possible. The interpreter should only attend remotely by exception.

It is best practice for the same interpreter to work with the child or young person at each interaction with health and social care if possible. This provides continuity for the child or young person, which may help the interpreter to build a relationship with them and communicate effectively.

Indicators:

Review of clinical practice; feedback from carers, children and young people; learning event for clinicians in training.

Outcome 2:
My IHA appointment considers my individual needs and any barriers that may make attending difficult. This makes me feel safe and helps me to engage.

Standard 2.1: Every child and young person should have equal access to an IHA that meets their individual needs, including considerations regarding equality, diversity and inclusion.

Guidance:

These considerations include disability, gender identity, race, religion or belief, age, pregnancy, sex and sexual orientation.

The IHA should consider the impact that the child or young person's needs may have had on their looked after status and implications for their health plan.

IHAs should respond to the health needs of children and young people from ethnic minority communities, with a particular focus on reducing the inequalities they may have already faced in accessing health care services.

Indicators:

Use of existing individual health summary or plan for the child or young person. For example, the universal Personal Child Health Record (PCHR), the NHSE health and care passport for children and young people with learning disabilities, the Continuing Care Plan in Wales and equivalents in other nations.

Standard 2.2: Children and young people should be told about their IHA appointment in advance, to give them and their supporting adults the opportunity to flag any barriers to their attendance and/or engagement.

Guidance:

Barriers to attendance and engagement may include a scheduling clash with an exam or their favourite class. Protective factors should also be considered in scheduling the IHA; for example, in some cases school may be a source of stability for the child or young person, so the IHA should be scheduled outside school hours if possible.

If the appointment cannot be changed to avoid these barriers for justifiable reasons, such as statutory timescales and health needs, then this should be clearly explained to the child or young person.

A decliner pathway should be in place to determine the response to children and young people that decline their IHA appointment. The decliner pathway should take an individualised and graduated approach; for example, after the first decline, the child or young person could be offered a virtual health consultation. This may be used to encourage them to attend an IHA appointment, though a face-to-face IHA remains best practice.

If the child or young person persistently declines to attend, then a notes review should be conducted that includes recommendations. A subsequent Review Health Assessment (RHA) should always be offered to the child or young person, even if they did not attend their IHA, as this can highlight persistent or emerging health concerns. The clinician who usually undertakes IHAs can be consulted after an RHA to ensure appropriate medical advice is available in the report.

Indicators:

Established and graduated decliner pathway in place.

Standard 2.3: Children and young people's views should be incorporated into the design of the IHA clinic.

Guidance:

Children and young people's views should be sought on how they perceive the clinic environment. Adjustments should be made to make the clinic more child and young person friendly, with consideration given to the needs of adolescents attending clinics in a paediatric setting.

Depending on the resources available, children and young people's views might inform the layout of the space, the furniture, resources available to take home, resources displayed in the clinic, the colour scheme or the location of the clinic itself.

Indicators:

Implementation of relevant recommendations such as 'You're Welcome' and 'Being Me'; work with local children and young people to understand their perspectives and gather ideas; a variety of mechanisms in place for children and young people to provide feedback on clinic design, for example Children in Care Councils or patient surveys.

Standard 2.4: Children and young people should give explicit informed agreement to take part in the IHA and for their information to be shared.

Guidance:

This is not always possible and decisions should be made in the best interest of the child. Young people who are competent have a right to agree or decline the IHA. For more information on decliner pathways, see Standard 2.2.

Consent can be difficult for the clinician to navigate. Consent is closely linked to competence, capacity, age and developmental stage of children and young people. Senior children in care team members (Level 4/Named roles) often have experience and expertise that can support decision making.

The principles of consent and the sharing of information are embedded in national health systems and legislation across the four nations. Refer to the specific relevant legislation and statutory guidance in your nation (see 'Standards and guidance').

Indicators:

Feedback from children and young people; percentage of IHAs that are agreed and declined by young people themselves.

Outcome 3:
I understand my health needs, my history and how to access more support. This is communicated to me in a way I understand.

Standard 3.1: The IHA report and plan should comprehensively describe the child or young person's health history, their health needs, how these needs will be met, by whom and an estimate of when this action will be taken.

Guidance:

The report and plan should be a holistic and comprehensive outline that encompasses physical health, emotional wellbeing, child development, social history and family history such as parental health and pregnancy information. It should recognise the child's strengths and resilience factors, as these may have a direct impact on the health recommendations.

The report and plan should also include information available from other sources prior to the IHA, such as GPs, other health records and social care. It is best practice to view these records prior to the appointment (related standards regarding information sharing are set out in Outcome 5). Review of records beforehand will help clinicians to have a trauma-informed approach to the IHA. Limited access to records should not be a barrier to delivery of the IHA, however. Services may need to strive to have access to this information.

The IHA report should consider any unmet health needs or incomplete health pathways due to neglect, Was Not Brought (WNB) or movement between local authority areas.

The IHA health plan should advocate for the child or young person. It should consider how the child or young person's history and health needs impact on their current functioning, with short and long-term implications. As part of this, the clinician may need to challenge the assumptions that have been made about the child or young person; for example, if the clinician feels that current education or placement provisions do not meet the child or young person's needs.

It may sometimes be appropriate to withhold direct patient access to some health information. This consideration applies to all sensitive safeguarding information where extra support may be required. A summary of the report and plan should be communicated to children and young people and/or carers at the time of the IHA. The summary should include any recommendations and resources and may be communicated verbally or in writing; for example, brief notes or QR codes. Written information should follow at a later date.

The clinician should share the full report with the child or young person's GP and social worker. For information regarding consent, see Standard 2.4.

The clinician should consider sharing all or parts of the report and health plan with other professionals relevant to the child or young person's care, such as health visitors, school nurses, social workers, dentists and/or optometrists. The clinician should aim to share the appropriate and proportionate amount of information required for the professional to meet the child or young person's health needs.

Indicators:

Audit of IHA report content.

Standard 3.2: IHA reports should be written in accessible language for the intended audience(s).

Guidance:

The intended audience may be different for different parts of the report. For example, if the summary of the report is primarily intended to be read by children and young people and/or caregivers, it should use plain language that interprets the findings of the IHA and explains medical terms.

Indicators:

Existence of organisational policy on how reports should be written according to intended audience; alignment with overarching standards regarding accessible communication, for example the NHS England Accessible Information Standard referred to at the beginning of this chapter.

Standard 3.3: IHA reports should convey the information necessary for secondary healthcare professionals to meet children and young people's healthcare needs.

Guidance:

It is best practice for children and young people to be referred directly to secondary care because this avoids unnecessary delays to them receiving care. It is also more efficient than requiring a referral from primary care. Local agreements and pathways should be established.

As per Standard 3.1, the IHA report or part(s) of the report should be shared with relevant professionals involved in the child's care, and should contain the appropriate and proportionate amount of information required for their needs to be met. If a referral is required, then the IHA report or part(s) of the report should be sent alongside the referral letter from the IHA clinician. This means that secondary care professionals should be able to care for the child or young person in a trauma informed way and without recourse to further information from primary care.

The health plan should outline secondary care referrals. As such, GPs can use the health plan to be aware of referrals without being directly involved.

Indicator:

Creation of health care pathways in local systems.

Standard 3.4: Children and young people and/or caregivers should receive information on further sources of support

Guidance:

This information should be included in the IHA health plan. It should be communicated in a way that the child or young person can engage with; for example, verbally, in a written leaflet or summary, as a web link or QR code.

The information should outline who to contact with any questions, referral information and sources of support in the community. It should be tailored to the individual child or young person's needs.

Indicators:

Clinicians have access to a compilation of information on community organisations.

Outcome 4:
Concerns about my health are acted upon in a timely way, so that I can feel well and do the things that matter to me.

Standard 4.1: Children and young people are encouraged throughout the IHA to express their health concerns and the things that matter to them.

Guidance:

Clinicians should clearly explain health-related concepts, such as emotional health and wellbeing. They should give children and young people opportunities throughout the IHA to reflect on their own health, and to consider whether support would make it easier to take part in activities that are important to them.

Children and young people should be allowed to direct some aspects of the IHA; for example, there should be flexibility in the appointment running order so that a child or young person's answers can determine the sequencing of questions.

Children and young people may be unable to express their health concerns and things that matter to them; for example, if they are pre-verbal or if emotional trauma prevents them from engaging fully with the IHA appointment. Behaviour may be a form of non-verbal communication for children and young people, which can be incorporated into the health assessment.

The perspective of the adult best placed to advocate for the child or young person's needs should be sought (see Standard 1.2).

All sources of information and opinion are important and should be referenced in the report. The voice of the child or young person should specifically be included.

Indicators:

Availability of resources to assist communication; availability of interpreters; where useful, incorporation of children and young people's behaviour or advocacy from an adult into the IHA report.

Standard 4.2: Clinicians are able to act autonomously to prevent delays and share information and health recommendations.

Guidance:

Clinicians should be able to initiate referrals into secondary care and request investigations and prescriptions. Clinicians should also be able to commence health pathways, or have the means to do so, without further healthcare appointments (see Standard 3.3).

System processes should allow clinicians to act autonomously within their professional guidelines and minimise the complexity of health pathways. This will help to improve adherence to health plans and improve children and young people's outcomes.

Related standards regarding information sharing are set out in Outcome 5.

Indicators:

Audit of IHA report content.

Standard 4.3: Clinicians have clear pathways and processes in place to ensure that outcomes will be regularly reviewed.

Guidance:

This should include routine activity, such as vaccinations, and more urgent activity, such as referrals for ongoing care. The clinician should feel confident that these multi-agency pathways are in place and that referrals will be acted upon and followed through by the relevant professional.

Indicators:

Provider-agreed policy and pathway; standard operating procedure (SOP) or equivalent in place; cross-agency audit of referral pathways.

Outcome 5:
Information, documentation and plans which are made as a result of my IHA will stay consistent if I move area or services, so that all of the professionals I work with are able to understand my health needs.

Standard 5.1: The completed IHA report should include important factual medical information and observations about the child or young person's wellbeing, including a summary of their own thoughts on their health and wellbeing.

Guidance:

As a result of their IHA, every child and young person should have at least the IHA report as a basic level of information about their own health regardless of their area, and a plan to get their needs met.

Indicators:

Use of an IHA form that asks for this information; adherence to national statutory guidance; time and resource is dedicated to information-gathering before the IHA appointment; agreements are in place with other agencies to act on referrals in a timely manner after the IHA, such as GPs and social work, including for emergency health needs.

Standard 5.2: Electronic records should be available across agencies and areas. If direct access is not possible, agreements should be established to facilitate information sharing across service and geographical boundaries.

Guidance:

Information sharing is especially important to meet the needs of children and young people that are highly mobile and/or placed out of area.

Information sharing agreements need to be in place to share health plans and other necessary medical information when a child moves out of area. This should include local authority and health notifications.

Information sharing agreements might be established between different local authorities or between primary and secondary care, for example. Paper records should only be used if unavoidable and should be uploaded to a digital format.

At the time of publication, we recognise that information sharing across agencies and areas is very challenging. The RCPCH will use this document, and others like it, to advocate for better information sharing infrastructure on a national level.

Level 5/Designated clinicians should engage with the wider health economy to advocate for better information sharing systems, as part of their work to represent children and young people in care in service planning decisions (for more information on Level 5/Designated roles, see Standard 8.2).

Indicators:

Establishment of information sharing agreements.

Standard 5.3: Children and young people who move to and from a different area should experience a seamless continuation of care.

Guidance:

The seamless continuation of care in a new area will improve children and young people's outcomes. A practical approach should mitigate against risks to health outcomes. For example, children and young people should retain their position in waiting lists, rather than being placed at the end of lists in their new area and experiencing delays to accessing care as a result.

The approach should also ensure continuity when this is in the best interests of children and young people, such as continuing engagement with the same support network. Care must not be paused or delayed whilst finances are discussed.

Responsibility for the transfer of care sits with each service provider. Open referrals should be moved to the new area and the child or young person should retain their position on new area waiting lists. If children and young people have only had their IHA prior to being discharged from care services, then their IHA recommendations should still be completed. This should be part of the Care Planning process.

Indicators:

Process in place to efficiently move referrals and waiting list positions to a new area; process in place to share information for children and young people leaving care (for example, if they are returning home).

Outcome 6:
I meet professionals who are supported, knowledgeable and have the right skills and time to help me.

Standard 6.1: The clinician should be a regulated health professional as per the statutory guidance of their nation. They must only conduct IHAs without direct clinical supervision if they have significant paediatric experience and have an up-to-date understanding and competence related to children and young people in care.

Guidance:

This knowledge should encompass the specific needs of children and young people in care, relevant services and sources of support in their area.

The service lead for children and young people in care, such as the Level 4/Named Doctor or clinical lead, should ensure that the clinicians conducting IHA in their service have the necessary experience, understanding and competence as per the Intercollegiate Document.

Indicators:

Completion of relevant training, such as IHA report writing; demonstrable understanding of children and young people in care and relevant concepts, such as trauma informed care, CYPSAR health and the impact of toxins in pregnancy such as alcohol and drugs; evidence of keeping their knowledge up to date; evidence of paediatric expertise and experience across the developmental stages.

Standard 6.2: All clinicians conducting IHAs should have opportunities for clinical and restorative supervision.

Guidance:

If a clinician does not have the knowledge, competencies and experience described in Standard 6.1, they should be supervised during the IHA by a colleague who does meet the standard. This supervision should encompass preparation for the IHA, the assessment itself and completion of paperwork.

All clinicians should be supported to engage in IHA clinical supervision and formal IHA peer review on a regular basis alongside colleague peer support. Clinicians should have appropriate connections and dedicated time for supervision because this supports staff wellbeing and quality improvement.

Supervision should be underpinned by an awareness of the impact that children and young people's stories can have on a clinician's own emotional health.

Indicators:

Establishment of peer support schemes and supervision sessions.

Standard 6.3: The clinician should have dedicated resources and time to conduct IHAs which allow for the complex nature of the IHA. This should be clearly described in their job plan or equivalent.

Guidance:

Resources should include a dedicated support workforce in addition to clinicians.

Additional time should be provided for clinicians to conduct IHAs with children and young people with additional needs; for example, communication needs. For more information on communication needs see Standard 1.3.

These IHA Delivery Standards should be used to direct job planning conversations alongside key performance indicators (KPIs) and quality assurance measures.

As per Standard 7.1, provider organisations should dedicate sufficient protected time and resource to IHA delivery.

Indicators:

Sufficient protected time for the clinician to complete the IHA and paperwork; adherence to Intercollegiate Document model job roles where applicable.

Outcome 7:
The provider organisations I come into contact with are fully resourced with the right time, staff and training to ensure a quality IHA that improves health and wellbeing.

Standard 7.1: Provider organisations should dedicate sufficient protected time and resource to IHA delivery.

Guidance:

The protected time and resource should include administrative staff and clinician time for preparation, such as communication with the social worker and review of pre-existing health records (for more information on review of health records, see Standard 3.1).

The protected time and resource should also include the appointment, report writing, peer review and support. This should account for working in a trauma informed way and additional time may be needed when working with children who have additional needs including CYPSAR-U, complex cases, neurodiversity and special educational needs and disability (SEND).

Services should recognise that demand for IHAs is likely to fluctuate and provide extra resource and capacity as required, rather than reducing the time for the IHA and compromising the care of children and young people as a result.

Where available, services should use evidence-based guidance to direct resource and service

capacity decisions. At the time of publishing, an up-to-date national version of this guidance does not exist but local services or wider regions may wish to create their own evidence-based guidance.

Indicators:

Evidence of service skill mix to support the gathering of information prior to the IHA appointment; provider policies mandate ring-fenced time and resources for IHA delivery, informed by relevant guidance and standards; evidence of ring-fenced time and resource, for example, in job plans and commissioning documents.

Standard 7.2: Provider organisations should enable the timely delivery of the IHA, in a manner that meets statutory guidance.

Guidance:

The IHA should be delivered in a timely manner because the health plan is instrumental to the care and outcomes of children and young people. The IHA ensures the continuation of current care and initiates care for unmet health needs.

There may rarely be clinical reasons for a delay in the delivery of the IHA, such as a child in intensive care. The delay in IHA delivery should be agreed between clinicians and social workers.

Some barriers to achieving a timely IHA may be outside the remit of health providers. These should be addressed via joint partnership working, such as with social care.

Statutory guidance regarding the timeline for IHA delivery may vary for different nations.

Services should be equitable for all children in care in the area regardless of originating authority, including children transferring between areas. Providers should facilitate this by providing the time and facility required for cross-border liaison, information gathering and notifications.

Indicators:

Adherence to timeline set out in statutory guidance; cross-border processes in place to facilitate timely IHA delivery; joint reporting between health and social care on timeliness, such as joint KPIs.

Standard 7.3: Provider organisations should have processes in place to monitor care after the IHA as set out in the healthcare plan.

Guidance:

The fulfilment of the healthcare plan is key to addressing the inequalities experienced by children and young people in care and is an important part of ensuring the delivery of a quality IHA. This may be achieved in conjunction with other professionals, such as GPs, social workers and IROs who should work together to establish local agreements.

Alternatively, dedicated staff such as care navigators may have responsibility for the sharing and follow up of recommendations in the healthcare plan.

Indicators:

Agreements in place for IHA healthcare plan delivery with other agencies; employment of staff to monitor progress of IHA healthcare plan delivery beyond the appointment; audit results of unmet health needs at RHA; IRO audit of Care Planning minutes to check for consideration of health plans and voice of child.

Standard 7.4: Level 4 competency roles/Named Doctors for Children and Young People in Care should have dedicated time for the responsibilities specific to their role, in addition to time for clinical work.

Guidance:

Role functions and titles may vary across the four UK nations, but the responsibilities of leadership and strategic level roles (Level 4 and Level 5) should align with the Intercollegiate Document's standards and guidance.

Examples of Level 4 competency role/Named Doctor for Children and Young People in Care responsibilities include the leadership of a service, quality assurance activity including work across professional and agency boundaries, process refinements and quality improvement within the provider organisation.

Indicators:

Dedicated time in job plan for Named/Level 4 Doctor for Children and Young People in Care responsibilities.

Standard 7.5: Provider organisations should have IHA quality assurance processes in place.

Guidance:

The Level 4 competency/Named Doctor, service lead or equivalent should routinely assess quality to inform the training and professional development of staff. They should also ensure that IHA delivery meets the relevant standards and objectives. Multiple providers should collaborate to ensure consistency across wider geographical health footprints and regions.

The Level 4/Named Doctor should be an informed resource for other staff and should support staff to access training specific to working with children and young people in care.

Level 5/Designated doctors should have access to Quality Assurance (QA) measures and reports from the provider (see Standard 8.2).

Indicators:

Services have QA mechanisms in place and encourage participation among staff members involved in IHA delivery; services reflect on their QA results and use the findings to inform their work; published QA work.

Standard 7.6: Provider organisations should support workforce and leadership development.

Guidance:

IHA services can only be delivered by a trained workforce that is supported by skilled leadership. Providers should provide training and professional development opportunities to strengthen all levels of the workforce, maintain their skills and facilitate succession planning.

Professionals working at Level 5 should support workforce development activity (see Standard 8.2 and Standard 8.3).

Indicators:

Provision of high quality training and professional development including supervision; leadership opportunities for clinicians.

Outcome 8:
Those responsible for the strategic planning of IHA services understand the resources that services need to ensure that my IHA is successful, and respond appropriately to provide this.

Standard 8.1: Service planning is informed by the statutory duties, standards, guidance and national recommendations that are relevant to children and young people in care.

Guidance:

Services and roles focused on children and young people in care are distinct from those for safeguarding. Funding, workforce and service specification decisions should be guided by an overarching aim to improve care and long-term outcomes for looked after CYP.

Legislation and statutory guidance may apply across partner agencies.

Indicators:

Nationally required reporting; adherence to NICE guidelines, such as Baseline Assessment Tool (BAT) results.

Standard 8.2: The interests of children and young people in care should be represented in service planning decisions.

Guidance:

Level 5 competency roles/Designated Doctors for Children and Young People in Care should have clear lines of communication and accountability with decision makers of all levels, to best represent

children in care in wider decision making.

Level 5 competency roles/Designated professionals should be informed by Level 4 competency roles/ Named Doctors for Children and Young People in Care, service data, public health and population information, health inequalities data, Joint Strategic Needs Assessments (JSNAs), standards, guidance and children and young people's perspectives.

Quality assurance findings should be shared with the Level 5 competency role/ Designated Doctor, so that they can be promoted into the wider health and local authority structures. Findings of unmet quality should be addressed by a joint response from strategic and provider levels.

Indicators:

Level 5 competency/Designated and Level 4 competency/Named Doctor for Children and Young People in Care roles are separate from the Level 5 competency/Designated and Level 4 competency/ Named Doctor for Safeguarding roles; Level 5/Designated Doctor involvement in the highest health structure decision making structure, such as Integrated Care Boards (ICBs) in England); regular audit, QA and Quality Improvement (QI) schedule against relevant standards; implementation of audit results to improve services for children and young people.

Standard 8.3: Level 5 competency roles/ Designated Doctors for Children and Young People in Care should have dedicated time for the responsibilities specific to the role.

Guidance:

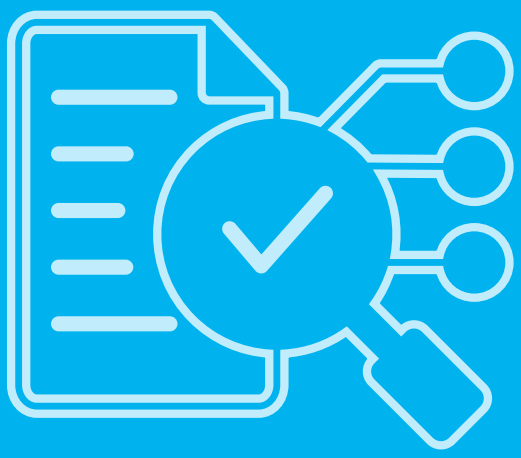
Level 5 competency roles/Designated Doctors should regularly share information and advocate for children and young people in care at the executive level within the ICB, Trust or Health Board and the wider health economy. Time for these responsibilities should be separate from time that the Level 5/Designated Doctor may have for clinical work.

The Level 5/Designated Doctor should also have access to necessary information, such as service data and audit results, and work closely with the Level 5/ Designated Nurse.

Indicators:

Children and young people in care Level 4 and Level 5 roles are separate from safeguarding children roles; children and young people in care Level 4 and Level 5 roles are filled; production of annual reports on IHA service provision and wider health provision for children and young people in care, led by the Level 5/Designated Doctor and Level 5/Designated Nurse, focused on their area and disseminated at executive level; inclusion of Level 5/Designated Doctor in relevant ICB/Trust/ Health Board discussions; working relationship between the ICB/Trust/Health Board and the local corporate parenting body; adherence to statutory guidance, Intercollegiate Document and shared performance indicators.

Initial Health Assessment Delivery Standards



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