

Promoting the Health of Looked After Children

A Study to Inform Revision of the 2002 Guidance

Ann Mooney, June Statham and Elizabeth Monck
Thomas Coram Research Unit
Institute of Education, University of London

Helen Chambers
National Children's Bureau



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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Children, Schools and Families.

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1. Introduction

1.1 Background

The government is committed to improving the health of looked after children and in the white paper *Care Matters: Time for Change* (DCSF, 2007), announced the intention to publish revisions to the 2002 guidance on improving the health of looked after children by the end of 2008 (since revised to Spring 2009). This will aim to strengthen protocols and agreements with NHS bodies, update regulations as necessary, and address the need for coordination within healthcare bodies to meet the needs of children in care. The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have been asked by the Department of Health (DH) to also develop joint guidance on improving the physical and emotional health of looked after children, which “will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness, and of the accessibility and acceptability to service users” (p2)¹. The SCIE / NICE guidance has a longer timescale and is not expected to report until late 2010.

The guidance currently in operation, *Promoting the Health of Looked After Children*, was published by the DH in 2002 and at present is statutory for local authorities, but not for healthcare bodies. It has been unclear how far health services (including public health) do follow the guidance, and what the major difficulties and issues for them might be if the existing recommendations became a statutory requirement. Analysis by Ofsted of the annual performance assessments (APAs) of local authorities in England has identified that ongoing monitoring and assessment of the needs of vulnerable groups, including looked after children, is a common weakness within children’s services partnerships, although little information is provided about how far the specific requirements of the current guidance on promoting the health of looked-after children are met by healthcare bodies.² The Healthy Care programme developed by the National Children’s Bureau³, which currently involves approximately 90 local authorities delivering a Healthy Care programme via local multi-agency partnerships, has identified a lack of clarity in at least some Primary Care Trusts (PCTs) about where responsibility for the health of looked after children lies, especially at strategic level.⁴

1.2 Aims of the study

The overall aim of the study reported here was to provide an evidence base to assist DCSF and DH in revising the guidance on improving the health⁵ of looked after children. Specific aims of the study were to:

1. Summarise the research and statistical evidence on the prevalence and nature of health problems among looked after children and the characteristics of the population of looked after children.
2. Estimate the gap between the requirements of the current guidance and current practice of health services.

¹ NICE/SCIE (2008) *Looked After Children: Final Scope*

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=42248>

² Ofsted (2007) *Narrowing the gap: the inspection of children’s services*. London: Ofsted

³ www.ncb.org.uk/healthycare

⁴ NCB (2008) *Briefing to support amendment to the Children and Young Persons Bill relating to the physical, emotional and mental health of children and young people in care*. www.ncb.org.uk/healthycare

⁵ The definition of health adopted in the 2002 guidance is deliberately wide and linked to the concept of physical and emotional wellbeing,

3. Identify any aspects of the guidance that are likely to present particular difficulties for health services if the guidance is placed on a statutory footing, and any steps that could be taken to address these difficulties.
4. Identify if there are additional topics that the revised guidance should address.
5. Provide examples of good or promising practice by local authority children's services and health services in promoting the health of looked after children.

1.3 Methodology

The study took a multi-method approach that drew together different sources of data: 50 individual interviews with key stakeholders at national, regional and local level; an overview of relevant research and statistics; written comments from professionals engaged in implementing the guidance; and an analysis of information in Joint Area Reviews relevant to the health of looked after children. Examples of good practice were obtained from all of these sources.

1.3.1 Literature and data review

Chapter three of the current guidance reviews research evidence covering the numbers and characteristics of looked after children in England, the prevalence and nature of their health problems and the views and experiences of young people themselves on the health provision they receive. A focused literature and data review was undertaken to update this evidence.

Relevant material was identified through a combination of internet/website searches and searches of key databases such as PubMed and Applied Social Sciences Index, using search terms such as 'looked after children', 'LAC', 'foster care(r)', 'health', 'health needs', 'needs analysis' and 'promoting health'. Searching was restricted to material published since 2002, when the previous guidance was written. Recent issues of key journals such as *Pediatrics* were hand searched for relevant articles. The overview also drew on research briefings produced by the Healthy Care programme⁶ and by Research in Practice,⁷ on previous work undertaken by the Thomas Coram Research Unit for the Department of Health,⁸ and on written material supplied by interviewees (see below).

Health outcome indicators were also summarised to provide information on regional variation and trends over time in the proportions of looked after children who had their teeth checked by a dentist, had their annual health assessment, and were up to date with routine immunisations⁹. Durham University Mapping Team shared data on designated staff for looked after children from the 2007 National Child Health, Child and Adolescent Mental Health and Maternity Services Mapping Exercise for analysis.

Information relating to the health of looked after children was also extracted from a random sample of 30 Joint Area Reviews (JARs) published from 2006-2008. JARs are undertaken by Ofsted every three years and published on the Ofsted website. They report on the outcomes achieved by children and young people in each local authority and evaluate the way local services, taken together, contribute to children's well-being. In the Joint Area Reviews undertaken before April 2007, the health of looked after children was reported under the Every Child Matters outcome *Being Healthy*, although this outcome addressed the health of *all* children in the authority not just those looked after. Since April 2007, the JAR format has

⁶ www.ncb.org.uk/healthycare

⁷ *Health and well-being: physical health*. Research and Practice Briefing 12. Dartington: Research in Practice.

⁸ Mooney A., Statham J. and Storey P. (2007) *The health of children and young people in secure settings*. www.ioe.ac.uk/tcru

⁹ <http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000785/index.shtml>

changed and looked after children is now a specific area for investigation, but with health as just one aspect of this. Analysis of the JAR extracts proved difficult due to lack of detail and inconsistency in the areas covered under health, but they proved a useful source of examples of good practice.

1.3.2 Interviews with key stakeholders at national and regional level

In consultation with DCSF and DH, representatives of relevant interest groups at national level and key individuals at both national and regional level were identified, and interviewed to obtain their views on implementation of the current guidance and the impact of it becoming statutory. Interviewees were sent a topic guide in advance covering the major topic areas of the current guidance (see appendix 1). Under each topic interviewees were asked about what was working well, the challenges and what would help overcome them. Effective practice in meeting the health needs of looked after children was also explored. Interviews lasted on average an hour and although some interviews were face-to-face, the majority were conducted over the telephone in order to make best use of the limited time available for the study. Notes were made during the interview and written up afterwards under common headings to facilitate analysis (further details regarding analysis can be found in chapter 3).

A representative from each of the following **national** organisations was interviewed (10 in total):

- Association of Directors of Children's Services
- British Association for Adoption and Fostering (Health Team)
- Care Services Improvement Partnership
- Community Practitioner Health Visitor Association
- Healthcare Commission
- National CAMHS Support Service
- National Safeguarding Children's Association
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Psychiatrists

Twenty five key stakeholders were interviewed at a **regional** level, between them covering all regions of England:

- The strategic leads for children's health and for public health in seven of the ten Strategic Health Authorities
- The strategic leads for children (in five of the nine regional government offices).
- All eight regional Healthy Care Partnership leads.

1.3.3 Local interviews

In addition to the regional and national stakeholders, we sought a local perspective through interviews in Primary Care Trusts (PCTs) with key individuals responsible for either the commissioning or the delivery of health services, and where possible with the local authority children's services lead with responsibility for looked after children. Interviewees in PCTs included leads for children's health and for public health, and designated doctors and nurses. Six local areas were selected, based on a combination of inspection report data and suggestions from national and regional stakeholders. They included both areas that were thought to be doing well in meeting looked after children's health needs, and those that were known to be experiencing some difficulties. As before, interviews were mostly conducted by telephone, and a topic guide was sent to interviewees before the interview (see appendix 2). Interviews focused on local practice, especially views on what was working well and what was more challenging in respect to meeting the guidance.

In addition, research team members attended a corporate parenting group and a regional group of looked after children's nurses to hear their views on revising the guidance. Finally, written comments were received from eight looked after children's nurses working in different parts of the country, and a joint response from one LA / PCT. These were in response to publicity about the project in the July / August 2008 edition of the Healthy Care Newsletter, which invited readers and Healthy Care partnership members to send comments about the guidance and its revision. A similar invitation appeared in the newsletter circulated to looked after children's nurses on the Royal College of Nurses database.

1.3.4 Good practice examples

Examples of good or promising practice were extracted from a range of sources including the published literature, Joint Area Review (JAR) reports, Healthy Care briefing papers¹⁰, audits of local Healthy Care programmes and information supplied by interviewees. Few of these examples have been externally evaluated to demonstrate actual improvements in health outcomes, but they highlight innovative ways in which various aspects of the guidance are being addressed. Selected descriptions are included in the form of text boxes throughout this report.

1.4 Structure of report

The rest of the report is organised as follows: chapter 2 summarises the research and statistical evidence on the prevalence and nature of health problems among looked after children and the characteristics of the population of looked after children, as well as published evidence on how well their health needs are being met and the views of young people themselves. Chapter 3 presents an overview of findings from the stakeholder interviews illustrating the differences between the guidance and current practice, the main areas of difficulty with the guidance and suggestions from interviewees about what might be done to address these difficulties. Examples of good practice are included throughout the report but especially in chapter 3, drawn from JAR reports, Healthy Care Programme briefing papers and local audits as well as from information provided by interviewees. Conclusions are drawn in chapter 5 using all the data sources for this study.

¹⁰ http://www.ncb.org.uk/Page.asp?originx_9834gc_55239231936145p49n_2006811526p

2. Evidence from research and literature

This chapter provides an overview of literature and prevalence data, organised in four sections:

1. The profile of looked after children
2. The nature and prevalence of health problems in looked after children
3. How well health needs are met, especially by health services
4. The views of looked after children on their health

2.1. Profile of looked after children¹¹

Some 59,500 children in England were looked after on 31 March 2008¹², excluding those in agreed short-term respite placements. However, due to movements in and out of care, more than a third as many children again will experience the care system during any one year. Many children enter care for short periods of time: nearly a third (31%) of those who ceased being looked after in the 12 months to March 2008 had spent less than a month in care. Such short periods of being looked after are likely to create particular challenges for assessing and meeting health needs, as is the extent of movement of children between different carers. This dynamic picture is particularly relevant when planning local service provision. In a PCT serving a total population of 100,000, approximately 165 children would be expected to experience being looked after in a year.

2.1.1 Where do young people who are looked after live?

The majority of children are looked after by foster carers (71%, with one in six of these placed with family or friends). Just 11 per cent of looked after children, almost all over the age of 10, live in residential homes. Eight percent of looked after children live with their parents subject to a care order, a proportion that has fallen from 10 per cent in 2004. A small number of children (290 in 2007) live in secure children's homes, either as 'welfare' placements (when they need to be in a secure institution for their own or others' safety) or placed by the Youth Justice Board because of offending behaviour¹³. Although over two thirds of those in secure children's homes are boys, typically aged 14 or 15, among children placed for welfare reasons girls are in the majority.

Nearly a third of children (30%) are placed outside of their local authority boundary, although around half of these still live within 20 miles of their home. This has implications for how health services are commissioned for these children, and who undertakes their annual review.

¹¹ Where possible, figures are from 2008 but some of the statistics were no longer published after 2006 (e.g. numbers looked after throughout the year) and in these cases the 2006 figures have been used, for example to calculate the number of LAC a PCT could expect to see over a year.

¹² DCSF (2008) Children looked after in England (including adoption and care leavers) year ending 31 March 2008. <http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000810/index.shtml>

¹³ DCSF (2007) Children accommodated in secure children's homes, year ending 31 March 2007, England and Wales. SFR23/2007. www.dcsf.gov.uk/rsgateway/DB/SFR/

2.1.2 Characteristics of young people

As at March 2008, 63 per cent of children looked after were aged 10 or over, and boys were in a slight majority (56%). The ethnic origin of 74 per cent was reported as White British, with the remaining 26 per cent being from a variety of other ethnic backgrounds. There were 3,500 unaccompanied asylum seeking children or young people, mostly living in London and the South East, who often have particular health needs both emotional and physical¹⁴. When children receiving respite care are excluded, the main reason for children of all ages becoming looked after is parental abuse or neglect, and 63 per cent are looked after under a care order with this being more common among younger children. Four percent have a 'main need code' of disability, although this is likely to be an under-estimate of the extent of disability among children looked after since it only identifies those children where disability is the primary reason that they are accommodated (see below).

2.1.3 Groups in care

A comprehensive study of over 7,000 children in the English care system¹⁵ identified six different groups of children, with differing characteristics and needs:

- **Young entrants** (43%). These children were under the age of 11, and became looked after primarily due to abuse and neglect.
- **Adolescent graduates** (26%). These young people had first entered the system under 11 for similar reasons, but were now older. They tended to have more difficulties at home, at school and with behaviour.
- **Abused adolescents** (9%). These young people were first admitted over the age of 11 for reasons of abuse or neglect. On average their behaviour was significantly more challenging than that of the adolescent graduates and they were also doing much worse at school.
- **Adolescent entrants** (14%). Also first admitted over the age of 11, but usually because relationships at home had broken down. Their families had fewer problems in themselves than those of the previous groups, but the young people showed challenging behaviour and were often doing badly at school.
- **Children seeking asylum** (5%) were almost always over the age of 11, and became looked after because they had no families rather than because their families had problems. They tended to do comparatively well at school and displayed less challenging behaviour than any other group.
- **Disabled children** (3%) were recorded as looked after because of disability (social workers reported that a much higher proportion of looked after children, 16%, had a disability, but this had not been recorded as their primary 'need code'). These children had comparatively high levels of challenging behaviour, were on average older than other groups and had been looked after for longer.

¹⁴ Chase E., Knight A. and Statham J. (2008) *The emotional well-being of young people seeking asylum in the UK*. London: BAAF

¹⁵ Sinclair I., Baker C., Lee J. and Gibbs I. (2007) *The Pursuit of Permanence: a study of the English Child Care System*. London: Jessica Kingsley Publishers

In this study, just under half of those who started to be looked after away from home left the care system within a year of arrival. The researchers found that the majority of placements within the first two years of a child's care career were intended to be short-term. Once a child had been looked after for a year or more, the chance of leaving within the next year was low (around five per cent for children aged between 11 and 15). Clearly, these different trajectories through the care system have implications for assessing and promoting looked after children's health, and suggest the need for closer working with children's birth families and with adoptive parents, rather than a focus solely on the periods when a child is within the care system.

2.2 The nature and prevalence of health problems and illness in looked after children

Since the 2002 guidance was prepared, new evidence has become available on the extent and nature of health problems among looked after children. This shows that looked after children and young people share many of the same health risks and problems of their peers, but often to a greater degree, and in the context of greater challenges such as discord within their own families, frequent changes of home or school, and lack of access to the support and advice of trusted adults. Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect (see below). They need local authorities as 'corporate parents' to ensure that the care system helps to redress some of these disadvantages, and supports them to achieve health and other outcomes similar to those of children and young people who have not had to be taken into care. The fact that longer-term outcomes for looked after children remain far worse than their peers is evidence of an important health inequality, and needs to be treated as a public health priority¹⁶.

2.2.1 Mental health and emotional well-being

The most extensive source of information on the prevalence of health problems among looked after children is a national survey undertaken by Melzer and colleagues for the Office for National Statistics (ONS), which obtained data in 2002 on over a thousand looked after children aged 5 to 17 from their carers, teachers and many of the young people (aged 11 to 17) themselves¹⁷. Mental health problems were identified by clinicians who reviewed this data.

The survey confirmed findings of earlier research^{18 19} about the high level of mental health need amongst looked after children, particularly those in residential care. Nearly half (45%) of looked after children were assessed as having a mental health disorder, rising to nearly three quarters (72%) of those in residential care. Among 5-10 year olds, 50% of boys and 33 per cent of girls had an identifiable mental disorder. Among 11-15 year olds, the rates were 55 per cent for boys and 43 per cent for girls. This compares to around 10 per cent of the general population aged 5 to 15.

¹⁶ Haywood J. and James C. (2008) *Improving the health of children in care and care leavers in London 2008/9*. Unpublished paper, Care Services Improvement Partnership

¹⁷ Melzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) *The mental health of young people looked after by local authorities in England*. London: The Stationery Office

¹⁸ Dimigen G., Del Priore C., Butler S. et al (1999) 'Psychiatric disorder among children at time of entering local authority care: questionnaire survey', *British Medical Journal*, 319, 675

¹⁹ McCann J., James A., Wilson S. and Dunn G. (1996) 'Prevalence of psychiatric disorders in young people in the care system', *British Medical Journal* 313, 15, 29-30

Clinically significant conduct disorders were the most common among looked after children (37%), while 12 per cent had emotional disorders (anxiety and depression) and 7 per cent were hyperactive. Differences were also found between children in different types of care. For example, less common disorders, particularly those on the autistic spectrum, were far more common among children in residential care than in other placements (11% compared to 2%); and children living under a care order with their natural parents were over four times as likely as those placed in foster care to have depression (9% compared to 2%). Even when compared to children in a community sample from the most deprived socio-economic groups, looked after children still showed significantly higher rates of mental health disorders²⁰.

Another source of information on the prevalence of emotional and behavioural difficulties among looked after children comes from the Looking After Children longitudinal study of 242 children and young people who became looked after for the first time in the late 1990s, and remained in care for at least a year²¹. Unlike the ONS survey this considered the needs of children *at the point of first entry into care* whereas Melzer et al. looked at the health of children already in care. Another difference was that rather than using clinical diagnostic criteria to identify mental disorders from interview and questionnaire data, this study identified emotional and behavioural problems from information recorded in case files by social workers and subsequently assessed by psychologists. A problem was identified when it became 'of concern to current or previous carers'. Using these methods, an even higher rate of emotional and behavioural difficulties was identified than in the ONS survey: 72 per cent of looked after children aged 5 to 15 had a mental or behavioural problem compared to 46 per cent in the ONS survey, with higher rates of conduct disorders (especially among boys) and emotional disorders (especially among girls). Among children starting to be looked after under the age of five (this age group was not included in the ONS survey), nearly one in five showed signs of emotional or behavioural problems.

A number of reasons are suggested for the higher prevalence rates found in the longitudinal study compared to the ONS survey. One could be that a lower threshold was adopted, although the researchers comment that 'the absence of a specific diagnosis by a trained practitioner or clinician does not necessarily mean the absence of a problem' (p229). Another is that children were only included in this study if they remained in care for at least 12 months, and it may be that such children are a more troubled group than those who leave sooner.

What is clear is that many children arrive in care for the first time with a high level of emotional and behavioural needs, which cannot therefore be attributed to the care system itself and must reflect adverse experiences in the home environment. Inadequate or abusive parenting can lead to significant attachment difficulties which affect children's ability to form strong and supportive bonds with others, and may require specific therapeutic interventions combined with support and training for carers.

Experiences of bereavement and loss are common among children who are looked after (including the loss of their birth family) and may exacerbate both physical and emotional health problems²².

²⁰ Ford T., Vostanis P., Meltzer H. and Goodman R. (2007) 'Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households', *British Journal of Psychiatry* 190, 319-325

²¹ Sempik J., Ward H. and Darker I. (2008) 'Emotional and behavioural difficulties of children and young people at entry to care', *Clinical Child Psychology and Psychiatry*, 13, 2, 221-233

²² National Children's Bureau (2007) *Bereavement, loss and children and young people in care*. Healthy Care Briefing. www.ncb.org.uk/healthycare

Although they are few in number, children placed in secure children's homes for welfare reasons are reported to have a particularly high level of mental health problems and disturbed behaviour²³.

2.2.2 Physical health

The ONS survey²⁴ found that two thirds of all looked after children had at least one physical health complaint. The most frequently reported were eye and/or sight problems, speech or language problems, bed-wetting (including among older children), difficulty with coordination, and asthma. Apart from asthma and eczema, these were all more common among looked after children than among children in the general population (Table 2.1).

A particularly comprehensive study undertaken in the US examined the medical records of all 6177 children taken into foster care in one state between 2001 and 2004²⁵. This supported and strengthened previous evidence of the much higher level of health care needs among looked after children compared to the general child population. One or more acute or chronic medical conditions was present in over half (54%) of the sample, in most cases requiring a medical referral. The most prevalent medical condition was overweight or obesity (35%, rising to almost two thirds of the adolescent group), followed by dental problems (22%). As with the English ONS survey, the reported prevalence of asthma was lower than that found in the general child population.

In a UK study of children looked after for at least a year²⁶ over half were identified as having an identified physical or health condition of sufficient seriousness to require out-patient treatment, and over a quarter had more than one condition. Mental and physical health problems often co-exist. Over three quarters of children with a mental health disorder in the ONS survey also had at least one physical complaint, compared with just over a half of children who were assessed as not having a mental disorder. This reinforces the need for mental and physical health services to work closely together and adopt a holistic approach to health needs. Otherwise, there is a risk that mental health problems such as conduct disorder will dominate any consideration of looked after children's physical health needs, and conversely that anxiety and affective disorders will be overlooked during physical health consultations²⁷.

²³ Held J. (2006) *Qualitative study: the use by local authorities of secure children's homes*. DfES Research report RR749. www.dcsf.gov.uk/research/data/uploadfiles/RR749.pdf

²⁴ Melzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) *The mental health of young people looked after by local authorities in England*. London: The Stationery Office

²⁵ Steele J. and Buchi K. (2008) 'Medical and mental health of children entering the Utah foster care system', *Pediatrics* 122, 3, 703-709

²⁶ Skuse T., Macdonald I. and Ward H. (2001) *Looking after children: transforming data into management information. Report of longitudinal study at 30 September 1999, third Interim report to the Department of Health*. Loughborough: Centre for Child and Family Research.

²⁷ Hill C. and Thompson M. (2003) 'Mental and physical health co-morbidity in looked after children', *Clinical Child Psychology and Psychiatry* 8, 3, 315-321

Table 2.1: Prevalence of physical conditions in 5-15 year olds who are looked after compared to the general population

| Physical condition | All children ¹ % | Looked after children ² % |
|------------------------------------|--------------------------------|---|
| Eye or sight problems | 11 | 17 |
| Speech or language problems | 4 | 16 |
| Bedwetting | 5 | 16 |
| Difficulty with co-ordination | 2 | 10 |
| Asthma | 16 | 10 |
| Eczema | 12 | 7 |
| Stomach or digestive problems | 6 | 6 |
| Hearing problems | 4 | 6 |
| Glue ear, otitis media or grommets | 5 | 5 |
| Kidney or urinary tract problems | 1 | 2 |
| Epilepsy | 1 | 3 |
| Migraine or severe headaches | 5 | - |
| Cerebral palsy | 0 | 2 |
| Heart problem | 1 | 2 |
| Congenital abnormality | 1 | 2 |
| Myalgic Encephalomyelitis | 0 | - |
| Cystic fibrosis | 0 | - |
| Diabetes | 1 | - |
| Blood disorder | 1 | - |
| <i>Total N</i> | <i>10,310</i> | <i>828</i> |

Source: ¹ Melzer H., Gatward R., Goodman R. and Ford T. (2000) *Mental health of children and adolescents in Great Britain*. London: The Stationery Office

² Melzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) *The mental health of young people looked after by local authorities in England*. London: The Stationery Office

When carers are asked to rate the general health of the children they look after, children living with foster carers are more likely to be rated as having very good health (69%) compared to children in other types of placement, especially residential care (41%) and those living independently (31%)²⁸. The general health of children seems to improve as their placement becomes more secure, suggesting that measures to improve placement stability could have a beneficial impact on looked after children's health. About two thirds of children in the ONS survey who had been in their placement for a year or more were assessed as having very good health, compared with just over a half of those who had been in their placement for less than a year.

²⁸ Melzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) *The mental health of young people looked after by local authorities in England*. London: The Stationery Office

2.2.3 Health related behaviour and lifestyles

The ONS survey included lifestyle questionnaires completed by 11 to 17 year old looked after young people. Almost a third reported being current smokers (rising to 69% in residential care, reflecting the greater proportion of older children in these placements). This information was collected in 2002, and rates may have reduced since then. One in twenty children with a mental disorder reported drinking alcohol almost every day compared with none of the children with no disorder. One in five of looked after 11 to 17 year olds had used cannabis, and the next most popular drugs were ecstasy and glue, gas or solvents. The greatest drug use was found among boys, children in residential care, children who had been in their placement for a short time, and children with a mental disorder. Another indicator of substance misuse is provided by national Performance Indicators. In 2007, 5 per cent of looked after children were identified as having a substance misuse problem during the year, nearly two thirds of whom received some treatment for this²⁹.

More recent, but less systematic, information comes from a 'Health and Wellbeing' event organised by Cafcass for young people in care. Many of the young people started to drink alcohol, smoke and experiment with sex at an early age, although only 11 per cent reported experience of drug taking³⁰.

A study in one Midlands local authority³¹ found that looked after children were more likely to be overweight and obese compared with their peers who were not looked after, and that the Body Mass Index (BMI) of a third of looked after children actually increased once they were in care.

2.2.4 Immunisation

A study examining the immunisation status of over 3,000 children looked after by nine health authorities across England, found that they were more than twice as likely as children living at home (33% compared to 15%) not to have received the meningococcal C vaccine³² (Hill, Mather et al., 2003). This is not just because children who become looked after are more likely to have missed immunisations before entering care. A study in Wales reported that despite statutory health assessments, children who had been in public care for at least six months were significantly less likely than age and sex matched children living in their own homes to have received immunisations against diphtheria, tetanus, pertussis and polio³³. Providing social services with information on the immunisation status of looked after children in the care of an urban unitary authority was found to have no appreciable effect on immunisation coverage for these children³⁴. However, all these studies were undertaken in the early 2000s and improvements in immunisation rates have since been recorded by most

²⁹ Department for Children Schools and Families (2008) *Outcome indicators for children looked after: twelve months to 30 September 2007, England*. Statistical first release SFR 08/2008
http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000785/SFR08_2008v2.pdf

³⁰ Cafcass (2008) *Health and Wellbeing review: the experiences of young people in care*.
http://www.cafcass.gov.uk/news/2008/health_and_wellbeing_review.aspx

³¹ Hadfield, S. and Preece, P. (2008) 'Obesity in looked after children: is foster care protective from the dangers of obesity?', *Child: Care, Health and Development* 34, 6, 710-712

³² Hill, C., Mather, M. and Goddard J. (2003) 'Cross sectional survey of meningococcal C immunisation in children looked after by local authorities and those living at home' *British Medical Journal* 326 (7385), 364-5

³³ Barnes P., Price L., Maddocks A., Cheung W.Y., Williams J., Jackson S. and Mason B. (2005) 'Immunisation status in the public care system: a comparative study', *Vaccine* 23, 21, 2820-2823

³⁴ Ashton-Key M. and Jorge E. (2003) 'Does providing social services with information and advice on immunisation status of 'looked after children' improve uptake?', *Archive of Diseases in Childhood* 88, 4, 299-301

local authorities³⁵. The average immunisation rate rose from 76.5 per cent in 2005 to 80 per cent in 2007³⁶.

2.2.5 Young people leaving care

Young people leaving care are a particularly vulnerable group, and research has consistently found that their health and well-being is poorer than that of young people who have never been in care^{37 38}.

Both young women and young men in and leaving care are more likely than their peers to be parents, with one study finding that almost half of young women leaving care became pregnant within 18 to 24 months³⁹, and another reporting that a quarter were pregnant or young parents within a year of leaving care⁴⁰. For some, this may be a positive choice⁴¹. Many aspects of young people's health have been shown to worsen in the year after leaving care.^{42 43} Compared to measures taken within three months of leaving care, young people interviewed a year later were almost twice as likely to have problems with drugs or alcohol (increased from 18% to 32%) and to report mental health problems (12% to 24%). There was also increased reporting of 'other health problems' (28% to 44%), including asthma, weight loss, allergies, flu and illnesses related to drug or alcohol misuse and pregnancy. It has been argued that young people leaving care should be able to continue to obtain health advice at what is often a very stressful time for them. Personal advisers should work closely with doctors and nurses involved in earlier health assessments and would benefit from training in how to promote both physical and mental health. Leaving care services should ensure that health and access to positive activities are included as part of young people's pathway planning, and could consider using their premises to offer health services⁴⁴.

³⁵ Ofsted, (2008) *Safeguarding children: The third joint Chief Inspectors' report on arrangements to safeguard children*. www.safeguardingchildren.org.uk

³⁶ Department for Children Schools and Families (2008) *Outcome indicators for children looked after: twelve months to 30 September 2007, England*. Statistical first release SFR 08/2008
http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000785/SFR08_2008v2.pdf

³⁷ National Children's Bureau (2008) *Promoting the health of young people leaving care*. Healthy Care Briefing. . www.ncb.org.uk/healthycare

³⁸ Broad B. (2005) *Improving the health and well-being of young people leaving care*. Lyme regis: Russell House Publishing

³⁹ Biehal N., Clayden J., Stein M. and Wade J. (1995) *Moving On: Young people and leaving care schemes*. Barkingside, Essex: Barnardo's

⁴⁰ Dixon, J. (2008) 'Young people leaving care: health, well-being and outcomes', *Child and Family Social Work* 13, 207-217

⁴¹ Chase E., Warwick I., Knight A. and Aggleton P. (2008) *Supporting young parents: pregnancy and parenthood among young people from care*. London: Jessica Kingsley Publishers

⁴² Dixon, J. (2008) 'Young people leaving care: health, well-being and outcomes', *Child and Family Social Work* 13, 207-217

⁴³ Ward J., Henderson Z. and Pearson G. (2003) *One problem among many: drug use among care leavers in transition to independent living*. London: Home Office

⁴⁴ Haywood J. and James C. (2008) *Improving the health of children in care and care leavers in London 2008/9*. Unpublished paper, Care Services Improvement Partnership.

2.2.6 Evidence from overseas

The UK is not unique in experiencing problems with addressing the health needs of children who are looked after. A national study in the US found that despite the publication of national guidelines regarding assessment, less than half of all the areas surveyed provided comprehensive physical, mental health and developmental examinations for all children entering out-of-home care⁴⁵. In Sweden, national cohort studies comparing outcomes for former care leavers with young people from adverse circumstances, but with no experiences of out of home care, have shown the former group to have an elevated risk of higher mortality, mental problems, suicide attempts and teenage pregnancy⁴⁶. Research on care leavers in Europe, the Middle East and North America has confirmed their greater vulnerability as a group to poor outcomes across a range of areas including mental health⁴⁷.

2.3 How well are health needs met, especially by health services?

2.3.1 Health assessment

Arrangements for health assessment and planning form a key part of the 2002 guidance. It is expected that an initial health assessment will be undertaken by an appropriately qualified medical practitioner, and result in a written health plan by the time of the first review four weeks after the child becomes looked after. The plan should set out how health needs identified in the assessment will be addressed, including objectives, actions, time-scales and responsibilities. Review assessments should be carried out every year (twice a year for children aged under five) by an appropriately qualified nurse.

An examination of the outcomes of statutory health assessments undertaken in the early 2000s confirmed that such assessments were able to identify health need and health neglect that might otherwise have gone unrecognised, but found that over a year later, recommendations in the assessments had failed to be implemented in almost half of cases. Many assessments appeared to function more as a disease screening exercise than as an opportunity to promote children's health⁴⁸.

More recently, an audit of 140 health assessments in a unitary authority participating in our study revealed considerable variability in the topics covered in initial health assessments. Nearly a quarter did not include a completed health care plan and only 22 per cent recorded information about family medical history (Table 2.2). Only around 1 in 10 noted that health care plan actions had been completed from the last assessment, although as these were initial health assessments on entering care, this would only have been applicable to those with a previous care history.

⁴⁵ Leslie L., Hurlburt M., Landsverk J., Rolls J., Wood P. and Kelleher K. (2003) 'Comprehensive assessments for children entering foster care: a national perspective', *Pediatrics* 112, 1, 134-142

⁴⁶ Vinnerljung B., Hjern A. and Lindblad F. (2005) 'Suicide attempts and severe psychiatric morbidity among former child welfare clients - a national cohort study', *Journal of Child Psychology and Psychiatry* 47, 7, 723-733

⁴⁷ Stein M. and Munro E. (eds) (2008) *Young people's transitions from care to adulthood: international research and practice*. London: Jessica Kingsley Publishers

⁴⁸ Hill C. and Watkins J. (2003) 'Statutory health assessments for looked-after children: what do they achieve?' *Child: Care Health and Development* 29, 1, 3-13

Table 2.2: Results of an audit of 140 initial health assessments

| Audit Criteria | Coverage % |
|---|---------------|
| Immunisation status | 90 |
| Current Health concerns | 86 |
| Medication, allergies | 85 |
| Developmental and educational status | 80 |
| Dental check history | 82 |
| Behaviour, emotional health, attachment | 78 |
| Health Care Plan completed | 78 |
| Examination with growth centiles | 67 |
| Advocacy issues | 62 |
| Health Promotion discussion | 61 |
| Legal status and consent | 55 |
| Hearing OK? | 54 |
| Optician check | 51 |
| Eating, sleeping, toileting | 45 |
| Brief summary of Care history | 47 |
| Past medical history including pregnancy toxins | 35 |
| Family medical history | 22 |
| Developmental assessment | 22 |
| Summarising paragraph at end of letter | 18 |
| SDQ, Conners Parent Rating Scale, Adolescent Wellbeing Scale | 18 |
| Last Health Care Plan actions completed from last assessment? | 11 |

Source: Data supplied by one of the case study PCTs

A published study comparing records kept by children's home staff with data from community child health records, carried out in 2000, found that important information about the health needs of looked after teenagers was not known to the care staff. Most information on birth history, developmental and early medical history, immunisations, growth, hearing and colour vision was in the child health records, and neither the child health records nor the care home records contained much information about the results of the young people's annual looked after medical examinations⁴⁹. An audit of immunisations of children in care in two local authorities likewise found problems with the recording of health data. Although children in public care had lower immunisation rates overall and more incomplete schedules than the local population, when other health records were checked it appeared that some children who were initially thought to have incomplete schedules had completed their immunisations, whereas others who were thought to be up to date had incomplete schedules⁵⁰.

⁴⁹ Bundle, A. (2001) 'Health of teenagers in residential care: comparison of data held by care staff with data in community child health records', *Archives of Disease in Childhood* 84, 1, 10-14

⁵⁰ Morrill J. (2003) 'The health needs of children in public care: the results of an audit of immunizations of children in care', *Public Health* 117, 6, 412-416

One small-scale study⁵¹ of the views of residential care workers in Scotland explored reasons for the poor rates of documentation and sharing of information about looked after children's health between health and social care staff. The British Association of Adoption and Fostering (BAAF) health record was rarely completely filled in and sometimes missing altogether. It often duplicated other records that care workers kept, and there were many examples of a new record being used when a child moved placement instead of the previous record being re-opened.

Since April 2008, all local authorities in England have been required to have the Strengths and Difficulties Questionnaire (SDQ)⁵² completed by a main carer for all children aged 4 to 16 years who have been in care for a year, in order to provide an annual outcome measure of the emotional and behavioural health of looked after children⁵³. In Northern Ireland, a focus group study was undertaken to obtain the views of social workers and their managers on the usefulness of the SDQ in identifying health needs. The questionnaire had been completed by the carers of 76 looked after children aged 3 to 17, and also by 64 teachers and 32 children aged 11 or over⁵⁴. The results were provided to social workers for consideration at the child's statutory review. In general, social workers and managers reported finding this screening very helpful in identifying both mental and physical health needs. However, it did not always lead to these needs being addressed. Pre-test and post-test file audits were undertaken to ascertain whether SDQ screening had informed the child's care planning process. While care plans reflected an increase in referrals for further assessment and screening for nearly half of the children, some children who had been assessed as having significant difficulties were not referred due to uncertainty about accessing appropriate services or concerns about swamping existing services.

2.3.2 Work with birth families and relatives

Much of the literature about looked after children focuses on those in foster or residential care. Little is known about the needs of children looked after at home by their families under a care order, or looked after by friends and family. There is also little attention to how birth families could be supported to take better care of their children's health, both before care is needed and after a child returns home⁵⁵. An innovative intervention in Australia, the Stargate Early Intervention Programme (see Box 2.1) demonstrates how birth parents can be involved in therapeutic assessment when their child enters care.

⁵¹ Hunter D., McCartney G, Fleming S. and Guy F. (2008) 'The views of residential care workers on the promotion of health and well-being of the children they care for' *Adoption and Fostering* 32, 4, 57-63

⁵² Goodman R., Ford T., Corbin T. and Melzer H. (2004) 'Using the Strengths and Difficulties Questionnaire (SDQ) multi-informant algorithm to screen looked-after children for psychiatric disorders', *European Child and Adolescent Psychiatry* 13, Sup 2, 25-31

⁵³ Department for Children, Schools and Families (2009) *Children looked after by local authorities in England guidance notes for the completion of the SSDA903 records*. London: DCSF

⁵⁴ Whyte S. and Campbell A. (2008) 'The Strengths and Difficulties Questionnaire: A useful screening tool to identify mental health strengths and needs in looked after children and inform care plans at looked after children reviews? A focus group study of the views of social workers and their managers', *Child Care in Practice* 14, 2, 193-206

⁵⁵ Scott J. and Hill M. (2006) *The health of looked after and accommodated children and young people in Scotland: messages from research*. Edinburgh: Scottish Executive

Box 2.1 The Stargate Programme in Australia

An innovative programme in Australia involved birth parents in a therapeutic assessment when their children entered care. The Stargate Early Intervention Programme was developed to assess and support all children and young people entering out-of-home care for the first time during one calendar year because of child protection reasons. The rationale was that entering care through this route was distressing and disruptive for both children and families, and that offering support only when a child was referred for specialist help was leaving it too late and risked missing those children with internalising rather than externalising problems. The programme provided a comprehensive multidisciplinary therapeutic assessment within a week to ten days of the child entering care, including interviews with carers and with birth parents, an appointment with a paediatrician and up to four individual sessions with the child. Although children already receiving a mental health service were excluded in order to avoid disrupting their treatment, more than 60% of participants were found to meet criteria for a major psychiatric diagnosis, with Post Traumatic Stress and Adjustment Disorders being the most common.

The involvement of birth parents was a key aspect of the programme, and an evaluation found that this had a number of important benefits such as helping to focus parents' attention on the needs of their child and away from the adversarial situation with child welfare services. Parental involvement was also thought important in assisting family reunification and recovery, especially since more than a third of participants returned to the care of their parents within six months of initial placement. Where ongoing treatment was recommended, the child was transferred back into the general child mental health service, or to a specialist therapy service. This was a major limitation of the programme, since lack of dedicated resources meant that further support could not always be provided. However, the Stargate Programme was judged successful in providing a proactive and child-centred 'triage' system for identifying those who needed more intensive treatment, whilst also providing support for every child and their family at the early stage of entry into care.

Source: Millburn N., Lynch M. and Jackson J. (2008) 'Early identification of mental health needs for children in care: a therapeutic assessment programme for statutory clients of child protection', *Clinical Child Psychology and Psychiatry* 13, 1, 31-47

In England, Hill⁵⁶ has identified a number of reasons why an accurate record of birth family health history is important for children who are looked after, including an awareness of conditions that might be genetically transmitted, and insight into possible causes of a child's emotional or behavioural difficulties. Many looked after children return to birth families once they leave care, so involving these families in initial health assessments could facilitate better awareness of health needs when children return home.

⁵⁶ Hill C. (2001) 'Health inheritance: the importance of family history for children in public care' *Adoption and Fostering* 26, 4, 35-43

2.3.3 Meeting mental health needs

Looked after children and their carers need access to the full range of child and adolescent mental health services, from promotion, advice and services in primary care/community setting to highly specialist provision⁵⁷. There is substantial local variation in the availability of mental health services to meet the needs of children and young people⁵⁸, including those who are looked after⁵⁹. It has been argued that for looked after children generally, who have almost always experienced difficult or traumatic situations, 'good mental health care should be more analogous to dental care such that regular check-ups, repair work and daily care need to be built into service provision'⁶⁰. This 'dental care' model of service provision was not much in evidence in one examination of specialist mental health projects for looked after children in England⁶¹. However, a more recent survey of CAMHS partnerships in London, completed by 28 of a possible 32, showed that all but one had developed designated or targeted CAMHS provision for children in their care. This provision varied as to which age range was served, and also whether the service was available to children living in the borough but placed by another local authority. Some services worked with care leavers up to age 25, others had a cut-off age of 16. Just under half had conducted a recent health needs analysis for children in care, but only three had developed an action plan to take this forward⁶².

Innovative services have been developed in some areas to improve the mental health and emotional well-being of looked after children. Young Minds in partnership with the National CAMHS Support Service⁶³ have published descriptions of six such services, and summarised their key characteristics as follows:

- flexibility
- joint commissioning
- strong leadership
- engagement with children and young people
- long-term work where needed
- holistic
- systemic thinking
- participative
- evidence-based
- reflective and responsive

⁵⁷ Department of Health (2002) *Promoting the health of looked after children*. London: DH. Page 50

⁵⁸ Ford T. (2008) 'Practitioner Review: How can epidemiology help us plan and deliver effective child and adolescent mental health services?', *Journal of Child Psychology and Psychiatry* 49, 9, 900-914

⁵⁹ Ofsted (2008) *Annual Performance Assessment (APA) 2007. Report on outcomes*. www.ofsted.gov.uk

⁶⁰ Cocker C. and Scott S. (2006) 'Improving the mental and emotional well-being of looked after children: connecting research, policy and practice', *Journal of the Royal Society for the Promotion of Health* 126, 1, 18-23 (quotation p20)

⁶¹ Cocker C. (2004) 'An examination of current specialist mental health projects for looked after children within England', *International Journal of Child and Family Welfare* 2-3, 134-56

⁶² Haywood J. and James C. (2008) *Improving the health of children in care and care leavers in London 2008/9*. Unpublished paper, Care Services Improvement Partnership

⁶³ Young Minds (2007) *Looking after the mental health of looked after children: sharing emerging practice*. www.youngminds.org.uk/publications

Box 2.2 CAMHS provision

In Westminster, looked after children and their carers have prompt access to good CAMHS advice, consultation and therapeutic intervention. CAMHS provision is enhanced through co-location of specialist posts within the looked after children's services. This results in good communication and networking with partner agencies, including out-of-borough CAMHS services. Of the local looked after children population in 2007, around 20 per cent were actively involved with CAMHS and a third of these received good direct therapeutic support.

2.3.4 Meeting health needs in secure children's homes

The 2002 guidance notes that children and young people cared for in secure settings are a particularly vulnerable group whose health needs risk becoming secondary to the need to keep them secure or to address offending behaviour (p41). An overview of the health of children and young people in secure settings⁶⁴ found considerably less information on the health of children in secure children's homes (SCHs) compared to Young Offender Institutions. A common problem was the difficulty in accessing young people's medical records especially when they moved frequently and placements were far from home. Resources to promote health in secure children's homes appeared very variable: for example in two homes of a similar size, one had two senior grade nurses available for two half days a week whilst the other had access to a school nurse just once a fortnight. In one SCH, the forensic CAMH service worked in the home one day a week, providing not only direct therapeutic work and psychiatric assessments with young people but also advising home staff on managing and working with individual children and providing staff training. Yet other SCHs had no dedicated CAMHS provision on site⁶⁵. Local authority managers who commission 'welfare' places in secure children's homes have expressed concerns about how well such placements are able to meet the needs of extremely vulnerable children⁶⁶. A training programme and resources for promoting the emotional and social well-being of young people in secure accommodation produced by the National Children's Bureau is being used by secure children's homes to improve practice⁶⁷.

2.3.5 Looked after children's nurses

The designated doctor and nurse have a strategic role in assisting PCTs to fulfil their responsibilities for promoting the health of looked after children. A 2002 survey of 45 looked after children's nurses⁶⁸ revealed considerable variability in their caseload and job content, although most nurses spent at least some of their time in a strategic role. All but nine undertook health assessments, but over a third were not part of a multi-disciplinary team, and not all nurse-led assessments were supervised by a registered medical practitioner as recommended in the 2002 guidance. Difficulties were particularly apparent for nurses working in a local authority setting, where they could be the only health professional and sometimes had little support or supervision.

⁶⁴ Mooney A., Statham J. and Storey P. (2007) *The health of children and young people in secure settings*. London: Thomas Coram Research Unit. <http://eprints.ioe.ac.uk/53/>

⁶⁵

⁶⁶ Held J. (2006) *Qualitative study: the use by local authorities of secure children's homes*. DfES Research report RR749. www.dcsf.gov.uk/research/data/uploadfiles/RR749.pdf

⁶⁷ Bird J and Gerlach L (2005) *Improving the Emotional Health and Well-being of Young People in Secure Care: Training for staff in local authority secure children's homes*. London: National Children's Bureau

⁶⁸ Hill C., Wright V., Sampeys C., Dunnett K., Daniel S., O'Dell L. and Watkins J. (2002) 'The emerging role of the specialist nurse promoting the health of looked after children', *Adoption and Fostering* 26, 4, 35-43

2.3.6 Information from national statistics and inspection reports

National statistics on health outcomes for looked after children indicate that there has been a year-on-year increase since the previous guidance was issued in the proportion of children (looked after continuously for at least a year) who have had their annual health assessment and had their teeth checked by a dentist during the year. Comparison across the period is difficult, however, because earlier figures also included the proportion of looked after children whose routine immunisations were up to date. It also needs to be remembered that children have a right to refuse a health assessment or dental check, and this will disproportionately affect ratings in those authorities with an older age profile of looked after children, since older children are more likely to refuse assessments. Bearing these caveats in mind, the C19 performance indicator, which averages the percentages of children receiving a dental check and annual health assessment, rose from just under a third of eligible children in 2001/02 to almost 89 per cent in 2006/07. Over three quarters (almost 80%) of children were also reported to be up to date with their routine immunisations in 2006/07, although this measure is no longer included in the C19 performance indicator⁶⁹.

These national figures disguise local and regional variation. Locally, the proportion of children in 2007-2008 looked after for at least 12 months who had had a dental check in the previous year ranged from 49 per cent to 100 per cent, and the proportion who had had their annual health assessment from 58 per cent to 100 per cent. Regional variations in the three main health outcome measures are given in Table 2.3. London authorities (both inner and outer) scored particularly well on the two measures (dental checks and annual health assessments) that are averaged to form the C19 indicator.

Table 2.3: Regional variation in health care indicators for children looked after for at least 12 months, year to 30 September 2007 (per cent)

| | North East | North West | Yorks & Humber | East Mids | West Mids | East Eng | London | South East | South West | All England |
|---|------------|------------|----------------|-----------|-----------|----------|--------|------------|------------|-------------|
| Children who had their annual health assessment | 92 | 88 | 84 | 83 | 76 | 81 | 90 | 78 | 87 | 84.4 |
| Children who had their teeth checked by a dentist | 87 | 86 | 82 | 84 | 85 | 88 | 89 | 83 | 89 | 85.8 |
| Children whose immunisations were up to date | 90 | 78 | 75 | 86 | 76 | 87 | 77 | 77 | 89 | 79.9 |

DCSF (2008) Outcome Indicators for children looked after, 12 months to 30 September 2007. www.dcsf.gov.uk

⁶⁹ DCSF (2008) Outcome Indicators for children looked after, 12 months to 30 September 2007. www.dcsf.gov.uk

A joint Chief Inspectors' report in 2008 confirmed improvements in health monitoring for looked after children and care leavers since 2005⁷⁰. However, the quality of individual health plans was still judged to be variable, and the role of corporate parent was not fully understood by all council members and officers. Overall, particular weaknesses in promoting the health of looked after children identified in inspection reports included:

- safe administration of medicines in residential settings;
- arrangements for securing health services for children placed out of authority; and
- waiting times for assessment and treatment for children with behavioural difficulties and lower levels of mental health needs. Fast-tracking arrangements for access to specialist CAMHS and therapeutic services for children with high levels of need, such as self-harming behaviour, were judged to be effective in most areas.

A summary of outcomes from the 2007 annual performance assessment of 137 local authorities' services for children and young people similarly reported an increasing emphasis on the health needs of children in care, but with some aspects needing further attention⁷¹. At least 15 councils were not providing adequate dental and health checks for looked after children. Higher performing councils, however, were increasingly developing more specialist multi-agency teams and specialist posts to promote the health of vulnerable groups including looked after children, and initiatives such as free access to leisure facilities for children in care were becoming more prevalent. Among all children, a number of health issues still gave cause for concern, such as rates of teenage pregnancy, obesity, smoking and alcohol misuse. These are areas where looked after children often have a high level of need, although only dental and health checks are subject to specific monitoring.

2.4 The views of looked after children on their health

Young people rarely perceive health as simply a matter of access to health services. From their perspective, the most important things affecting their health are their feelings about life, their housing situation, having close personal relationships, their care experience and depression⁷². More recently, a DVD made by young people in Cornwall illustrated what 'healthy care' meant to them. Key aspects were relationships, emotions and feeling cared for and loved, as well as physical and bodily care. 'It's all about needing people to notice when we do well'⁷³.

Research with young people in general finds that they rarely perceive health, in the more narrow medical sense, as a major life concern in the way that adults often do⁷⁴. In a survey of nearly 100 young people living or having lived in residential care in Scotland⁷⁵, a common view was that 'health means nothing to me, can't relate to it'.

A recent report by the Children and Family Court Advisory Support Service (Cafcass)⁷⁶, based on the views of participants in a 'Health and Wellbeing Day' for young people in care,

⁷⁰ Ofsted, (2008) *Safeguarding children: The third joint Chief Inspectors' report on arrangements to safeguard children*. www.safeguardingchildren.org.uk

⁷¹ Ofsted (2008) *Annual performance assessment (APA) 2007. Report on outcomes*. www.ofsted.gov.uk

⁷² Broad B. (2005) *Improving the health and well-being of young people leaving care*. Lyme Regis: Russell House Publishing.

⁷³ 'Healthy Care Rules', DVD produced by Cornwall County Council Looked-After Children Development Team.

⁷⁴ Shucksmith J., Hendry L., Wood S. and Dewsbury G. (1997) *Young people's perception of their own health needs*. Edinburgh: Health Education Board for Scotland.

⁷⁵ Ridley J. and McCluskey S. (2003) 'Exploring the perceptions of young people in care and care leavers of their health needs', *Scottish Journal of Residential Care* 2, 1, 55-63

⁷⁶ Cafcass (2008) *Health and Wellbeing review: the experiences of young people in care*. http://www.cafcass.gov.uk/news/2008/health_and_wellbeing_review.aspx

found that the majority of them were happy but felt they needed more support from their carers and social workers. Key findings included:

- more than a third of the young people felt that their health was only average;
- a large number felt that they were experiencing or had experienced stress;
- cost was seen as a barrier when considering healthy eating;
- very few people chose to go to professionals when considering sexual health;
- young people in care sought support from family and friends they left behind;
- peer pressure had a big impact on lifestyle choice for young people.

Young people in a mixed residential children's home identified the health topics that they would most like to receive information on as stress, keeping fit, substance use and sexual health. They often felt that they did not have an opportunity to raise the issues that concerned them during medical examinations⁷⁷. There is some evidence that where health assessments are carried out by specialist looked after children's nurses, the health promotion element is greater and there is more opportunity for young people to discuss health and lifestyle issues⁷⁸.

2.4.1 Views of care leavers

Studies of young people leaving care typically report that their health concerns are similar to those of young people outside the care system (such as smoking, sexual health and STIs). Unlike most of their peers, they have to deal with such problems while learning to live independently. Support from a leaving care key worker or Personal Adviser can be extremely helpful at this time, although the level of such support is very varied⁷⁹. Small-scale local studies about health services⁸⁰ have identified that young care leavers value supportive and friendly health professionals; would like to keep the same GP if possible; and like the idea of young people's clinics although not all are sure what they are. Some were not sure how to make a dental appointment; and some preferred to use accident and emergency departments at hospitals rather than a GP because they did not have to make an appointment. Young people also expressed concern about the cost of glasses. All wanted easy-to-use and young-person friendly information about health and how to use health services.

Peer research carried out by young care leavers themselves tends to reveal a more positive picture than most other research studies. The *What Makes the Difference* (WMTD) project trained care leavers to undertake 265 interviews with other care leavers aged between 15 and 23, from 15 local authorities. The majority of these young people said they were registered with health professionals and felt confident about accessing advice, and more than three quarters felt that leaving care services showed interest in their health⁸¹.

⁷⁷ Bundle, A. (2002) 'Health information and teenagers in residential care: a qualitative study to identify young people's views', *Adoption and Fostering* 26, 4, 19-25

⁷⁸ Hill, C. (2002) 'The emerging role of the specialist nurse: promoting the health of looked after children', *Adoption and Fostering* 26, 4, 35-43

⁷⁹ Goddard J. and Barrett S. (2007) *The health needs of young people leaving care*. Social Work Monograph 22. Norwich: University of East Anglia

⁸⁰ National Children's Bureau (2008) *Promoting the health of young people leaving care*. Healthy Care Briefing. . www.ncb.org.uk/healthycare

⁸¹ Rainer WMTD and National Children's Bureau (2007) *What Makes the Difference? Peer research study of the views of care leavers in England*. London: Rainer WMTD and NCB

2.4.2 Views of young parents

Young parents who are care leavers report wide variations in support available to them across the country, including access to sexual health services before they became pregnant. Many fear involvement with services that could help them to look after their child's health as well as their own, in case it leads to their child being taken into care⁸².

2.4.3 Views on mental health

Focus groups conducted with looked-after young people aged 12 to 19 found that they particularly welcomed the more informal approach of mental health services provided by the voluntary sector. They also valued choice in whether or not they participated in counselling or therapy, and some control of the agenda⁸³. Other studies have also emphasised the importance of choice and respect for children's views among those providing mental health services⁸⁴. Children's concerns may differ from those of their carers: for example a study in one London local authority found that young people in care tended to identify internal emotional problems, whereas their carers predominantly focused on externally visible problem behaviours⁸⁵.

It has been argued that a key factor contributing to the emotional well-being of looked after children is infrequent changes of placement and carer⁸⁶. In an American study, placement stability was an important predictor of behavioural well-being (measured using the Child Behaviour Checklist and temperament scores) after 18 months in foster care, regardless of the levels of difficulty children had experienced before entering care⁸⁷. However, remaining in an unsuitable placement just to avoid changes of carer is not the answer. More than two thirds of looked after children surveyed in 2008 by the Children's Rights Director thought that their last placement change had been in their best interests. The main reasons they gave were that they felt happier, safer or better looked after in their new placement, that they didn't get on with someone or get enough support in their last placement, or that they liked their new carers better⁸⁸.

⁸² Chase E., Warwick I., Knight A. and Aggleton P. (forthcoming 2008) *Supporting young parents: pregnancy and parenthood among young people from care*. London: Jessica Kingsley Publishers

⁸³ Stanley N. (2002) 'What young people want' *Community Care*, 15 August 2002, www.communitycare.co.uk

⁸⁴ Davies J. and Wright J. 'Children's voices: a review of the literature pertinent to looked-after children's views of mental health services', *Child and Adolescent Mental Health* 13, 1, 26-31

⁸⁵ Beck A. (2006) 'Users' views of 'looked after' children's mental health services', *Adoption and Fostering* 30, 2, 53-63

⁸⁶ Kelly S. and Hodson R. (2008) *Stability of placements of looked after children: number of moves*. Dartington: Research in Practice

⁸⁷ Rubin D., O'Reilly A., Luan X. and Localio A.R. (2007) 'The impact of placement stability on behavioural well-being for children in foster care', *Pediatrics* 119, 2, 336-344

⁸⁸ Morgan, R. (2008) *Children's care monitor 2008: children's views on how care is doing*. London: Ofsted

3. Evidence from stakeholder interviews

This chapter focuses primarily on presenting findings from the interviews with key stakeholders at national, regional and local level, indicating how well the current guidance is met and where revisions were thought to be needed. Where appropriate, information is also included from the Child Health, Child and Adolescent Mental Health and Maternity Services Mapping Exercise, and from our analysis of a sample of Joint Area Reviews.

It is important to note that we were interviewing people with very different responsibilities and therefore not all topics were covered with all interviewees: for example a public health lead may well not be able to comment on designated roles or health assessments and plans. For this reason, it was not judged appropriate to undertake any quantitative analysis of how many people said what. We also took the decision to include points that were made by only one or two people, when these appeared particularly pertinent and relevant to revising the guidance.

Interviewees were asked to comment on specific areas of the current guidance and what needed to change, but a number of cross-cutting themes also emerged such as the need to raise the profile of looked after children and the need for an holistic approach to health. An overview of interviewee responses organised around the following aspects of the current guidance is presented, followed by the cross-cutting themes:

- Strategic planning and corporate parenting
- Joint working and commissioning
- Responsible commissioner regulations
- Designated and named health professionals
- Health assessments
- Health planning
- Provision of health services
- Health promotion
- Transition

3.1 Strategic planning and corporate parenting

Planning and developing services to meet the health needs of looked after children requires understanding what their needs are, where there are gaps and where service improvement is required. Yet planning often occurred in the absence of a needs analysis and looked after children were not always prioritised in the Joint Strategic Needs Analysis (JSNA). Effective strategies to inform planning, which it was suggested could be referred to in the guidance were:

- good information systems that can provide data on quality;
- ensuring looked after children's health is prioritised in JSNAs and Children and Young People's Plans and includes data from carers and looked after children and young people;

- annual audits of health assessments;
- collating data from local authority management information systems; and
- making explicit the links between the JSNA, Local Area Agreements, PCT operating plans and the commissioning agenda.

The concept of corporate parenting was said to be poorly understood, particularly among health professionals and social workers. Further clarification would be welcomed in the guidance - what it means, how it can be supported, and where responsibility ultimately rests. Several interviewees felt that corporate parenting responsibilities should be extended to PCTs and CAMHs with the corporate parenting group having statutory powers.

Box 3.1 Joint Strategic Needs Assessment

Bristol has put strong emphasis on Joint Strategic Needs Assessment (JSNA), and has identified vulnerable and at risk groups as a priority including looked after children. The JSNA manager is responsible for analysing data on looked after children and using this as the foundation for commissioning of services. A consultant in public health for children has been appointed to support a more evidence-based approach to improving outcomes for vulnerable groups in particular looked after children. There is good joint working between the jointly appointed Director of Public Health and the Director of Children's Services, and a strong focus by the Children and Young People's Partnership on the needs of looked after children, including the 'Be healthy' outcome. The Partnership is chaired by the PCT Chief Executive, supported by three jointly appointed commissioners of health services based in the city council.

3.2 Joint working and commissioning

Joint working, the extent of which varied across areas, was said to be hindered by a silo mentality, poor communication including tensions in sharing information and confidentiality, the recent reorganisation across PCTs, systemic problems in social care systems and in particular joint working with health. It was also hampered by a fundamental misconception across agencies as to what healthy care meant for looked after children. It was often said to be construed as a medical model.

Where joint working worked well, interviewees referred not only to the commitment and enthusiasm of particular individuals and good working relationships, but to formal structures for joint working such as multi-agency boards and committees, joint planning and joint commissioning - for example jointly funded posts - and integrated or multi-disciplinary teams and services. Where joint working relied solely on champions, important though these were, interviewees pointed to the danger of the work unravelling when these people left.

Box 3.2 Worcestershire Healthy Care Board

Worcestershire has a Healthy Care Board which is a subset of the corporate parenting group. The membership of the board is made up of the service development manager for looked after children, the head of specialist children's services for Worcestershire PCT, the named nurse, the operation manager for independent reviewing officers, the programme lead for the young people's substance misuse team, the lead nurse for schools, consultant paediatrician acute services, named doctor for looked after children/medical officer for adoption, teenage pregnancy co-ordinator, healthy lifestyles manager, Team Manager Integrated Service for Looked after children (ISL), operational manager area services and the service manager 16+ targeted services. The ISL is a multi-agency team which includes health practitioners working alongside social workers, education staff and a community & leisure development worker who support children and carers by ensuring looked after children are given priority in accessing Community and Mental Health Services (CAMHS), disseminating information and providing training to carers, and in ensuring health assessments are completed.

In facilitating joint working, emphasis was also placed on the importance of understanding each agency's roles and protocols, better communication between agencies and between the DH and DCSF, clear protocols and systems for information sharing, developing shared performance indicators, and joint working at both strategic and operational levels. In some areas it seemed that although joint working happened operationally, it was not supported strategically. Healthy Care Partnerships⁸⁹ were said to provide mechanisms for joint working as did the Healthy Care Programme Audit. One Regional Healthy Care Programme Lead suggested use of this audit should be mandatory, or at least a recommendation in the guidance.

Joint commissioning and the pooling of budgets was perceived as helping to move looked after children up the Health agenda and a driver for service improvement, although a SHA children's lead observed that PCTs were wary of pooled budgets, preferring to align their budgets with the LA. Joint commissioning was considered to be poorly understood and practice patchy across the country. As a consequence, the revised guidance needs to address and strengthen joint commissioning (including good practice examples of joint commissioning). In some regions there has been a move towards regional commissioning, which according to one interviewee had the potential to bring some consistency in approach and help to avoid the current 'post-code lottery'.

Box 3.3 Partnership working in Richmond

In Richmond, the Joint Area Review reports that good systems are in place to ensure that the health needs of looked after children are identified and can be met effectively. The multi-agency team, which includes a clinical psychologist, education staff and assigned specialist nurse, is proactive in following up any issues if necessary. Looked after young people and care leavers are very positive about the value and the ease of access to drop-in advice and support from the multi-agency team, in relation to their health and education needs.

⁸⁹ Healthy Care Partnerships are multi-agency groups which aim to provide a co-ordinated approach to the development and improvement of services for looked after children

3.3 Responsible commissioner regulations

Although the *Care Matters* implementation plan recommends that out-of-area placements should be reduced, the latest statistics (see 2.1) show that 3 in 10 children are placed outside the boundary of their home authority. Although national figures are not available, there is known to be considerable movement of looked after children in and out of LAs and their PCTs. The responsible commissioner regulations state that the 'home' PCT should take responsibility for ensuring a looked after child receives the services they need. The principle may be a sound one, but this is not yet working well in practice. This was one area of the guidance where most of those with knowledge of the responsible commissioner regulations reported difficulties. Interviewees spoke about the guidance being confusing and open to different interpretations resulting in confusion as to which PCT had responsibility, differences in cross-charging, difficulties in joint working and fragmentation of services. Those PCTs that were 'net importers' of looked after children with very few of their own children being placed out of area found that they were at a disadvantage if charging was based on a 'quid pro quo' basis, and some were 'out of pocket' and uncertain whether it would be cost effective to set up infrastructures for recouping the costs. Poor communication between placing and receiving PCTs and LAs meant that PCTs could be unaware that a child had been placed in their area until or unless an approach was made to a service. Although social workers have responsibility for notifying receiving PCTs of a child's arrival, the system often seemed to break down. An interviewee representing a national organisation was of the opinion that social workers struggled with this aspect of their work due to not understanding how the health system worked, compounded by the huge local variation in health systems for looked after children.

Out of area placements were sometimes described by interviewees as being 'forgotten' by both placing and receiving PCTs/LAs and being absent from strategic planning. Concern was raised as to whether out of area placements have their health needs adequately met particularly when placement planning appeared to give little consideration to the services offered by the receiving PCT for looked after children's health, despite the recommendation to do so in the current guidance. However, a national representative reported that health assessments and plans were often not available before care planning meetings. It was said that some receiving PCTs prioritised their own children and targeted services were unavailable to 'incomers' because the placing PCT either refused or was unable to pay. Child and Adolescent Mental Health Services (CAMHS) were cited as particularly difficult for out of area placements to access, which was thought to be due to resourcing issues or an unwillingness to prioritise this group. To overcome this problem some areas had negotiated with their own CAMHS to see their out of area placements thus accessing the service more speedily, but inevitably this depended on how far away the placement was.

In the London region, a 'Pan-London Passport' has been developed by Care Services Improvement Partnership, the regional Government Office and Young London Matters, which links to the London Pledge for Children in Care. It aims to ensure equality and ease of access for children placed out of their borough to services which support their mental health, emotional well-being and placement stability.

Differences in local health systems for looked after children meant that service quality could not always be assured. In fact, some LAs / PCTs sent their own health practitioners to undertake health assessments of 'their' children placed out of area in an attempt to guarantee quality as well as ensuring continuity in health personnel for the child or young person. However, this practice was criticised by others on the grounds that the practitioners would be unaware of the services available in the area.

Not surprisingly, greater clarity in the guidance was called for regarding the implementation of the responsible commissioner regulations in terms of responsibility, the pathway and protocols across health and social care for notification and transfer of records, the monitoring of health plans, and charging. Suggestions for specific changes in the guidance included: a national charging scale or reciprocal arrangements for charging agreed nationally; stating unambiguously that PCTs will assume immediate responsibility for the health of any looked after child resident in their area and that they will have access to all health services; making the regulations statutory with sanctions applied for non-compliance. To support improved communication between PCTs and LAs, a national database of looked after children's health professionals was proposed.

3.4 Designated and named health professionals

In our interviews we were told of areas without a designated doctor, sometimes attributed to recruitment problems, and occasionally to the requirement not being statutory. Analysis of the 2007 data from the National Child Health, Child And Adolescent Mental Health, and Maternity Services Mapping Exercise revealed that almost a quarter of the 152 PCTs did not record having a designated doctor, though 89% recorded having a designated nurse⁹⁰. Interviewees in our study suggested that commissioners did not always understand these roles and, along with the provider / commissioner split, which was a cause of concern for some, the guidance needed to clarify the roles of designated doctor and nurse, especially if they were located in the provider rather than commissioning arm. Views were mixed as to where the roles should be placed, though on balance the provider arm was favoured. It was considered essential however that the roles fulfilled a strategic function and had some influence on commissioning: "It is essential to have a senior manager to advocate for the health of looked after children, who is confident to get the job done, and push the system to work for the child" (national stakeholder).

Interviewees supported the specification in the current guidance that the designated doctor be a senior paediatrician. In fact, of those PCTs recording a designated doctor in the Child Health, CAMHS and Maternity Services Mapping Exercise all but one was a paediatrician. As recommended in the guidance, the designated doctor should be a community paediatrician since it was argued that they have the appropriate training, particularly in public health and in the effects of neglect and attachment disruption, as well as experience of working across agencies. GPs were thought to lack this essential experience and set of skills.

Box 3.4 Liverpool Health of Looked After Children Team

Liverpool has a health team that includes designated doctor, a senior nurse (band 8a) and specialist nurses as well as trained school nurses. Following the doctor's initial health assessment, school nurses write a personal health plan and give a copy to the carer and child. A copy is sent to the senior nurse who manages the leaving care nurse team to ensure Quality Assurance. This service then administers the plans and sends a copy to the Independent Reviewing Officer (IRO), nurse, social worker, and child. The IRO team manager attends joint management meetings and reports progress on attendance at health assessments and reviews, so that the nurse manager can follow up with social work teams.

⁹⁰ From those not recording a designated doctor or nurse it is not possible to distinguish between missing responses and those who do not have one.

It was reported that in some areas the looked after children health service had combined with Child Protection under a safeguarding umbrella resulting in less resourcing for looked after children and in some cases failure to implement the guidance due to Child Protection taking priority. Concern was expressed, particularly among looked after children's nurses, that looked after children responsibilities were being subsumed under the safeguarding role resulting in some confusion and the dilution of this work. There was a view that work with looked after children needed to be kept separate, because although safeguarding was integral to the work of a looked after children nurse, such nurses required a different skill set: "The role is coordination of services around the child including support and advice for social workers and carers as well as a support, training, advice and challenging role in a multi-agency arena. They provide specialist interpretation of health information known about a child, and that requires considerable skill" (Looked after children's nurse).

In clarifying the role of designated doctor and designated nurse interviewees spoke about the need for a competency framework for all professionals working with looked after children. The British Association for Adoption and Fostering (BAAF) has developed job descriptions for these roles and some areas such as Kent had made a start in developing a competency framework. Continuing professional development was also considered essential, particularly as this was generally given little attention, and adequate support and supervision too, particularly clinical supervision. In a survey of 95 medical advisers undertaken by BAAF in 2007 (personal communication) almost three quarters (72%) reported no clinical supervision for their specialist work with looked after children. Concern was raised by some looked after children's nurses about the lack of clinical supervision for those nurses employed by local authorities.

Workloads varied considerably depending on demand and investment by the PCT, for example from 1:500 in one PCT to 1:200 in another. In data from the Child Health, CAMHS and Maternity Services Mapping Exercise the full-time equivalent for designated nurses ranged from 0.25 to 3.0 and for designated doctors from 0.05 to 1.0. Capacity issues included not having enough nurses for the number of looked after children, little or no administrative support, and doctors not having enough sessions for direct work with children and young people. There were particular difficulties for looked after children's nurses in the rural area included in our study, where undertaking health assessments (including for children placed by other local authorities) involved significant travelling time.

Two surveys by BAAF, one of medical advisers and another involving 57 specialist nurses, also highlight capacity difficulties. For example, 31 per cent of doctors and 60 per cent of nurses were reported to have insufficient time during working hours to complete health assessment administration. In the 2007 Joint Area Review for Bedfordshire it was reported that the limited provision of designated nurse time resulted in inconsistent quality of assessments. Clearly, sufficient time is needed to fulfil the work required of designated doctors and nurses, although specifying a ratio of worker to children was thought to be difficult since it depended not only on the size of the looked after children population, but also the needs of this population. However, a representative from a national organisation was of the opinion that PCTs should provide health teams based on a nationally agreed per capita figure for looked after children.

The proposal in Care Matters for a named health professional, or lead health professional as some were apt to call them, was generally endorsed among those commenting on it, although a strategic lead in one PCT highlighted funding issues if it became a requirement for every looked after child to have a named health professional. Although the named health professional could be a nurse or a GP, the general consensus, certainly among looked after children's nurses, was that this role should be undertaken by a looked after children's nurse. Several areas were already fulfilling this requirement. For example in Bradford a named health professional was assigned to the young person and remained responsible for them

throughout their time in care and regardless of where they were resident. This practice encouraged continuity in relationships and with it the benefits such continuity could bring.

One looked after children's nurse was concerned that health visitors and/or school nurses may be assigned the role of named health professional and that they would not have the necessary skills and experience with looked after children to undertake this role. There was some ambiguity and confusion among those interviewed as to how the different roles - designated nurse, lead professional and named health professional - should fit together and work in practice, and greater clarity would be useful in the revised guidance. One interviewee commented on the danger of having too many leads and the confusion that this could generate. She advocated a social pedagogic approach⁹¹ because, in her opinion, a health led approach encouraged a silo mentality.

3.5 Health Assessments

There was considerable variability as to who did health assessments not only across areas, but within areas too, particularly in some large shire counties. In some areas, all initial health assessments were done by a consultant community paediatrician, whilst in other areas it could be a GP, the Looked After Children Nurse, health visitors (for children under 5) or school nurses. The quality of assessments undertaken by GPs was frequently singled out for criticism, although a minority of interviewees thought that if quality issues could be addressed, through provision of training and specifying the required competencies in the commissioning process, then assessment by GPs could offer children a more 'normalising' experience. Assessment by looked after children's nurses was seen to offer a number of benefits, for example the fact that a relationship had often already been established with looked after children and they preferred someone who was known to them, as well as the specific expertise that looked after children's nurses gained from working with this group. Those advocating that nurses should undertake initial health assessments stressed that it should be a senior nurse. Others saw the task as one for a consultant paediatrician, preferably a community paediatrician, and emphasised that paediatricians not only had the necessary skills and expertise but also the weight to push recommendations forward. The following different practices were reported in relation to responsibility for initial and review health assessments:

- a) All initial health assessments (IHAs) by consultant community paediatrician, but health reviews by health visitors (under 5s) and school nurses.
- b) IHA and most reviews undertaken by community paediatrician.
- c) All IHA by paediatrician and all reviews by named looked after children's nurse.
- d) No designated doctor, so GP or looked after children's nurse does initial assessment with health visitors and school nurses doing reviews.
- e) Nurse led team carries out all initial assessments and review.

The quality of health assessments and dental checks was frequently raised as an issue that needs to be addressed. The focus of the national indicators on number of assessments completed, together with a lack of specified standards and quality assurance, were thought to focus attention on quantity rather than quality and risked encouraging a 'tick-box' mentality. Different models of assessment across the country mean that there is no

⁹¹ Social pedagogy adopts a holistic 'whole child' approach and is often referred to as 'education in its broadest sense'. It encompasses upbringing, child-rearing, nurturing, socialisation and supporting development .
<http://www.socialpedagogyuk.com/>

consistency and considerable variability in what is covered in initial health assessments, as was illustrated earlier in the audit of 140 health assessments undertaken in one PCT (Table 2.2). The inconsistency and concern about quality led some areas to send their own staff, usually a looked after children's nurse, to undertake assessments of their out of area placements as discussed above (section 3.3). A number of recommendations were made to help remedy these issues, which could be included in the revised guidance (Box 3.5).

Box 3.5 Recommendations to improve health assessment

- specifying the skills and competencies required to do health assessments;
- statutory annual training for those doing assessments to ensure common standards;
- having a standardised assessment framework and/or quality standards that embrace a holistic approach and against which PCTs could be measured by SHAs (the BAAF forms were used in many of the areas represented, but they were not universally endorsed);
- an initial health assessment that was comprehensive and multi-agency covering medical and public health, health promotion, mental health and well-being (many felt that insufficient attention was given to this), vision and dental checks, and a speech and language assessment.

In the context of assessment coverage, a consultant paediatrician commented on the number of mental health assessment tools and the need to develop one assessment that could detect need at each of the different service levels.

In achieving a comprehensive assessment it is important to collect a family history and access past medical records as recommended in the current guidance. One designated doctor described how he aimed to meet the birth parents of as many looked after children as he could because this was the only way he was able to build a health history which was comparable to that of a child from an intact family. However, the difficulties in getting information from birth parents, the delays in obtaining medical records, and the problems created by data protection for sharing information were all raised by interviewees as major issues. Taking into account a child's experiences before coming into care was also an important component of the health assessment, which was sometimes overlooked or not given sufficient attention.

Having a comprehensive initial assessment could, it was suggested, lead to greater flexibility in the frequency of reviews, particularly among those children who were healthy and in a stable placement. In one area children who were healthy were not seen for a review, but a questionnaire was sent to the child's GP, carer and the young person where appropriate. Although some criticised assessments that took place without the child being present, this practice seemed in the circumstances described to be trying to some extent to accommodate the desire among looked after children not to be seen as different from their peers. In fact, several interviewees raised this issue about the purpose of the annual health review for those children who are healthy - "other children and young people don't have them" - and a number of respondents in one area questioned whether it would be better to place the focus for health assessments on children coming into care and children on the edge of care, both of whom are more vulnerable to chronic health conditions going undetected. A designated doctor suggested the need for flexibility in the timeframes for reviews saying that whereas some children would need to be reviewed more frequently, for others it could be less frequent.

Some interviewees discussed the problem of young people, particularly those in their teens, refusing health assessments and the strategies that may encourage a better uptake among this group, or alternatives to an assessment. These included:

- a virtual assessment;
- adapting 'Teen Life Check' (a self-assessment tool to help young people aged between 11-14 assess their health and well-being and get information and advice about healthy lifestyles) for use with looked after children;
- meeting young people informally to discuss health issues;
- offering assessments in non-medical venues; and
- consulting with young people about what would change their mind about having a health assessment.

Box 3.6 The Quays in Southampton: using non-health settings for assessments

Aware that the medical centre was not an environment conducive to teenagers and concerned about the low uptake of assessments among this group, the team in Southampton set up a clinic in the Quays Leisure Centre covering health assessments for looked after children, sexual health and substance misuse advice for all young people. A 'one stop shop' has been created combining health with sport and leisure facilities, to which looked after children are given free access. As a result, the uptake of assessments among teenagers has increased.

Box 3.7 Increasing uptake of health assessments

In Worcestershire a group of looked after young people and staff worked with a professional company to produce a Lego animated film explaining health assessments for looked after children. The DVD clearly explained that health was about healthy living and the five outcomes of Every Child Matters, and not just about taking a medical view. The evaluation of the young people's feedback showed not only enjoyment of the process, but enhanced self-esteem and well-being. The DVD and leaflet is currently being distributed to all Worcestershire foster carers, and is believed to be having a positive effect on the uptake of health assessments.

The involvement of young people in health assessments and health plans was considered fundamental - "if they do not know and understand what is going on, what is the point?" - but the participation of young people was said to be variable across PCTs and not particularly high on SHA agendas. In one PCT, children could choose the time and venue for the assessment and became engaged with their own assessment as soon as they were competent. Other examples of young people's involvement included helping to design leaflets and the paperwork which went out to them inviting them for assessment, service development and evaluation, such as developing a business card with details of how to contact the health team and exploring the possibility of a texting service, and including young people in interviews for key posts.

Box 3.8 Annual health checks

Looked after children in Redcar and Cleveland have a choice over where their annual health check takes place. Older children are able to attend appointments unaccompanied if they wish and can decide if this should be carried out by the designated looked after children nurse or their own GP.

3.5.1 Improving timeframes for health assessment

Interviewees were asked about the timeframes for assessments and reviews and how well these were met. One interviewee, a HCP lead, commented that timeframes could be a source of antagonism for PCTs and LAs alike. Where there were problems this was attributed to delays in requesting an initial health assessment, delays in the transfer of records and information, and children and young people not attending appointments. Looked After Children Nurses in particular were of the opinion that social workers were unable to fulfil their duties regarding health in terms of notification, paperwork, ensuring attendance, implementation of health plans and that this was in part attributable to the pressures they worked under and not prioritising health. With regard to both assessments and health plans, interviewees commented that it was important for social workers to alert agencies and pass on information quickly. However, identifying the relevant health professionals could be problematic and it was suggested that a national database with the contact details for designated roles in each PCT would therefore be beneficial. Other suggestions to help resolve these issues included:

- universal protocols for sharing and transferring records;
- providing guidance on confidentiality issues;
- an electronic record of assessment;
- each young person having a 'health passport' that stayed with them;
- emphasis in the guidance on the role carers have in ensuring children are enabled to attend health assessments; and
- training for social workers to improve their understanding of the health assessments and the importance of taking an holistic approach to health.

3.6 Health plans

The 2002 guidance states that a health assessment should be carried out within four weeks of a child becoming looked after and this should then form the basis of a health plan to be regularly reviewed. As with assessments, health plans were reported to vary in quality and were not always implemented effectively, due to a failure to monitor whether or not actions were carried out. There was some confusion as to who was ultimately responsible for monitoring implementation and it was hoped that the revised guidance would provide clarification. Although a health professional, such as a looked after children's nurse, was suggested by some as the person who should take responsibility because they had the relevant skills, a designated nurse said that she would not have the capacity to monitor every plan if that became a requirement. Some said there should be a statutory duty on social workers or jointly on social workers and looked after children's nurses to monitor plans. There was general support for the idea that Independent Reviewing Officers (IROs) should be responsible for reviewing implementation and challenging agencies if they failed to meet

their responsibilities, such as acting on health plans. However, IROs' lack of health experience, large workloads, tendency to focus on education and child protection, and lack of independence were all said to contribute to this not always being done effectively. Few were reported to have received training in this aspect of their work. This led respondents from one area to suggest that it would be useful if the guidance outlined the skills and knowledge base required by IROs to monitor the implementation of health plans.

Box 3.9 Independent Reviewing Officers

Lewisham represents the interests of looked after children through a challenging and independent reviewing officer and advocacy service, which reports quarterly to senior borough officers. The service is promoted through the Make It Better magazine, which provides a valuable forum for looked after children and care leavers, encouraging them to contribute poems and stories, and provides information on topics such as healthy eating, bullying and sexual health.

Several interviewees mentioned that they did not have good databases from which they could establish whether plans were being followed up, although one designated nurse described how her PCT had developed a database for looked after children which made the monitoring of individual plans relatively easy.

3.7 Provision of health services

This section of the interview focused predominately on GP and dental services and Child and Adolescent Mental Health Services (CAMHS), particularly access and waiting times.

3.7.1 GP services

For some areas GP registration was problematic due to a reluctance of GPs to register temporary residents. Temporary registration of looked after children meant that health records were not transferred, resulting in temporary sets of records and missing information. A statutory requirement for GPs to permanently register all looked after children and unaccompanied asylum seekers in their area would help to ensure the transfer of health records. Raising awareness among GPs of the health needs of looked after children and specifying GPs responsibilities more clearly were mentioned as important in bringing GPs 'on board'. In one local area, awareness training was offered to all health professionals including GPs, although this was not thought to be a widespread practice. However, awareness training may not be enough and a senior health manager suggested that other incentives may be needed such as enhanced payments for GPs permanently registering looked after children.

3.7.2 Dental services

The point was made that registration with an NHS dentist was difficult not just for looked after children, because of the shortage in many areas of the country. Although dental checks may be carried out, it was not entirely clear if it was always a dentist who undertook them. Several areas used the specialist paediatric community dental service when local independent NHS provision was not available. Responses from one area suggested that the revised guidance should recommend initial dental screening by the specialist paediatric community dental service, and that this service should ensure a child was dentally fit before transfer to a general dental practice. One interviewee said that dentists should be instructed that looked after children were a priority, whilst another explained the need for dentists to be better informed regarding dental decay, particularly among infants, and its link with deprivation. A

designated nurse described how they were working with the dental health commissioner to build a peripatetic service for looked after children. In this PCT there was a dental bus in the area three days a year for care leavers' use.

3.7.3 Child and Adolescent Mental Health Services (CAMHS)

As outlined in chapter 2, research evidence supports the view held by interviewees that many looked after children have significant mental health needs. Difficulties however were reported in accessing CAMHS, particularly for out of area placements, manifested in long waiting lists for assessments and services even when looked after children are fast-tracked, and a lack of appropriate services. Several reasons were put forward to account for these difficulties including:

- a refusal to provide services until children were in a stable placement, though as one interviewee pointed out, many children need the support of CAMHS before placement stability can be achieved;
- inappropriate or difficult referral pathways;
- a failure to prioritise looked after children within CAMHS;
- PCTs not giving children's mental health priority (partly attributable, according to one senior medical adviser, to CAMHS not being clear about the benefits of a good service in terms of outcomes);
- overstretched services that lack capacity;
- an inadequate focus on services at Tiers 1 and 2; and at Tier 4, a shortage of inpatient care resulting in inappropriate placements in secure units and Youth Offending Institutions which prioritise short-term work; and
- changes in the funding formulas for CAMHS having a negative impact in some areas.

The mental health needs of looked after children were considered best met when there was a dedicated CAMH service for this group, or a dedicated CAMH post integrated within a looked after children team. Between 2003 and 2006 the number of targeted and dedicated worker teams that had a looked after children or social services focus has steadily increased⁹². In 2006, 53 per cent of CAMHS caseload for looked after children received care from a multi-professional generic team, 31 per cent from a targeted team, 8 per cent from dedicated worker teams, 6 per cent from tier 4 teams and 3 per cent from generic discipline teams, though this varied across SHAs.

Several service models were described to reduce pressure on CAMHS and help to ensure that children most in need were seen quickly (see boxes 3.10-3.12). Interviewees described different approaches to addressing the need for more provision at Tiers 1 and 2 such as training and supporting those working with looked after children, for example carers and school nurses, to enable them to offer this service, emphasising that more input at these levels would help alleviate crisis intervention at a later point. Examples of such practice included:

- family support clinics run by nurses with mental health expertise as the first point of contact for carers and children with high SDQ scores, from which direct referrals

⁹² Barnes, D., Parker, E., Wistow, R., Dean, R. with Thomson, C. (2007) *A Profile of child health, child and adolescent mental health and maternity service in England 2007*. Durham: Durham University.

could be made to CAMHS or other specialist mental health services as appropriate; and

- 'Relateen' services offered by Relate and based in secondary schools for looked after children and their peers.

Box 3.10: Promoting mental health: a multi-agency team

The Multi-Agency Liaison Team (MALT) in Camden has significantly improved mental health outcomes for young people, especially looked after children (JAR report, 2008). MALT is jointly commissioned and offers a Tier 3+ service, but also acts as a screening and targeting point for other CAMHS type service in the area. A good range of mental health facilities at different levels has been developed in Camden, and the MALT has helped to curb a tendency for referrers to make referrals to two or three places at once.

Box 3.11: Promoting mental health: a 'triage' service

A 'roots and branch' review of CAMHS in one LA area resulted in the appointment of a CAMHS worker dedicated to looked after children and the move to a 'triage' system for all children so that urgent cases could be seen quickly. These changes saw a significant reduction in waiting time. The changes also included a fast track system to advise carers on mental health and emotional well-being. Since there was no new funding for these changes in the service resources had to be annexed from elsewhere, which was difficult to do. Clinicians were also resistant initially to the proposed service changes and needed convincing that it was the right thing to do.

Box 3.12: Promoting mental health: a consultative model

In Worcestershire, initial health assessments are undertaken either by the designated doctor, who is an associate specialist paediatrician, or under her supervision. Information from the assessment together with information collected from other relevant sources such as teachers and carers is used by the clinical psychologist to assess need and to develop a health plan for those children with mental health needs that can be met by Tiers 1 and 2. This earlier support service is provided outside of the CAMHS system. This model reduces pressure on CAMHS who might otherwise be seeing children that do not need their service.

Other suggestions put forward for consideration in the revised guidance included:

- a statutory requirement for PCTs to ring-fence funding for looked after children so that a minimum CAMH service could be assured;
- making it illegal to insist on a child being in a stable placement before support is offered;

- CAMHS adopting a more flexible approach e.g. offering evening and weekend visits rather than insisting that young people come out of school to attend clinics, and being willing to see children and young people in places other than clinics;
- all residential units to be supported by a CAMHS worker such as a psychologist;
- training for Accident and Emergency (A&E) staff in assessing mental health, as many looked after children present at A&E; and
- a referral pathway that includes professionals other than social workers.

Interviewees stressed the need for the guidance to emphasise a broader understanding of mental health, with two suggesting that the CAMHS title was stigmatising and should be removed from the guidance.

3.7.4 Quality of service provision

Although some interviewees argued that looked after children should be fast-tracked or prioritised for treatment, particularly for CAMHS, the view was also expressed that they should not be prioritised unless there was a clinical need, though when looked after children moved into another area they should not go to the bottom of the waiting list but should retain their place according to the referral date. To address the unacceptable delays in receiving treatment that many looked after children experience, a regional government officer suggested that it should be statutory to provide services when they were needed. Two doctors mentioned the higher rate of 'no shows' among this group of young people at clinics and thought that it was imperative for these young people to be followed up and not 'written off'. In this respect, the important role that social workers and carers have in enabling young people to attend appointments should be emphasised in the revised guidance.

Very few interviewees referred to World Class Commissioning (WCC)⁹³, but a senior health manager reasoned that since WCC was about commissioning for quality it could lead to improvements in services: "through WCC there is a requirement to know what 'good' looks like - the clearer we are about that, the better the chance of influencing the commissioning process". Respondents from across two regions referred to the need for national benchmarking of services to assess effectiveness of health provision for looked after children and for statutory minimum standards for services, whilst a looked after children's nurse suggested that the role of the Healthcare Commission should be to monitor service provision. Another senior health manager thought that the guidance should include the recommendation that commissioned services adhere to 'You're Welcome' Standards⁹⁴ which relate to a child friendly and welcoming service.

Although when discussing the availability of services interviewees tended to focus on targeted provision, the point was occasionally made that the guidance needed to emphasise more strongly the need for access to both targeted and generic services. Furthermore, the importance of seeking the views of children and young people and tailoring services to meet their needs should be prominent in the guidance. As articulated by one national representative: "the aim should be to ensure that this group of children and young people get local services quickly through their carers and are not made to feel different".

⁹³ http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083204

⁹⁴ Department of Health (2005) *You're Welcome quality criteria: making health services young people friendly*. London: DH

Box 3.13 Using mainstream services

Looked after children and young people in Worcestershire are encouraged to use mainstream health services, in particular those offered by the school health services. The statutory health assessments are offered to school aged children by their school nurse, and young people attending high school have full access to the regular school nurse drop-ins, and 'time 4 you' sessions which run throughout the county.

3.8 Health promotion

Although there were examples across the country of good practice in health promotion (see boxes 3.14-3.21), the general impression given by interviewees was that health promotion was variable in its practice and underdeveloped in some PCT areas. It was said that health promotion should be covered in the initial health assessment and subsequent reviews, but how well this was done, particularly if GPs were doing the assessments, was questioned. In the audit of initial assessments undertaken in one area (see table 2.2), health promotion had been addressed in approximately two-thirds (61%) of the 140 assessments although its quality had not been assessed.

Health promotion was seen as not just the responsibility of health professionals, but a responsibility across the corporate parent partnership. Therefore it was important that all those working with looked after children receive appropriate training to ensure that they were able to undertake health promotion, though training was reportedly low in some regions. In particular, the critical role that carers play in promoting health needs to be emphasised in the revised guidance and, because carers and social workers often have a poor understanding of health and therefore do not see health as part of their job, it is important to be explicit about what is expected of them. The point was also made by a corporate parenting group that universal as well as targeted services have a duty to promote the health of looked after children and this should be included in the guidance.

Box 3.14 Health promotion in Tower Hamlets

In Tower Hamlets, the Options sexual health service and the looked after children's nurses provide drop-in clinics at the two residential homes. The two designated nurses are family planning trained, and the looked after children teams have received sex and relationships education training. Healthy lifestyles are promoted through work with foster carers, residential homes and other service providers. For example, foster carers are now better able to help the young people they foster to access sports and to promote dental health, and they have received substance misuse training. One of the residential homes has successfully tackled smoking cessation and is promoting an interest in healthy eating through growing vegetables.

Box 3.15 Sexual health

The sexual health of young people looked after in Shropshire is supported through the CHAT (Confidential Help and Advice for Teens) scheme delivered in secondary schools by school nurses. These nurses prioritise Lac and children at risk through confidential support at drop in centres within the schools. Relationships and sex education training for carers and social workers is provided linked to a programme of policy development.

Training and continuing professional development should focus especially on the promotion of mental health and emotional well-being, attachment disruption, bereavement and loss, and relationships and sexual health. The Healthy Care Programme was thought to provide a good model for local training and could be recommended in the revised guidance, whilst the CSIP publication on emotional health and well-being should underpin all work in this area⁹⁵. Regarding sexual health, a public health lead in a government office wanted the revised guidance to acknowledge the different skills, training and support required to promote sexual health with this group of young people: “As a corporate parent, [you] can be dealing with young people who could be victims or perpetrators of sexual abuse or who have sexually aggressive behaviour - the training and support of staff faced with these scenarios is very different from training and supporting staff to work with young people generally around sex and relationships”. This latter point is important in view of the new legislation on sexual health education within the mainstream school curriculum.

Box 3.16 Healthy Care training programme

A Healthy Care training programme has been developed for foster carers and residential childcare workers. This two-day practical and participatory programme aims to build on the existing knowledge and skills of participants and is available to download from www.ncb.org.uk/healthycare. In some authorities, it is delivered by looked after children’s nurses and experienced foster carers. Those who have taken the course report that it helps them to understand the importance of promoting children and young people’s emotional health and wellbeing.

Box 3.17 Training for carers

In Liverpool, all residential social workers and foster carers have attended Healthy Care training, with follow up training available on drugs; Sex and Relationships Education; food; and dental health promotion. The city runs a Healthy Homes Award for foster carers and residential homes linked to payment for skills.

⁹⁵ DH, NHS South Central and South East, CSIP (2008) *Children and Young People Promoting Emotional Health and Well-Being* <http://www.southeast.csip.org.uk/silo/files/children-and-young-people-promoting-emotional-health-and-wellbeing.pdf>

Box 3.18 Support for foster carers

A magazine style resource for foster carers has been produced by the South West Regional Healthy Care Programme and the National Children's Bureau, with funding from Public Health. A small editorial board of foster carers was involved in deciding on content and commenting on the design. The aim of the magazine is to make carers aware of their role in promoting the health of the children they care for, and it covers diverse topics such as fostering resilience, attachment theory, healthy eating, and completing the Strengths and Difficulties Questionnaire. It also includes first hand information from foster carers themselves. The magazine is sent to all foster carers in the south west region, and electronic copies are available on the Healthy Care Programme website.

<http://www.ncb.org.uk/Page.asp?sve=783>

There were several examples across PCTs of health professionals such as looked after children's nurses delivering training to carers and other health professionals. A clinical psychologist in one PCT for example led workshops on attachment. These were initially started for carers, but had since been extended to include educational psychologists, social workers and lead teachers. It was not possible in the time available to obtain information on the content of these courses, nor whether they had been evaluated and shown to be effective. This is not to say that the courses were not worthwhile, but it is impossible to say how useful they were in tackling children's specific and long-term needs. Evaluations of foster carer training to date tend to show carer satisfaction with the courses but little impact on children's behaviour, so there is a need to use courses with proven or promising effectiveness wherever possible (for example treatment foster care resources⁹⁶).

To raise awareness of the important role public health have in meeting the health needs of looked after children, the regional director in one SHA had circulated information on the health needs of this group to all directors of public health in her region. The current guidance recommends the development of a public health plan, and senior health managers in particular said that if this was made a statutory duty it would reinforce the need to develop a public health strategy and training programme both at regional and local level. One interviewee wanted to see joint commissioning of a public health training programme led by public health, but involving care leavers as co-trainers, to deliver on the DCSF and NICE / SCIE guidance.

Again, the importance of listening to what young people say they want in terms of their health was stressed in this part of the interview, and also the need to take an holistic approach to health promotion that included life skills training such as how to access information. A survey of care leavers in one LA found that most did not know how to register with a GP when moving to a new area. Some mentioned the effective role that the arts and creativity could play in promoting the health of vulnerable children

⁹⁶ Dorsey S., Farmer E., Barth R., Greene K., Reid J. and Landsverk J. (2008) 'Current status and evidence base of training for foster and treatment foster parents', *Children and Youth Services Review*, 30, 12, 1403-1416

Box 3.19 Arts and crafts activities

Shropshire Healthy Care Partnership has developed links with the local arts and culture department and other arts-related groups within the district councils. At the Healthy Care launch for foster carers, a video showed a wide range of community arts and cultural activities and carers were asked if they would be interested in participating in such activities. Foster carers are now routinely invited to arts and cultural activities across the county and the children and young people they care for are taking up these opportunities. This has created a link between foster carers and arts-related groups in the community and has increased the uptake of arts activities in this rural area.

Box 3.20 Leisure and fun

A leisure and fun coordinator has been appointed to the Integrated Service for Looked After Children in Worcestershire, to support and encourage looked after children and young people to engage in leisure activities of their choice and to support foster carers to make this happen. The role also includes advocating and raising awareness for the inclusion of LAC within community facilities and activities, and running an advice and information service about leisure and community activities throughout the county.

Box 3.21 The KATY Project

The Knowsley Action Team for Youth (KATY) project is a partnership between the police and social services which provides personal and social development opportunities for young people who are looked after by the Local Authority. Activities include horse riding and snorkelling, team building exercises, life skills training, residential weekends and visits to places of interest. The project has been running for nine years and was commended in the authority's Joint Area Review.

3.9 Transition

Among interviewees, consistent concern was voiced about how leaving care and transition to adult services was managed. There was consensus that this was an especially difficult area that was often poorly managed, particularly for out-of-area placements and for children with mental health needs. Difficulties included health services having little if any input at this time, differences in threshold criteria which could leave some young people without a service and therefore particularly vulnerable, and leaving care nurses (where there was such a specialist post) having insufficient capacity to fully meet need.

There were a number of examples both at regional and local level illustrating how a strategic approach could be taken to address this issue. The East of England SHA had set up a Transitions Steering Group to develop a strategy for the region. In Worcestershire, one of the six aims of the Healthy Care Board is healthy transition to adult services, which includes an action plan with criteria for success in meeting this aim. Both a SHA public health lead and a policy officer in a regional government office suggested that the revised guidance should explicitly refer to auditing the health needs of care leavers and how they are met in order to inform planning in this area.

Box 3.22 Transition

Bexley's Joint Area Review report judged that transition arrangements for young people as they move from the looked after service to the care leaving service were well managed. The Leaving Care Service provides a high level of support to young people as they adapt to independent living, supported by health, Connexions and housing services. All care leavers are allocated to a social worker and most have up-to-date pathway plans.

A better infrastructure was considered important for the support of young people at transition. This should include better integration between health and social care, a named health professional for looked after children aged 16+ (some areas did have specialist nurses attached to leaving care teams), care pathways for mental health teams and improved arrangements for Tier 4 discharge. A children's lead in a regional government office referred to the DH publication, *Getting it Right for Young People*⁹⁷, a good practice guide for disabled young people experiencing transition, and would like to see a similar guide for looked after children.

Suggestions put forward for the revised guidance included a greater focus on transition, health assessments as part of the after care plan, priority to looked after children for adult services particularly mental health, and the inclusion of examples of good practice in managing transition for young people leaving care. Some examples of good transition practice provided by interviewees included:

- using BAAF leaving care forms to provide a summary which is given to care leavers;
- 'exit interviews' for all young people leaving care, conducted by the designated doctor, who provides the young person with their own written health history and copies this to the GP and social worker;
- leaving care nurse attending the local authority on the day young people come into the office to receive their weekly allowance; and
- care leavers told by the designated doctor and nurse that they can come back any time.

Discussing transition led some interviewees to question the age range covered by the guidance. It was generally thought by those who commented that the age range should be clarified and brought in line with the Children Act to cover children from birth to 18. Some wanted to see corporate parent responsibilities, and thus the guidance, extended to cover young people beyond the age of 18, as recommended in Care Matters. In discussing how children generally are not all ready to advocate for their own health at 18 and how some will need continued support and encouragement sometimes into their 20s, a national representative commented "Not all [looked after children] will get GCSEs at 16 because their life has been so miserable, but with support and help they might do them when they are 18 or even in their twenties and it's the same with health".

⁹⁷ Department of Health (2006) Transition: getting it right for young people. Improving the transition of young people with long term conditions from children's to adult health services

3.10 Cross-cutting themes and other issues

3.10.1 Raising the profile of looked after children

A common view among interviewees (with a few notable exceptions, especially among senior health managers) was that the health of looked after children has too low a priority at strategic level in PCTs and in SHAs. Although SHAs often had a person with lead responsibility for children, looked after children was often a small part of their remit, whilst Directors of Public Health often appeared to be unaware of the specific needs of this group. Senior health managers were reported to prioritise the adult agenda, driven by the financial penalties they (PCTs) can incur. This low profile for looked after children's health was attributed to the guidance not being statutory, to a lack of specific PCT targets and poor performance management. Local Area Agreements (LAAs) were viewed by some interviewees as ineffective in providing leverage to commission better services for looked after children. There are few national LAA indicators focusing on the health of looked after children, and the one that focuses on emotional health and well-being - NI 58 - has been selected by only five LAs / PCTs in England as one of their local priorities⁹⁸.

Joint Area Reviews and Annual Performance Assessments were considered by one senior health manager not to provide detailed information or a sufficient focus on quality in meeting the health needs of looked after children. In our analysis of a sample of 30 JARs, we also found insufficient detail together with differences in reporting which made it difficult to draw comparisons. The Comprehensive Area Assessments (CAAs) which are replacing Comprehensive Performance Assessments (CPAs) are based on local priorities and systems and although it was said that they should include looked after children's health, as one interviewee pointed out, unless this is a local priority it is unlikely to be picked up.

Making aspects of the guidance statutory was generally viewed as a positive (and on some issues an essential) step, since it was thought this would help raise the profile of looked after children, improve resourcing, strengthen multi-agency working and understanding of corporate parenting, and ultimately improve health outcomes. Several interviewees wanted to see the guidance state unequivocally that the health of looked after children was a priority for all relevant bodies and promoting the health of looked after children a statutory duty. A children's lead in an SHA however thought there was no need to change the status of the guidance as there was already a duty to cooperate and, furthermore, making it statutory did not guarantee compliance. This point was also made by another two interviewees who nevertheless did support statutory status.

That there should be better performance management, with national indicators more sensitive to looked after children's health and reflecting upon the quality of provision and how well health needs are met, was a recurrent theme. However, a public health respondent from a regional government office suggested that new targets / indicators were unlikely to be drawn up and that the revised guidance should therefore help PCTs and LAs to understand that focusing on the health of looked after children can help them achieve their existing targets, such as reducing health inequalities, reducing teenage pregnancies, and improving educational attainment. As several interviewees emphasized, children and young people need to be healthy, both physically and emotionally, before they can begin to achieve academically or in the adult world. Making very explicit in the guidance the links between looked after children's health and current policies/initiatives relevant to PCTs, such as the Joint Strategic Needs Analysis, World Class Commissioning, Children's Trusts, safeguarding and health inequalities, in a language understood by health, would also help to raise the profile of looked after children strategically within the health sector.

⁹⁸ <http://www.idea.gov.uk/idk/core/page.do?pageId=8399555>

Currently, there are few systems within SHAs for monitoring implementation apart from monitoring immunisation rates and the CAF19 indicator, but with statutory status, the SHA would be in a better position to manage the performance of PCTs. That their role should be strengthened in the guidance with greater clarity regarding how they should manage performance, was mentioned by several interviewees.

In addition to performance management, specific strategies to help raise the profile of looked after children's health included: inclusion of looked after children in the SHA's quarterly report to PCTs; DH regional health teams together with Leads in the Government Offices and SHAs working together to prioritise the health of looked after children; and ensuring looked after children's health was addressed in the regular discussions with PCTs (i.e. 'Priorities Conversations').

Where a high profile for looked after children had been achieved, this was attributed to a number of factors: good strategic leadership marked by a high level of commitment and recognising that this was an important group; and 'champions' for looked after children that include elected members and PCT children's leads. Commitment is needed from **both** LAs and PCTs, since neither agency can effectively promote looked after children's health and well-being without the support and co-operation of the other.

3.10.2 Taking an holistic approach to health

Time and again, interviewees emphasised the importance of a holistic approach to health where the varying needs of children are not dealt with independently, but where health is understood as embracing physical health, mental health and emotional well-being. Such an approach is already taken in the 2002 guidance, but interviewees wanted the new guidance to stress the important role training plays in helping to ensure this approach is understood and taken up by all those working with looked after children. This applies particularly to health professionals, social workers and carers, all of whom play such a critical role in promoting the health of looked after children.

3.10.3 Not being seen as different

Several interviewees discussed the tension inherent in wanting to create experiences for looked after children that are akin to those of children from intact families, whilst at the same time adhering to requirements such as annual health reviews and the necessary reporting requirements regarding safety. One interviewee gave a number of examples illustrating the conflict that can arise between aiming to encourage independence among young people and their taking responsibility for their own health and reporting requirements. For example, a young person with asthma who was self-medicating was required to keep a daily record, not only because there was the fear that it might not be undertaken properly, but because this was an inspection requirement. This is a complex area and this interviewee felt a national steer was needed in the guidance about how the standards and goals for looked after children fit together, and which addresses whether these goals are supporting or working against the process of 'normalisation'.

3.10.4 Additional topics to include in the guidance

Topics that interviewees thought should be included or given more attention in the revisions to the 2002 guidance included:

- the roles and responsibilities of health services in relation to children being adopted,
- children on the edge of care;

- involving birth parents;
- care leavers;
- children in care for less than six months;
- looked after children in youth offending institutions; and
- guidance about the level of resourcing required to support looked after children.

4. Conclusions

Looked after children may only account for a small proportion of those for whom health authorities need to provide services, but they have significant health needs and have on average far poorer outcomes than other children. They need access not only to the kind of support and services to promote good health that all children are entitled to, but additional help to address needs that may be a consequence of their difficult experiences before entering care. Looked after children have usually experienced - and continue to experience - significant disadvantage and inequality. Promoting their health and well-being needs to be seen as a public health priority to address long-term health inequalities, despite the small size of this population of children.

Compared to all children, those who are looked after have far higher levels of mental health difficulties and poorer emotional well-being. Less information is available on their physical health, despite the requirement to assess their health annually, and the guidance could perhaps suggest ways in which the information that is collected at local level could be used to provide better epidemiological data, for example through auditing health assessments or requiring information about looked after children to be included in Joint Strategic Needs Analyses. Although less well documented than their mental health, looked after children have also been shown to be more likely than other children to have physical health problems for example with their eyesight, speech and language, bedwetting and physical coordination. Mental and physical problems often coexist, which emphasises the importance of assessment and services taking a holistic approach. There was strong support in both the literature reviewed and from analysis of our interview data for taking a holistic approach to the health of looked after children, recognising the importance of emotional well-being, security and stability, positive activities and educational opportunity in promoting good health. Looked after children are also more likely than their peers to participate in unhealthy behaviour such as smoking, drug and alcohol misuse, and experimenting with sex at an early age.

We found clear evidence of improvements in promoting looked after children's health since the 2002 guidance was published, but there is still some way to go. The following areas were identified as problematic in both the literature review and interview data:

- quality of health assessments and health plans;
- timely implementation of health plans;
- obtaining and transferring medical information;
- capacity of looked after children's nurses and doctors;
- insufficient attention paid to primary mental health needs;
- waiting times for assessment and treatment for children with behavioural difficulties and lower levels of mental health need; and
- understanding and acceptance of the role of corporate parent in promoting health and well-being.

Because much of the 2002 guidance is open to interpretation, and because it is not statutory on health, it is implemented in different ways and this has resulted in variable practice and provision and an inequitable service across the country. Much current good practice is due to the enthusiasm and commitment of particular individuals. Making the guidance statutory will not necessarily guarantee it will be implemented across the board, but SHAs will then have to performance manage PCTs and would be in a stronger position to insist on improvements in practice to meet the guidance than they appear to be now. Although there needs to be a degree of flexibility at the local level to be able to meet needs of different populations, nevertheless, greater clarity if not prescription seems to be called for particularly with respect to:

- corporate parenting, which should be made a statutory responsibility of health as well as children's services;
- responsible commissioner regulations;
- designated and named roles; and
- the content of health assessments, quality of health plans and monitoring of action / delivery.

There was, however, no clear consensus among those we interviewed about what this clarification should entail, and a range of views is presented in chapter 3 of this report. It could be helpful if the revised guidance contained a timeline illustrating the roles and responsibilities of different professionals and agencies from the time a child becomes looked after, including initial health assessments, reviews, monitoring the implementation of care plans etc.

One area where there was considerable agreement was the need for a greater focus on the issue of quality, and addressing the current lack of mechanisms for monitoring and improving the quality of health assessments, health plans and of services overall. A number of suggestions were put forward, including specifying the skills and competencies required to undertake health assessments, quality standards for health plans, greater availability of training and resources (such as those offered by the Healthy Care programme), national benchmarking of health provision for looked after children and a stronger role for SHAs and Government Offices in monitoring the quality of services.

Effective multi-agency partnerships and joint working were characteristic of areas where the guidance was being more successfully implemented. Shared targets, pooled or aligned budgets, and joint appointments can all facilitate multi-agency partnerships and joint working. There was a clear need for greater coordination between health bodies, particularly at a strategic level. On the basis of the evidence we were able to collect, Public Health appears less engaged than other health services in work with looked after children. The guidance needs to emphasise how Public Health should work together with clinical health and CAMHS, and then with local children's services, to develop a social rather than purely medical model for promoting the health of looked after children. Developing mechanisms to bring together all those with strategic responsibility for children's health and focus their attention on looked after children, such as auditing the work of Healthy Care Partnerships within a region, has been found to significantly improve joint working. The potential contribution of other agencies such as leisure, arts and housing could also be highlighted in the guidance, and links made to the Healthy Schools Programme, as well as to broader anti-poverty and equality agendas.

Training was highlighted as playing an important role in helping to raise the profile of looked after children, breaking down 'silo' mentalities, and promoting understanding of the needs of these children and how they can be met. Such training is needed for all those working with looked after children, both directly and indirectly, across a range of areas.

Another overarching theme was the importance of involving children and young people in work to improve their health and well-being, and understanding the aspects of health that are important to them - which may differ from the priorities of professionals and carers. The report contains some innovative examples of how this is being done, for example through the involvement of looked after young people in planning groups and on interview panels for key posts, financing and supporting them to produce videos about the health issues that matter to looked after children, and creating a personalised 'health history' as part of ongoing support for young people leaving care. Listening to young people's wishes and ideas and responding to them, even if they cannot be carried out, is important role-modelling behaviour by carers, health professionals and social workers. It is important that services demonstrate their sustained capacity to hear the views of children and young people and to act upon them.

Our focus in this study was primarily on health bodies, but revisions to the 2002 guidance may need to strengthen aspects relating to children's services, particularly the role of social workers in promoting children's health and their responsibilities for notifying PCTs when a child comes into care or moves to another area. A clear message from the study was that neither health nor children's services acting alone can hope to make substantial improvements to the health of looked after children. Also both targets / performance indicators (as at present) *and* mechanisms to improve quality such as more widespread training are likely to be needed. The underpinning theme was that working together is needed to bring about change.

Finally, we were struck by how much of what interviewees said should be in the revised guidance is in fact already addressed in the guidance published in 2002. There appears to be fairly widespread lack of awareness of the detailed content of the current guidance, although in the case of health bodies this could be partly due to the fact that there has so far not been a requirement for them to follow it. It does suggest, however, that if the revised guidance is to further improve practice in promoting the health of looked after children, issues of dissemination and support for implementation will be crucial. Interviewees spoke about the value of someone working through the guidance with people in order to help them understand its content, as well as wider dissemination of the revised guidance and the need for resources to support its implementation.

Appendix 1



Promoting the health of looked after children: revising the guidance Interview Topic Guide - national and regional interviews

We want to find out:

- How well the guidance is being met (what the difficulties are and how these might be resolved);
- What the impact will be of making the guidance statutory for PCTs etc;
- If there are additional topics that should be addressed in the guidance.

We will be talking to a wide range of key stakeholders and therefore some of the topics listed below may be more relevant to you than others.

Commissioning, joint working and corporate parenting

- Strategic planning and performance management (how health needs are identified and understood - needs analysis; health of LAC an identified priority, e.g. LAA plans; local targets; national indicator; SHA vision for future? SHA role)
- Implementation of responsible commissioner regulations
- Joint working between PCTs and LAs - how well does this work? Inter-agency planning and joint commissioning? What facilitate/hinders joint working?
- Out of authority placements / cross-authority commissioning (e.g. ensuring implementation of health plan, health reviews undertaken and monitoring performance re assessments and reports)
- Examples of good practice

Designated doctors and nurses

- Meeting requirement for designated doctor and nurse (including qualifications / grades / training)
- Key features of the roles (including contribution to planning/strategy/quality assurance)
- LAC nurses' workload and time commitment for LAC work (distinct from safeguarding / public health and schools)
- Relationship with commissioners/commissioning

Health assessments and planning

- Quality of health assessments (including dental assessments) - content e.g. assessing mental health and emotional well-being? Reasons for coming into care taken into account in assessments and plans? Who does them? Take-up? Quality assurance?
- Role of doctors and nurses in initial and subsequent assessments and in health plans
- Meeting timeframes for health assessments and reviews
- Content of health plans (and coverage) and effective implementation (e.g. reviewing and monitoring) - social care and/or health lead responsibility? How fits with review by IRO?
- Involvement of children and young people in health assessments and health policies
- Examples of good practice

Provision of services

- Registration with GPs and NHS Dentists (delays?; temporary / permanent registration; records / information - fast tracking transfer of records)
- Availability of full range of CAMHS - degree to which LAC prioritised; extent of targeted / dedicated CAMHS for LAC; difficulties with service thresholds
- Timely access to services - ensuring waiting list priority
- Health promotion - sexual health and relationships; mental health including loss and bereavement and bullying' healthy eating and physical activity; drugs and alcohol (how undertaken; extent it is individualised)
- Role of residential staff and foster carers (receiving information about LAC's health; health promotion, training)
- Examples of good practice

Leaving care and transition to adult services

- How is this transition addressed? Who has responsibility for overseeing transition? Is there any follow-up after transition? Extent to which adult health services are involved

Case studies

- Suggestions for case studies to include areas that appear to be doing well in implementing the guidance and those doing less well

Appendix 2



Promoting the health of looked after children: revising the guidance Interview Topic Guide - local interviews

Over recent weeks we have been talking to key stakeholders at national and regional level about how well the guidance is working and what might need to change. We now want to learn more about what happens at the local level in promoting the health of looked after children and meeting their health needs. We are particularly interested in:

- What works well and why?
- What is likely to be difficult if the current guidance becomes statutory?
- What would help to make it less difficult?

We are talking to people with different responsibilities across PCTs and LAs and therefore some of the topics from the guidance listed below may be more relevant to you than others, and our discussion can focus on those. We will not be identifying individuals we have interviewed for the study nor the areas they represent.

Commissioning, joint working and corporate parenting

- The guidance relating to Health bodies emphasises inter-agency children's services planning and that the health and well-being of LAC should be identified as a local priority. Is the health of LAC a priority in your area? What enables (or would enable) this to happen?
- What structures are in place to plan, manage and monitor the delivery of health care for LAC?
- How is LAC health included in the Children and Young People's Plan? Is there a Joint Strategic Needs Analysis which informs joint planning and the commissioning of services?
- What multi-agency working is there at strategic and operational level to promote LAC health and wellbeing?
- How well does corporate parenting work in your area to promote health and well-being - does it involve health services?
- Are services commissioned from more than one health Trust? If so how are services co-ordinated across the Trusts? Does this provide any particular opportunities or challenges?.

Responsible commissioner regulations (out of authority placements)

- The 'home' PCT has responsibility to ensure health needs are met. How is this achieved in your area?
- How well does commissioning for out of authority placements work - both placing and receiving? (e.g. mechanisms for communication, monitoring implementation of health plans)

Designated doctors and nurses for LAC

- Do you have a designated doctor - how much time do they have?
- How do the designated doctor and nurse advise on and contribute to planning, strategy and audit of quality standards for health services for LAC?
- Are you able to meet the guidance which states that the designated doctor should be a senior paediatrician, preferably a consultant community paediatrician? Is this important?
- Do the designated doctor and nurse have sufficient capacity to fulfil their role? If not, what needs to happen to change this situation?

Health assessments and planning

- Who undertakes a) initial health assessments and b) subsequent assessments in your area?
- What do they cover? Is any data collected from birth parents?
- How is the quality of health assessments and health reviews assured?
- Are there any difficulties in meeting the timeframes for health assessments and reviews?
- How comprehensive is the health care plan or health recommendations resulting from the assessment? Does it usually cover all the issues identified in the assessment?
- How do you ensure effective implementation of the health recommendations / health plan?
- What systems are in place for sharing information about LAC health between agencies?
- Are looked after children and young people involved in health assessments and health policies? How?

Provision of services and health promotion

- Accessing services, particularly CAMHS, can be difficult. What could be done to overcome these difficulties?
- How does your PCT / LA make sure that the services commissioned e.g. CAMHS are of good quality?
- How could GPs be encouraged to register LAC?
- How far do PCTs prioritise LAC (e.g. maintaining their place on a waiting list when they move)?
- How is health promotion and health education addressed for looked after children? Does anyone take responsibility for ensuring this is done? Is health promotion for LAC specifically addressed in public health strategies and policies?
- How is health promotion and training of carers commissioned and delivered? What % of carers have been trained?

Leaving care and transition to adult services

- How is the health element of care leaving or transition to adult services addressed? Is there any follow-up after transition?

FINALLY...

- What do you think works well in promoting the health of LAC in your PCT/LA?
- Has the current Guidance helped you to improve the health of LAC?
- What are the key issues that you think need to be addressed in the revised Guidance?

THANK YOU VERY MUCH FOR YOUR HELP

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