

# Statutory Guidance on Promoting the Health and Well-being of Looked After Children



department for  
children, schools and families



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# Executive summary

## Scope of this guidance

This statutory guidance is issued to local authorities, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) and applies to England only. It is issued to all three under sections 10 and 11 of the Children Act 2004 and they must have regard to it when exercising their functions. The guidance is also issued to local authorities under section 7 of the Local Authority Social Services Act 1970 and local authorities must act under it in discharging their duties to promote the health of the children they look after.

## Health problems in looked after children

Looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers in part due to the impact of poverty, abuse and neglect.

## Joint working between local authorities, PCTs and SHAs

Local authorities and PCTs should work together with other partners in the Children's Trust to commission health services, including CAMHS, for all children and young people in their area. The starting point for commissioning health services for looked after children should be the Joint Strategic Needs Assessment and the Children and Young People's Plan.

Local authorities should have a system in place to monitor whether the health needs of children placed out-of-authority are being met.

Local authorities should, before a placement is made, notify the child's registered practitioner, parents (in most cases) and those caring for the child. When the child starts to be looked after, changes placement or ceases to be looked after the local authority should, as a legal requirement:

- Notify the PCT for the area in which the child is living
- Notify the PCT and the local authority for the area in which the child has been placed.

Local authorities should have agreed local mechanisms with the PCT to ensure that guidance on the responsible commissioner is adhered to when making placement decisions and to resolve any funding issues that arise.

When a local authority, acting either independently or jointly, arranges such accommodation, the “originating PCT” remains the responsible PCT for secondary healthcare services. This applies even when the child changes GP practice. The “originating PCT” is the PCT that makes such an arrangement, or the responsible PCT immediately before a local authority makes such an arrangement. The “originating PCT” should notify the PCT in whose area the child is placed.

Whether or not those delivering services to looked after children work within integrated looked after children teams, it is the responsibility of all staff working with looked after children to ensure they liaise effectively with professional colleagues to ensure that health and care planning meets the child’s needs.

It is the responsibility of the local authority to make sure that health assessments are carried out. PCTs have a duty to comply with requests by local authorities for help in the exercise of their functions.

It is the responsibility of the local authority to make sure that every child it looks after has a health plan which forms part of the overall care plan. PCTs must cooperate with the local authority to ensure that the health plan is effective.

Local authorities are responsible for making sure that a Strengths and Difficulties Questionnaire (SDQ) is completed for every child they look after aged between 4 and 16 inclusive.

Both local authorities, PCTs and SHAs need to build awareness of the high level of mental health needs amongst looked after children into their strategic planning and their operational delivery of CAMHS services.

Healthcare within children’s home settings should be delivered at least to the standards outlined in the National Minimum Standards.

Personal advisers should work closely with doctors and nurses involved in health assessments and would benefit from training in how to promote physical and mental health.

### **The roles and responsibilities of local authorities**

Local authorities should have arrangements in place, in accordance with relevant regulations, to ensure that every child it looks after, regardless of where that child is placed, has:

- his/her health needs fully assessed

- a health plan which clearly sets out how health needs identified in the assessment will be addressed. This includes intended outcomes, measurable objectives to achieve outcomes, actions needed, who will take them and by when
- his/her health plan reviewed.

Local authorities should make plans at a strategic level to ensure that local delivery of these arrangements and at an operational level should act as a parent and advocate for each child looked after by them.

Local authorities should make sure that the voices of looked after children are heard as part of the process of informing the commissioning, planning, delivery and evaluation of services.

The child's social worker is responsible for making sure:

- he or she has a health plan which is drawn up in partnership with the child, his or her carer and (where appropriate) parents, and other agencies and
- that (while many actions in the plan may be the responsibility of other agencies) the plan is implemented and reviewed in accordance with the regulations.

The Independent Reviewing Officer (IRO) should ensure that the child's health plan is reviewed at least every six months in accordance with the regulations.

Social workers should ensure that foster carers are given a written health record for each child in their care. This record should include: the child's state of health and identified health needs and it should be regularly updated and moved with the child.

Local authorities, normally through the social worker, should ensure that foster carers and residential care workers know how to contact designated and lead health professionals for each child in their care and how to access the services the child needs.

Local authorities should provide looked after children with free access to positive activities and related facilities they own, deliver and commission. This includes access for looked after children who are teenage parents with arrangements for necessary childcare.

## The roles and responsibilities of the NHS

Under the Children Act 1989 and amended legislation PCTs and SHAs have a duty to comply with requests from the local authority to help them provide support and services to children in need. For the duty to be discharged effectively PCT commissioners need to ensure the services they commission meet the particular needs of looked after children.

In meeting the health needs of looked after children PCTs and SHAs need to focus on ensuring that they are able to access universal services as well as targeted and specialist services where necessary. The NHS contributes to meeting the health needs of looked after children by

- commissioning effective services
- delivery through provider organisations
- individual practitioners providing co-ordinated care for each child, young person and carer.

Chief Executives of PCTs need to satisfy themselves that there are arrangements in place to meet the health needs of looked after children and young people. This includes being satisfied that there are robust systems and day-to-day processes in place for meeting those needs in relation to strategic commissioning, including for looked after children who are placed out of the PCT area.

A full checklist of the arrangements which Chief Executives of PCTs need to be sure are effectively in place can be found under the heading Primary Care Trusts and Commissioning in the chapter on Roles and Responsibilities of the NHS.

Primary Care Teams have an important role to play in the identification of the individual health care needs of looked after children and young people. They act as advocates for the health of every looked after child and young person and make sure they have timely and sensitive access to a general practitioner or other professional where appropriate, including specialist services.

A full range of the ways in which primary care teams should contribute to meeting the health needs of looked after children and young people is set out under the heading Contribution of Primary Care Teams.

Health care plans are not solely the responsibility of the health service but rely on the social worker and foster carer/residential worker and NHS staff working together. Identifying one person who takes the lead for the NHS as a central point of contact in the NHS helps everyone play their part in implementing the health plan. It also helps social workers, carers and young people navigate the NHS where they encounter a problem.

The lead health professional may be a different type of health professional for different children – this will be determined locally in response to the needs of the child and local service arrangements.

# Preface

## 1 Scope and purpose of the guidance

- 1.1 This guidance concerns the delivery of services from health agencies and local authorities to promote the health of looked after children and young people. It is written in the context of a holistic model of health which takes account of wider determinants of health and wellbeing. It is therefore relevant to all Children's Trust partners.
- 1.2 This guidance applies in relation to England only. It is issued to local authorities under section 7 of the Local Authority Social Services Act 1970 and they must act under it in the exercise of their social services functions. It is also issued under sections 10 and 11 of the Children Act 2004. Local authorities, Primary Care Trusts (PCTs), and Strategic Health Authorities (SHAs) in England must have regard to it when exercising their functions under those sections. Local authorities and PCTs are the key bodies within a Children's Trust with the expertise, the ability and the responsibility to improve the health of looked after children and young people. Where other bodies are referred to, this is because they may be commissioned to provide services for local authorities, PCTs or SHAs when local authorities are exercising their functions carried out under section 10. The guidance supersedes the 2002 guidance, "Promoting the Health of Looked After Children". It is for strategic managers, policy makers and commissioners. Frontline practitioners will also find it useful.
- 1.3 The **purpose** of this document is to give guidance to local authorities and their Children's Trust partners mentioned in paragraph 1.2 on the exercise of their functions in relation to:
- the promotion of co-operation to improve the well-being of children and young people; and
  - the making of arrangements to ensure that they take account of the need to safeguard and promote the welfare of children when doing their jobs.

The **aim** is to make sure that all looked after children and young people are physically, mentally, emotionally and sexually healthy, that they will not take illegal drugs and that they will enjoy healthy lifestyles.

## 2 Principles

- 2.1 The principles that underpin this guidance are that the system for promoting the health of looked after children should:
- Deliver services that are tailored to the individual and diverse needs of children and young people;
  - Put the voices of children, young people and their families at the heart of service design and delivery;
  - Address health inequalities and have an emphasis on prevention;
  - Make sure that health needs are accurately assessed and met;
  - Deliver excellent, world-class, standards of care;
  - Make sure all professionals working with looked after children have a clear understanding of the roles and responsibilities of all relevant agencies;
  - Be holistic, including consideration of physical health, sexual, emotional and mental health, wellbeing and health promotion;
  - Use integrated working and joint commissioning based around effective partnerships at both strategic and individual case level to improve service delivery, information sharing, confidentiality and consent.
- 2.2 Across children's services there has been, and continues to be, substantial change in the way that services are commissioned and provided. A key objective of these changes is to improve outcomes for vulnerable children.
- 2.3 The guidance aims to support local authorities, SHAs and PCTs to meet the health needs of *all* looked after children. Some groups of looked after children, for example asylum seeking children and disabled children, may have particular needs. It is important that services carry out assessments of local need and agree to meet the needs of particular groups of children in their area as part of the commissioning cycle and delivery arrangements.



# Introduction

## 3 The policy context

3.1 The policy context for this guidance is the overarching Every Child Matters framework for improving outcomes for children and young people and the programme set out in the White Paper, *Care Matters: Time for Change*<sup>1</sup>, for improving outcomes for looked after children. Local authorities, SHAs and PCTs have a shared responsibility in helping to achieve Every Child Matters outcomes for looked after children.

Key policy frameworks that inform and support this guidance are as follows:

- Every Child Matters
- Children's National Service Framework (NSF) (2004)
- *Care Matters* White Paper (2007)
- The Children's Plan: building brighter futures (2007)
- High Quality Healthcare for All and World Class Commissioning (2008)
- Children and Young People in Mind: National CAMHS Review (2008)
- 2020 Workforce Strategy (2008)
- Department of Health Transforming Community Services Programme
- Transforming Community Services: Enabling new patterns of provision (2009)
- Healthy Lives, Brighter Futures: the strategy for children and young people's health (2009)
- DH / DCSF Strategy on the health of children in the youth justice system (2009)
- Healthy Child Programme (0 – 5) Pregnancy and the first years of life (re-launched 2009)
- Healthy Child Programme 5-19 (2009)

3.2 This guidance also needs to be read alongside the forthcoming NICE/SCIE guidance on the health of looked after children which will be published in 2010.

1 *Care Matters: Time for Change*, DCSF, 2007

## 4 Legislative and regulatory framework

### 4.1 The Children Act 1989

4.1.1 The Children Act 1989 provides a comprehensive framework for the care and protection of all children and young people in need, including those living away from home. Local authorities have a specific duty under section 22 of that Act to safeguard and promote the welfare of each child they look after. Under section 27 of that Act, local authorities are entitled to expect other authorities and certain NHS bodies to assist them in discharging their functions to children in need, looked after children and their parents and carers.

### 4.2 The Children Act 2004

4.2.1 The Children Act 2004 introduced a new duty (section 10) to co-operate at a strategic level on local authorities, PCTs and other relevant children's services partners. The same partners were also placed under a duty (section 11) to make arrangements to ensure that they take account of the need to safeguard and promote the welfare of children in the discharge of their own functions.

### 4.3 The Children and Young Persons Act 2008

4.3.1 The Children and Young Persons Act 2008 amends the Children Act 1989, strengthening the legislative framework underpinning the care system and putting in place the structures to enable children and young people to receive high quality care and support. Amongst other provisions the amendments to the Children Act 1989 require local authorities to take steps that secure sufficient suitable accommodation within their area and improve care planning by strengthening the role of the Independent Reviewing Officer (IRO).

### 4.4 The Care Standards Act 2000

4.4.1 The Care Standards Act 2000 and the Regulations and National Minimum Standards made under it, contain provisions in relation to the welfare, health and illnesses of children who are looked after in establishments regulated by the Act.

### 4.5 The Mental Health Act 2007

4.5.1 The Mental Health Act 2007 amended the Mental Health Act 1983. Amongst other provisions it requires hospital managers to ensure that patients aged under 18 admitted to hospital for a mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). This is due to be fully implemented in 2010.

## 4.6 The Mental Capacity Act 2005

- 4.6.1 The Mental Capacity Act 2005 generally only applies to people aged 16 or over and provides a statutory framework to empower and protect people who may lack capacity to make some decisions for themselves, for example, people with dementia, learning disabilities, mental health problems, stroke or head injuries, who may lack capacity to make certain decisions.

# Evidence and context for the guidance

## 5 Profile of looked after children

5.1 Some 59,500 children in England were looked after on 31 March 2008<sup>2</sup>, 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.

- 71% of looked after children are with foster carers, with 1 in 6 of these placed with family or friends;
- 11% of children, almost all over the age of 10, live in residential homes;
- 8% of looked after children live with their parents subject to a care order;
- 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 behaviour<sup>3</sup>.

5.2 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 and provided for these children as the PCT which is the responsible commissioner for health services for these children is often not the PCT which is providing the service.

5.3 As at March 2008:

- 63% of children looked after were aged 10 or over;

2 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>

3 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/](http://www.dcsf.gov.uk/rsgateway/DB/SFR/)

- Boys were in a slight majority (56%);
- The ethnic origin of 74% was reported as White British.
- 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<sup>4</sup>;
- When children receiving short term breaks are excluded, the main reason for children of all ages becoming looked after is parental abuse or neglect, and 63% are looked after under a care order with this being more common among younger children;
- 4% have a 'main need code' of disability, although this only identifies those children where disability is the primary reason that they are accommodated.

## 6 Evidence from research and practice

### 6.1 The nature and prevalence of health problems in looked after children

6.1.1 Since the publication of the 2002 guidance, 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. They can have 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. Longer-term outcomes for looked after children remain worse than their peers<sup>5</sup>.

### 6.2 Mental health and emotional well-being

6.2.1 A national survey undertaken by Meltzer and colleagues for the Office for National Statistics (ONS) confirmed findings of earlier research<sup>6 7</sup> about the high level of mental health need amongst looked after children, particularly those in residential

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

5 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

6 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

7 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

care. 45% of looked after children were assessed as having a mental health disorder, rising to 72% of those in residential care. Among 5-10 year olds, 50% of boys and 33% of girls had an identifiable mental disorder. Among 11-15 year olds, the rates were 55% for boys and 43% for girls. This compares to around 10% of the general population aged 5 to 15.

- 6.2.2 Clinically significant conduct disorders were the most common among looked after children (37%), while 12% had emotional disorders (anxiety and depression) and 7% were hyperactive. 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 disorders<sup>8</sup>.
- 6.2.3 A further source of information on the prevalence of emotional and behavioural difficulties among looked after children is the Looking After Children longitudinal study of children and young people who remained in care for at least a year<sup>9</sup>. This considered the needs of children *at the point of first entry into care* and identified emotional and behavioural problems from information recorded in case files by social workers and subsequently assessed by psychologists. Using these methods, it was found that 72% of looked after children aged 5 to 15 had a mental or behavioural problem compared to 45% in the ONS survey. 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.

### 6.3 Physical health

- 6.3.1 The ONS survey<sup>10</sup> found that two thirds of all looked after children had at least one physical health complaint. Looked after children are more likely than their peers to experience problems including speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems.

### 6.4 Young people leaving care

- 6.4.1 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

8 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

9 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

10 Meltzer 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

people who have never been in care<sup>11 12</sup>. Both young women and young men in and leaving care are more likely than their peers to be teenage parents, with one study finding that almost half of young women leaving care became pregnant within 18 to 24 months<sup>13</sup>, and another reporting that a quarter were pregnant or young parents within a year of leaving care<sup>14</sup>. For some, this may be a positive choice<sup>15</sup>.

- 6.4.2 Many aspects of young people's health have been shown to worsen in the year after leaving care.<sup>16</sup> 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.

## 7 How well are health needs met, especially by health services?

### 7.1 Information from national statistics and inspection reports

- 7.1.1 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 who have had their annual health assessment and had their teeth checked by a dentist. By 2006/7 89% of looked after children had received a dental check and a health assessment<sup>17</sup>. There is local and regional variation within these national figures.

11 National Children's Bureau (2008) Promoting the health of young people leaving care. Healthy Care Briefing. [www.ncb.org.uk/healthycare](http://www.ncb.org.uk/healthycare)

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

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

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

15 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

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

17 DCSF (2008) Outcome Indicators for children looked after, 12 months to 30 September 2007. [www.dcsf.gov.uk](http://www.dcsf.gov.uk)

7.1.2 A joint Chief Inspectors' report in 2008 confirmed improvements in health monitoring for looked after children and care leavers since 2005<sup>18</sup>. 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 areas for development 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.

7.1.3 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 looked after children, but with some aspects needing further attention<sup>19</sup>. Higher performing councils were increasingly developing specialist multi-agency teams and posts to promote the health of vulnerable groups including looked after children. Initiatives such as free access to leisure facilities for children in care were becoming more prevalent.

## 7.2 Health assessments

7.2.1 Research considered or carried out to inform this guidance indicated that:

- Statutory health assessments were able to identify health need and health neglect that might otherwise have gone unrecognised.
- There is variability in the extent to which recommendations in the assessments had been implemented.
- Many assessments appeared to function more as a disease screening exercise than as an opportunity to promote children's health<sup>20</sup>.
- There is considerable variability in the topics covered in initial health assessments, with nearly a quarter not including a completed health care plan and only 22% recording information about family medical history. Information

18 Ofsted (2008) Safeguarding children: The third joint Chief Inspectors' report on arrangements to safeguard children. [www.safeguardingchildren.org.uk](http://www.safeguardingchildren.org.uk)

19 Ofsted (2008) Annual Performance Assessment (APA) 2007. Report on outcomes. [www.ofsted.gov.uk](http://www.ofsted.gov.uk)

20 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



about the health needs of looked after teenagers in children's homes was not always known to care staff<sup>21</sup>.

- There are gaps in the recording of health data.

### 7.3 Designated professionals

7.3.1 Child Health Mapping<sup>22</sup> in 2007 found that 76% of PCTs reported having a designated doctor for looked after children in post. Some of these posts were shared and almost all were paediatricians. Designated nurses for looked after children were in 93% of PCTs of which 96% were senior nurses.

### 7.4 Work with birth families and relatives

- 7.4.1 There is limited information 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 limited 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 home<sup>23</sup>. Hill<sup>24</sup> identified a number of reasons why an accurate record of birth family health history is important for looked after children, including an awareness of conditions that might be genetically transmitted, and insight into possible causes of a child's emotional or behavioural difficulties. These issues may become particularly problematic at a later stage if a child will live permanently outside their birth family, for example through adoption, and there is a potential loss of access to any family health information not recorded on the child's file.
- 7.4.2 Many looked after children return to birth families once they leave care, so involving these families in initial health assessments could provide an opportunity to directly obtain child and family health history as well as obtain consent to gather further necessary data from GPs, consultants and hospitals, thus resolving many of the current difficulties. Having a complete personal and family health history would considerably enhance the value of all health assessments and facilitate better awareness of health needs when children return home.

21 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

22 National Child Health, CAMHS and Maternity Service Mapping, 2007

23 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

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

## 7.5 Meeting mental health needs

7.5.1 There is substantial local variation in the availability of mental health services to meet the needs of children and young people<sup>25</sup>, including those who are looked after<sup>26</sup>. Increasingly, CAMHS partnerships are providing designated or targeted CAMHS provision for children in their care. However there is variability as to the age range served, and whether the service was available to children living in the authority but placed by another local authority. Some services work with care leavers up to age 25, others have a cut-off age of 16. Innovative services have been developed in some areas to improve the mental health and emotional well-being of looked after children.

## 7.6 Meeting health needs in secure children's homes

7.6.1 An overview of the health of children and young people in secure settings 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 variable<sup>27</sup>. 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 health needs of extremely vulnerable children<sup>28</sup>.

## 8 The views of looked after children on their health

8.1 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 depression. 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 do<sup>29</sup>. A recent report by the Children and Family Court Advisory Support Service found that:

- 25 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
- 26 Ofsted (2008) Annual Performance Assessment (APA) 2007. Report on outcomes. [www.ofsted.gov.uk](http://www.ofsted.gov.uk)
- 27 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/>
- 28 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](http://www.dcsf.gov.uk/research/data/uploadfiles/RR749.pdf)
- 29 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.

- more than a third of the young people felt that their health was only average;
- a large number felt that they were 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 seek support from family and friends they left behind;
- peer pressure is a big impact on lifestyle choice for young people.

8.1.1 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 examinations<sup>30</sup>.

## 8.2 Views of care leavers

8.2.1 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 varied<sup>31</sup>. Small-scale local studies about health services<sup>32</sup> have identified that young care leavers value supportive and friendly health professionals; would like to keep the same GP if possible; and liked the idea of young people's clinics. 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.

## 8.3 Views on mental health

8.3.1 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 agenda<sup>33</sup>. Other studies have also emphasised the importance of choice and respect for children's

30 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

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

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

33 Stanley N. (2002) 'What young people want' *Community Care*, 15 August 2002, [www.communitycare.co.uk](http://www.communitycare.co.uk)

views<sup>34</sup>. Children's concerns may differ from those of their carers: for example a study in one local authority found that young people in care tended to identify internal emotional problems, whereas their carers predominantly focused on externally visible problem behaviours<sup>35</sup>.

34 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

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

# Statutory Guidance

## 9 Joint working and responsibilities of local authorities, Primary Care Trusts and Strategic Health Authorities

### 9.1 Strategic working

9.1.1 Whilst this guidance contains separate sections on the responsibilities of local authorities and the NHS, many of these responsibilities can only be delivered by the different agencies co-operating through their Children's Trust.

9.1.2 This is underpinned by section 10 of the Children Act 2004, which names specific statutory 'relevant partners', including PCTs and schools<sup>36</sup>, which must co-operate with local authorities in making arrangements to improve children's well-being in their area<sup>37</sup>. The partnership between the local authority and the PCT is the driving relationship of the Children's Trust and neither a PCT nor a local authority can deliver its priorities without the active co-operation of the other.

9.1.3 *Healthy lives, brighter futures: the strategy for children and young people's health* (2009) sets out how Children's Trust co-operation arrangements can enable PCTs and local authorities to make a reality of their partnership to deliver improved health outcomes for children and young people, including looked after children. These key points include:

- using the Joint Strategic Needs Assessment for establishing a shared vision of local service needs;
- clear, transparent local plans for children's health as part of the Children and Young People's Plan;
- an agreed approach to commissioning at local authority/PCT level, which includes a framework for practice-based commissioning and incorporates commissioning by schools.

9.1.4 The PCT and the local authority should agree joint action on looked after children's health issues in the area, with joint scrutiny of feedback from children, young

36 The inclusion of schools is subject to the Apprenticeships, Skills, Children and Learning Bill becoming law in November 2009

37 In addition to existing statutory 'relevant partners' (District Councils, PCTs, the SHA, Police, probation, Youth Offending Teams) the Apprenticeships, Skills, Children and Learning Bill, once it receives royal assent, will expand the number of 'relevant partners' to include: maintained schools, academies, non maintained special schools, further education institutions (FE and sixth form colleges), city technology colleges, city colleges for the technology of the arts and Job Centre Plus.

people and carers. There should also be agreement on providing accessible and comprehensive information to looked after children and carers about what health services, advice and support are available locally to meet their needs.

- 9.1.5 It is also vital that local authorities, PCTs and SHAs work collaboratively with other Children's Trust partners, including housing and leisure services so as to avoid duplication and ensure a coherent and comprehensive approach to meeting looked after children's health needs. Cross-cutting initiatives on child poverty and equalities will also be relevant to the health needs of looked after children.

## 9.2 Commissioning health services for looked after children

- 9.2.1 Local authorities and PCTs should work together and with other partners in the Children's Trust to commission health services, including CAMHS, for all children and young people in their area, in accordance with the principles outlined in the joint DCSF / DH guidance on commissioning published in 2009 to support Healthy Lives, Brighter Futures.<sup>38</sup>
- 9.2.2 The starting point for commissioning health services for looked after children should be the **Joint Strategic Needs Assessment (JSNA)** and the **Children and Young People's Plan (CYPP)**. The CYPP should inform and be informed by the statutory JSNA. The JSNA should identify current and future health needs of the local population, across all age groups. The CYPP will be the agreed joint strategy of the partners in the Children's Trust on how they will co-operate to improve children's well-being<sup>39</sup>.
- 9.2.3 The Children's Trust Board should carry out a thorough and up-to-date analysis of children and young people's needs, including those of looked after children<sup>40</sup>, mapped against existing services, to identify gaps in provision and inform strategic commissioning priorities. Epidemiological information collected at a local level through health assessments and to inform Government statistical returns should be used, at an aggregate level, to inform both these strategic documents.
- 9.2.4 The partnership of local authorities, PCTs and SHAs will need to ensure that commissioning health services for all children in the area includes all the steps in the commissioning process as outlined in the joint DCSF/DH commissioning guidance and the world class commissioning framework on which it is based.

38 Securing better health of children and young people through world class commissioning: A guidance to support delivery of "Healthy lives, brighter futures: The strategy for children and young people's health" 2009

39 Subject to the Apprenticeships, Skills and Learning Bill becoming law in November 2009 the CYPP will become the responsibility of the Children's Trust Board, on which the PCT and local authority will be represented, and not just the responsibility of the local authority as at present.

40 Healthy Child Programme (0 – 5) and (5-19)

As part of this exercise, it will be necessary to ensure that the particular needs of looked after children and young people (and of other vulnerable groups) are considered by commissioners when they are identifying needs and developing strategic commissioning frameworks and priorities to address local needs. When commissioning specific services for looked after children, it is essential to ensure that the views of looked after children and young people and their parents and carers, are taken into account and that sufficient resources are allocated to meet the identified need. It is crucial that commissioners are aware that the identified health needs of looked after children are likely to be greater, and their resilience less, than for the general population of children in the area and understand the particular issues accessing services for this group. Strategic partnerships such as the Substance Misuse Partnership can provide information as part of this process and should be involved in commissioning decisions as far as possible.

### 9.3 Out of authority placements

- 9.3.1 Under section 23(7) of the Children Act 1989, local authorities have an existing duty to place children near to their homes. This duty will be strengthened by section 9 of the Children and Young Persons Act 2008<sup>41</sup>, when commenced, which places local authorities under a general duty to take steps that secure, so far as is reasonably practicable, sufficient suitable accommodation within their area to meet the needs of the children they look after. They will also have a new specific duty<sup>42</sup> when making individual placement decisions, to provide the child with accommodation within their area unless that is not reasonably practicable or consistent with the child's welfare.
- 9.3.2 If the authority decides to place a child outside of their area because there is no suitable accommodation in their own area, then with the PCT they should make arrangements to secure appropriate health services for the child, in accordance with the health assessment and the child's health plan.
- 9.3.3 Local authorities need to have a system in place to monitor whether the health needs of children placed out of authority are being met. The review of the care plan (within 28 days, three months, six months and at six monthly intervals thereafter and at other times if necessary) should be the normal mechanism for doing this.

41 Section 9 of the 2008 Act, which amends Part 3 of the Children Act 1989 by inserting a new section 22G. This provision has not yet been commenced.

42 Section 22C(9) of the Children Act 1989, inserted by section 8 of the Children and Young Persons Act 2008. This provision has not yet been commenced.

## 9.4 Notification of placement

9.4.1 In accordance with the *Arrangements for Placement of Children (General) Regulations 1991*<sup>43</sup>, when a child starts to be looked after or changes placement, local authorities should, before the placement is made, notify the child's registered medical practitioner, parents (in most cases) and those caring for the child. When a child starts to be looked after, changes placement, or ceases to be looked after, the local authority should also notify:

- The PCT for the area in which the child is living;
- The PCT and the local authority for the area in which the child is to be placed.

9.4.2 These legal requirements are intended to ensure that the looked after child and their carers have access as soon as possible to all the support services available to them.

## 9.5 The responsible commissioner

9.5.1 Improving access to the full range of health services, including CAMHS, is a priority for achieving good outcomes for looked after children. However, many miss out on mainstream services, particularly if they are moved out of their home area.

9.5.2 Department of Health guidance issued in 2007<sup>44</sup> sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, i.e. determining who pays for a patient's care. It is important that local authorities have agreed local mechanisms with the PCT to ensure this guidance is adhered to when making placement decisions and to resolve any funding disputes that may arise.

9.5.3 Regulations, referred to in this guidance as "the 2007 Amending Regulations" (Annex A) which came into force on 1 April 2007, introduced changes to the PCT responsible for commissioning or providing secondary healthcare services. The amendments relate to four groups of children and young people up to the age of eighteen where arrangements are made to place the child/young person in accommodation in the area of another PCT (or of a Local Health Board in Wales) and the child needs secondary healthcare services. One of the four groups of children is looked after children and children leaving care ("relevant children").

43 S.I. 1991/890. A copy of the regulations can be found on the legislation section of the OPSI site at [www.opsi.gov.uk](http://www.opsi.gov.uk)

44 Who pays? Establishing the responsible commissioner



- 9.5.4 In summary, the changes mean that where a PCT or a local authority, acting either independently or jointly, arrange such accommodation, the “originating PCT” remains the responsible PCT for secondary healthcare services. This applies even where the child changes their GP practice. The “originating PCT” is the PCT that makes such an arrangement, or the responsible PCT immediately before a local authority makes such an arrangement. The originating PCT should notify the PCT in whose area the child is placed.
- 9.5.5 As the responsible commissioner, the originating PCT will need to make arrangements for the child’s health assessment to be undertaken. When a child is first placed by a local authority, the local authority has a shared responsibility with the relevant PCT or NHS Trust to ensure a full health assessment takes place and that a health plan is drawn up. Which staff actually undertake the assessments is for the responsible commissioner to decide informed by practical considerations.
- 9.5.6 The 2007 Amending Regulations only apply to arrangements made after 1 April 2007 and are not retrospective. Arrangements for primary healthcare services are unchanged i.e. they are determined by GP registration.
- 9.5.7 For children placed by a local authority in accommodation in the area of another PCT or a Local Health Board in Wales prior to 1 April 2007 and then moved again by the local authority to accommodation in a different area after 1 April 2007, the responsible PCT will be the PCT in whose area the placing local authority is situated. This promotes consistency with the principle of the responsible commissioner being the PCT coterminous with the placing local authority (the responsible authority). If there is more than one such PCT, the PCT responsible is the PCT that was responsible for providing services to the child immediately before the local authority placed the child.
- 9.5.8 If a looked after child or child leaving care is moved out of the PCT area, arrangements should be made through discussion between the “originating PCT”, those currently providing the healthcare and the new PCT provider to ensure continuity of healthcare. The originating PCT remains responsible for the provision of healthcare services, and PCTs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care for the individual child or young person. It is important to ensure a smooth handover of clinical care to the new area, where that is the agreed best arrangement for the child. The needs of the child should be the first consideration.
- 9.5.9 PCTs need to understand the current flows of looked after children both in and out of the PCT area and agree local arrangements for ensuring children outside the area continue to have their statutory health needs assessment and that services are commissioned to meet the needs identified.

## 9.6 Framework for healthy care

9.6.1 Local authorities and PCTs are advised to develop a framework that Children's Trust partners can use to assess their work to improve the health and well-being of looked after children and young people. The National Healthy Care Standard is a useful approach for the development of such a framework and also provides access to downloadable resources and materials to support work on promoting the health and emotional well-being of looked after children and young people and regional networks to share learning and experience. ([www.ncb.org.uk/healthycare](http://www.ncb.org.uk/healthycare))

## 9.7 The management and delivery of services

9.7.1 Whether or not those delivering services to looked after children work within integrated Looked After Children teams, it is the responsibility of all staff working with looked after children to ensure they liaise effectively with their professional colleagues to ensure each looked after child's care planning reflects and meets their health needs.

9.7.2 Lines of accountability and responsibility should be clear and all staff should receive effective supervision and support. All staff working with looked after children need to understand the referral pathways in relation to specialist services, including substance misuse services and Child and Adolescent Mental Health services.

## 9.8 Health assessments

9.8.1 Detailed guidance on health assessments can be found in the Practice Guidance. It is the responsibility of the local authority to make sure that health assessments are carried out for every looked after child. PCTs have a duty to comply with requests<sup>45</sup> by local authorities for help in the exercise of their functions to make sure that this happens in accordance with statutory requirements on local authorities. The following principles should be taken into account when planning or conducting health assessments:

- Each child or young person should have a holistic health assessment on entering care.
- This first assessment should be undertaken by a registered medical practitioner in accordance with the Children Act (Miscellaneous Amendments) (England) Regulations 2002. These are due to be superseded by the Care Planning Placement and Case Review (England) Regulations 2010 which are currently being prepared. Review assessments may be carried out by an appropriately qualified registered nurse/midwife.

- The first health assessment should result in a health plan by the time of the first review of the child's care plan, four weeks after becoming looked after.
- All children who become looked after will have had a Core Assessment and the record of this assessment should be updated in the light of the child's changed circumstances (i.e. that is looked after and has been placed in accommodation by the local authority).
- Attention should be given to the continuity of previous plans and interventions where appropriate.
- All staff with information about the child's health should ensure this is made available to the person undertaking the assessment as soon as possible.
- Local areas may find it helpful to have a system of identifying one health professional to undertake the co-ordinating role for individual children's health.
- The health assessment is not an isolated event, but part of a continuous process, with emphasis being put on ensuring actions in the health plan are being taken forward.
- Successful health assessments will require a flexible and child-centred approach, appropriate to the child or young person's age and stage of development.

9.8.2 For children placed out of authority, the responsible commissioner PCT and the PCT where the child lives will need to reach agreement as to which PCT's staff carry out health assessments for each child. Factors that responsible PCTs may wish to consider when reaching a decision include:

- The need to ensure that they are satisfied with the quality of health assessments and follow-up to the actions that are identified in the assessments;
- How far away the child is placed. Where a child is placed further away, travelling time may make it more practically sensible for the responsible PCT to commission the receiving PCT;
- The need for a child-centred approach. Staff in the PCT where the child lives are more likely to be aware of the availability of local services which can meet the child's needs.

9.8.3 Looked after children may also undergo routine health checks at school, alongside their peers. In these instances, where the outcomes of the checks are normally notified to parents, the outcomes of checks for looked after children should be notified to both the main carer and to the child's social worker. The information should also be provided to parents of children accommodated under section 20 of the Children Act 1989.

## 9.9 Health Plans

### 9.9.1 Key principles of the health plan

As with health assessments, making sure that every looked after child has a health plan which forms part of their care plan, is the responsibility of the local authority that looks after the child. It is essential that PCTs co-operate with local authorities to make sure health plans are effective. The following principles should be adhered to when preparing, drafting and reviewing health plans:

- The health plan should clearly set out the objectives, actions, timescales and responsibilities, arising from the health assessment.
- The health plan should be reviewed in line with the statutory review<sup>46</sup> time-scales. Health assessments must be undertaken twice a year for children under 5 years, and annually for children and young people 5 years and over.
- The local arrangements for reviewing the health plan will balance the sensitive and confidential nature of the child's and young person's health information, whilst ensuring it is appropriately integrated into the overall care plan, in order to ensure that required actions are monitored.
- The lead health record for the looked after child or young person should be the GP-held record. A copy of the health assessment and plan should be part of this.
- The health plan should be drawn up in conjunction with a health care professional, and with the child's parents whenever practicable.
- Fostering service providers should work with foster carers to provide information about the child's health needs for the planning and review process.

9.9.2 The health plan should be continued as appropriate when the child returns home.

## 9.10 Content of the Health Plan

9.10.1 The content of the health plan will vary according to the age and development of the child. The content should always reflect the issues that are addressed at the health assessments, including physical and emotional health. Guidance on age-appropriate content for the health assessment, and therefore the health plan, can be found in the Practice Guidance. The following should be included as a minimum in all health plans, in line with the requirements of the Regulations:

- The child's state of health, including physical, emotional and mental health;

- The child's health history including, as far as practicable, their family's health history;
- The effect of the child's health history on their development;
- Arrangements for the child's medical and dental care appropriate to their needs, including:
  - a. routine checks of the child's general state of health, including dental health;
  - b. treatment and monitoring for identified health (including physical, emotional and mental health) or dental care needs;
  - c. preventive measures such as inoculation;<sup>47</sup>
  - d. screening for defects of vision or hearing; and
  - e. advice and guidance on promoting health and effective personal care;
- Any planned changes to the arrangements.

## 9.11 Assessment for emotional and behavioural difficulties

9.11.1 From April 2008 all local authorities in England have been required to provide information on the emotional and behavioural health of children and young people in their care. PCTs and Mental Health Trusts should support local authorities to make sure this process is carried out in a way that best reflects the needs of the child or young person.

9.11.2 Local authorities are required to make sure that a Strengths and Difficulties Questionnaire (SDQ) is completed for each of their looked after children aged between 4 and 16 inclusive. The questionnaire should be completed by the main carer, preferably at the time of the child's statutory annual health assessment. The authority will need to distribute and explain how to use the questionnaires to each carer.

9.11.3 Local authorities should ensure that they follow the DCSF guidance<sup>48</sup> on this process and PCTs should support local authorities in doing this, for example by ensuring that SDQs are built into the annual health assessment and are used when new placements commence. The SDQ is a reliable and valuable screening tool for mental health problems and can therefore be helpful in uncovering previously unidentified mental health problems. As such, it should be used as evidence to support a referral

47 Comprehensive information on immunisation including the current routine childhood vaccination schedule is available at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk)

48 Guidance on data collection on the emotional health of looked after children <http://www.dcsf.gov.uk/datastats1/guidelines/children/pdf/SDQ%20guidance%20update%20Dec%202008.pdf>

to local targeted and specialist mental health services, using the local referral systems and protocols.

9.11.4 Referral to specialist mental health assessment and treatment, where this is appropriate, should be considered as part of the process when deciding placement choice.

9.11.5 Where an SDQ completed by a carer suggests there may be a difficulty, it will be important to seek completion of the SDQ by the child and the child's teacher to obtain further perspectives. If these further reports also raise concerns, consideration should be given to the use of a diagnostic tool to enable an appropriate intervention to be identified, as SDQs are not a diagnostic tool and should not be relied upon as the only source of information on the emotional health of looked after children.

## 9.12 Child and Adolescent Mental Health Services

9.12.1 Child and Adolescent Mental Health Services (CAMHS) play a crucial role in assessing and meeting the child's mental health needs identified as part of the SDQ screening process and via other means. Local authorities, PCTs and SHAs need to build awareness of the high level of mental health needs amongst looked after children into their strategic planning and their operational delivery of CAMHS services. The CAMHS review<sup>49</sup> recommended that "Children and young people and their families who are vulnerable, such as children in care, children with disabilities and children with behavioural, emotional and social difficulties, should be confident that:

- their mental health needs will be assessed alongside all their other needs, no matter where the need is initially identified;
- an individualised package of care is available to them so that their personal circumstances and the particular settings where they receive their primary support, appropriately influence the mental health care and support they receive;
- for those experiencing complex, severe and continuing or long-term needs, these packages of care will be commissioned by partners in the Children's Trust and delivered where possible in the local area. Effective regional and national commissioning will occur for provision to meet rare needs. "

9.12.2 As a result of the evidence collected through the CAMHS review and through the fieldwork carried out to inform the revision of this guidance, PCTs are required to ensure that:

49 Children and Young People in Mind: Final report of the National CAMHS Review, 2008, [www.dcsf.gov.uk/camhsreview](http://www.dcsf.gov.uk/camhsreview)

- a child is never refused a service on the grounds of their placement being short-term or unplanned;
- there are referral pathways that are understood and used by all agencies that come into contact with the child;
- CAMHS services provide targeted and dedicated services to looked after children where this is an identified local need. This could include a dedicated team or seconding a CAMHS professional into a looked after children multi-agency team.

### 9.13 Healthcare within children's homes

9.13.1 Healthcare for children living in children's homes should be delivered at least to the standards outlined in the National Minimum Standards<sup>50</sup>. Particular attention should be paid to what is said in the National Minimum Standards regarding the administration of medicines within the homes, including the requirement that medicines are kept securely. Young people in children's homes have some of the highest levels of mental health difficulties and staff should be equipped with the skills and knowledge to respond appropriately to their needs and to provide a healthy environment which promotes health and wellbeing in its broadest sense.

### 9.14 Confidentiality

9.14.1 The principles and legal requirements concerning confidentiality can be found in Annex B and should be adhered to at all times.

### 9.15 Adoption

9.15.1 Local authorities and PCTs should work together to make sure adoption panels are able to secure access to timely medical advice so as to avoid delays in the making of an application for a placement order. Panels require comprehensive health information about a child and the availability of good health advice is essential.

9.15.2 Social workers should request health assessments, which may include the requirements for any medical reports necessary for the purposes of placement order proceedings, at an early stage in planning for permanence for children. To this end, local authorities should ensure that robust arrangements are in place for the timely commissioning of health assessments. Local authorities should be ready to file the medical (and other) reports required under Rule 29 of the Family Procedure (Adoption) Rules 2005, and Annex B to the Practice Direction which supplements Rule 29(3), in accordance with the Court timetable.

9.15.3 The Arrangements for Placement of Children Regulations 1991 and the Review of Children's Cases (General) Regulations 1991 set out the requirements for health assessments and reviews and these Regulations should be adhered to by local authorities at all times.

9.15.4 It is proposed that the practice of issuing a new NHS number when a child is adopted should be brought to an end. This is because important medical records are being lost due to the introduction of new NHS numbers. A date for the new policy is currently being agreed with stakeholders and from that date the following policy should be applied:

- Adopted children retain their original NHS number.
- Arrangements should be put in place for local authorities to request the shielding of demographic data in the medical records of children placed for adoption where, after a risk assessment, it is deemed necessary (i.e. in the cases where birth family members will use all endeavours to trace an adopted child). This should be done through the NHS Information Centre applying the "S" flag in the NHS Connecting for Health system.

## **9.16 Children on the edge of care and the involvement of birth families**

9.16.1 Whilst the number of children in care at any one time is typically around 60,000, more than a third as many children again will experience the care system during any one time in a year. Nearly a third (31%) of those who ceased to be looked after in the 12 months to March 2008 had spent less than a month in care. This means that work with children on the edge of care and with birth families before, during and after a period of care is crucial to ensuring successful outcomes for vulnerable children.

9.16.2 As far as possible, efforts should be made to involve birth families in initial health assessments so as to ensure as accurate a picture of health needs as possible and to facilitate better awareness of health needs if a child returns home. This does not necessarily mean that the child's parents need to attend the initial health assessment, but consideration should be given to seeking information about the child's and the family's health history from them or other members of the child's family in a way that would not harm the interests of the child. In the case of a competent child, consent should be sought from the child to their confidential information being shared, and the child should see a copy of any medical reports before they are shared. Where a child refuses to allow information to be shared, clinicians should explain that it may jeopardise the prospects of a placement. In some circumstances there may be an overriding public interest to support information sharing without consent – e.g. where it is thought that withholding data may put the child or others at risk of serious harm. It is important to be clear that any sharing of parental information needs to be with the consent of the



parents, unless this is impossible or where not sharing the information would put the child at risk.

- 9.16.3 It is recommended that those working with children who may be on the edge of care use the recognised framework for assessing their needs<sup>51</sup> to ensure that where possible health needs are identified before a child comes into care, and are met within their birth family.

## 9.17 Leaving care

- 9.17.1 This guidance refers to looked after children. However, neither young people's health needs nor the responsibilities of local authorities cease when young people enter adulthood. The fact that these young people do not have the same family support as other young people means they are more vulnerable to falling through gaps between children's and adult's services.
- 9.17.2 Care leavers are at particular risk of becoming pregnant at a young age and may require additional support to access specialist advice on contraception and sexual health. This should be provided within the Children's Trust's Teenage Pregnancy Strategy in line with *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts*<sup>52</sup>. For pregnant care leavers who decide to continue with their pregnancy, the guidance, *Teenage parents: who cares? A guide to commissioning and delivering maternity services for young parents*<sup>53</sup> should be used to inform the provision of maternity services to looked after children and adolescent care leavers. The guidance, *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*<sup>54</sup> should be used to inform on-going support services for looked after children and care leavers who are parents.
- 9.17.3 Young people leaving care should be able to continue to obtain health advice and services at what is often a very stressful time for them. Personal advisers should work closely with doctors and nurses involved in 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 services<sup>55</sup>. CAMHS transitions should be planned at

51 Framework for the assessment of children in need and their families, Department of Health, 2000

52 Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies, DfES, 2006

53 Teenage parents: who cares? A guide to commissioning and delivering maternity services for young parents, DCSF / DH / Royal College of Midwives, 2008

54 Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts, DCSF, 2008

55 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.

least 6 months in advance of the 18th birthday, in line with recommendations in the CAMHS Review.

- 9.17.4 Care leavers with complex needs, including those with disabilities, may transfer direct to adult services and the pathway plan will need to ensure that this transition is seamless and supported. For care leavers whose needs do not meet the criteria for support by adult services, their Personal Adviser should ensure that all possible forms of support, including that offered by the voluntary sector, should be identified and facilitated as appropriate. Further information on transition can be found in both joint DCSF / DH guidance<sup>56</sup> and in Standard 4 of the National Service Framework for Children, Young People and Maternity Services, DH/DCSF 2004.

## 10 Roles and responsibilities of local authorities

### 10.1 Duties to looked after children

- 10.1.1 Local authorities have a duty to safeguard and to promote the welfare of the children they look after<sup>57</sup>. Local authorities should make arrangements to ensure that every child who is looked after has:

- his / her health needs fully assessed;
- a health plan which clearly sets out how health needs identified in the assessment will be addressed, including intended outcomes for the child, measurable objectives to achieve the outcome, actions needed to meet the objectives, the person responsible for each action and the timescales for achieving this; and
- his / her health plan reviewed.

This should all be done in accordance with the relevant Regulations<sup>58</sup> and best practice to ensure that it is possible to comply with these requirements in every child's case.

- 10.1.2 Local authorities should make plans at a strategic level to ensure local delivery of these arrangements and at an operational level to act as a parent and advocate for each child in their care.

56 Transition: moving on well, a good practice guide for health professionals and their partners on transition planning for young people with complex health needs or disability, DCSF/DH 2008  
57 section 22 of the Children Act 1989

58 Arrangements for Placement of Children (General) Regulations 1991 (as amended) and the Review of Children's Cases Regulations 1991 (as amended)

10.1.3 The legal status of children who are the subject of a care order is not affected by detention under the Mental Health Act or in custody. The responsibility of the local authority to promote the welfare of looked after children who are so detained remains and every effort should be made to make sure these children's health needs are identified and met, wherever they are living.

10.1.4 The local authority has a legal duty under the Children Act 1989 to support its looked after children. The local authority will aim to perform that duty as a good corporate parent and should aim to do at least what a good parent would do. It is the local authority **as a whole** which has responsibility for that child.

## 10.2 Involvement of children and young people – Children in Care Councils and the Pledge

10.2.1 Local authorities should make sure that the voices of children and young people are at the heart of informing the commissioning, planning, delivery and evaluation of services for looked after children and young people. This could include a Children in Care Council with direct links to the Director of Children's Services and Lead Member. All looked after children should have the opportunity to express their views and influence the services, including health services, and support that they receive. It is important to recognise that the aspects of health that are important to children and young people may differ from the priorities of professionals and carers.

10.2.2 Any local authority "Pledge" to looked after children should cover the health services and support looked after children can expect to receive.

## 10.3 Information on the health of looked after children

10.3.1 The Integrated Children's System (ICS) should be used to record information at child level and the health plan should be recorded in full within the ICS Care Plan. At an aggregate level information from the ICS about the health needs of looked after children should be used to inform policy development and commissioning.

## 10.4 The role of the social worker

10.4.1 It is the role of the social worker to ensure that adequate arrangements are made for the child's care and that a plan is made, in partnership with the child, their carer, their parents and other agencies, so that the child's future is secure. This plan should include a Health Plan, based on the needs identified in the health assessment. The social worker is also responsible for ensuring that the plan is implemented and

reviewed in accordance with Regulations<sup>59</sup>, although many of the actions may be the responsibility of other agencies.

## 10.5 Care planning and reviews

- 10.5.1 A literature review commissioned by the DfES<sup>60</sup> found substantial evidence that instability in early childhood had a profound effect upon development and upon ability to form relationships in the future. It would therefore be inconsistent with local authorities' duties to promote the child's welfare to change the placement unless it is clearly in the child's interests to do so. This is particularly important in the early years of a child's life and local authorities should do all they can to support placements so that moves do not happen without very good, child-related, reasons.
- 10.5.2 The child's health needs should be set out in the health plan which in turn should form part of each child's care plan. The child's care plan, including the health plan, should be reviewed at the prescribed intervals (within 28 working days of the child being looked after, then within three months of the last review and thereafter at six monthly intervals), ensuring that the plans, together with the Personal Education Plan, complement each other and deliver improved outcomes for the child.

## 10.6 Role of the Independent Reviewing Officer

- 10.6.1 As part of their responsibility to monitor the Care Plan, the IRO should ensure that the child's Health Plan is reviewed at least every six months, in accordance with the Regulations<sup>61</sup>. In cases where the IRO identifies deficiencies in the quality of the Health Plan or where actions within the health plan are not being carried out, the IRO must bring the deficiencies to the attention of the appropriate level of management within the authority, using the local authority's dispute resolution process if necessary. IROs should ensure that looked after children are involved at every stage of the review of their health plan.

## 10.7 Supporting foster carers to promote health

- 10.7.1 Standard 12 of the National Minimum Standards for fostering services<sup>62</sup> and the Fostering Services Regulations 2002 must be adhered to at all times. This includes a requirement that each foster carer is given basic training on health, hygiene issues

59 Arrangements for Placement of Children (General) Regulations 1991 (as amended) and the Review of Children's Cases Regulations 1991 (as amended)

60 Placement Stability – a review of the literature, Emily P Munro and Ainsley Hardy

61 Arrangements for Placement of Children (General) Regulations 1991 (as amended) and the Review of Children's Cases Regulations 1991 (as amended)

62 Fostering Services: National Minimum Standards, DH, 2002

and first aid, with a particular emphasis on health promotion and communicable diseases.

- 10.7.2 Foster carers should be given a written health record for each child in their care, which includes the child's state of health and identified health needs and is regularly updated and moved with the child. In most cases, foster carers should also be given the child's or young person's health plan as it is foster carers who have day-to-day responsibility for making sure a child's health needs are met. However, it should be noted that consent to this should be obtained in the case of young people who are "competent" in line with the criteria outlined in the Fraser Guidelines<sup>63</sup>. Local authorities must ensure that information about any health needs or behaviours which could pose a risk of harm to the child, the carer or to members of their family / household, is passed on to the carer at the time of placement, along with information about the support which will be available to the child and carer to address and manage these difficulties.
- 10.7.3 Local authorities should ensure that foster carers and residential care workers know how to contact designated and lead health professionals for each child in their care and how to access the services the child needs. This may include access to CAMHS consultation services for the child or carer. Foster carers and residential care workers should ensure that each child in their care attends all relevant health appointments, including their health assessment.

## 10.8 Access to Positive Activities

- 10.8.1 Access to positive leisure activities is vital to well-being and provides opportunities to meet and interact with others, to build social or other skills and self-esteem, to develop friendships and to come into contact with trusted adults. *Statutory Guidance on Section 507B Education Act 1996* published in 2008 outlined how the Government expects local authorities to fulfil their duties with regard to young people in care. Directors of Children's Services are responsible for ensuring that looked after young people enjoy the same or better levels of engagement in positive activities as their peers. Operationally, it will be for the responsible social worker to ensure that the children and young people receive appropriate financial and practical support to access good quality activities, including encouraging and enabling carers to support young people to sustain their engagement.

63 Gillick -v- West Norfolk And Wisbech Area Health Authority and Department of Health and Social Security, House of Lords, 17 October 1985

10.8.2 The statutory guidance states that to fulfil this expectation, local authorities will need to:

- provide young people in care with free access to the positive activities and related facilities they own, deliver or commission; this should include access for young people in care who are teenage parents with arrangements for necessary childcare;
- prioritise young people in care when planning which young people should be offered opportunities to participate in youth work activities;
- overcome similar cost barriers where other providers – such as schools, businesses or charities – impose charges to participants;
- ensure that they ascertain and take account of the views of children in care, and the views of the Children in Care Council, whose opinions should help to shape the local offer of positive activities.

## Key Points for Local Authorities

### Strategic:

- Are the health priorities for looked after children reflected in the CYPP and monitored by the Children's Trust Board?
- Are all local authority officers and Members aware of their responsibilities to the children they look after?
- Does the Children in Care Council influence the development of health services and does the Pledge to looked after children make commitments on meeting their health needs?
- Does the Joint Strategic Needs Assessment take into account the health needs of looked after children?
- Is the Integrated Children's System used to inform decision making in relation to the health and wellbeing of looked after children?
- Is commissioning of health services for looked after children done in accordance with the DCSF/DH commissioning guidance (Securing better health of children and young people through world class commissioning: A guidance to support delivery of "Healthy lives, brighter futures: The strategy for children and young people's health" 2009)?

**Operational:**

- Do local authority staff work closely with health professionals to ensure looked after children's health needs are anticipated and met – including those who are teenage parents?
- Do social workers ensure that each looked after child has a health plan that forms part of the care plan and that actions in that plan are followed up?
- Are both plans reviewed in accordance with the Regulations?
- Does the Independent Reviewing Officer consider a child's health needs and ensure the health plan is effective and that actions are taken?
- Are foster carers provided with the training and information they need to support the health needs of the children they care for?
- Are SDQs carried out in relation to all looked after children? Are the results submitted as part of the SSSA903 data collection? Is action taken when an SDQ indicates a possible mental health problem?
- Is health provision put in place immediately when a child is placed out-of-authority?
- Are health providers notified when a child is placed out-of-authority?
- Do local authority staff understand the responsible commissioner arrangements?
- Are all looked after children and young people, including teenage parents, able to access positive activities such as arts, sport and culture?
- Are arrangements in place to ensure care leavers' health needs, including mental and physical health, are met and form part of their pathway plan?
- Do personal advisers work closely with health professionals?

**11 Roles and responsibilities of the NHS**

11.1 The NHS has the major role in ensuring the timely and effective delivery of health services to looked after children and young people. Under the Children Act 1989 PCTs and SHAs have a duty to comply with requests from the local authority to help them to provide support and services to children in need.

11.1.2 Looked after children and young people tell us they want to be treated in the same way as other children and young people, but what we know is that the NHS can only effectively meet their needs when it has systems and processes in place to actively track and target their health needs. That is why the statutory health assessments and health care plans are so vital. The challenge is to involve children

and young people and their carers in local arrangements so that their needs are met without making them feel different. The focus should be on ensuring their access to universal services as well as targeted and specialist services where necessary. The ultimate aim is that their health needs are met in the same way as other children and young people. Account needs to be taken of their health history and experiences before becoming looked after. Effective provision is also required for their health needs when they leave the care system, whether that is as they become adults, return to their birth families or become adopted.

11.1.3 The NHS contribution to the health of looked after children is made in 3 ways:

- Commissioning effective services;
- Delivery through provider organisations;
- Individual practitioners providing co-ordinated care for each child or young person and carer.

11.1.4 The support and contribution of the NHS is crucial to ensuring that local authorities fulfil all the responsibilities of corporate parenting and that looked after children achieve the same optimal outcomes as any good parent would wish for their child.

## 11.2 Primary Care Trusts and Commissioning

11.2 As commissioners of health services for looked after children/young people and other children in need, Chief Executives of PCTs should satisfy themselves that:

- Appropriate arrangements are in place to meet the health needs of children and young people who are looked after.
- Strategic commissioning as part of Children's Trust arrangements focuses on health services which meet looked after children's needs locally and are informed by their views.
- Systems are in place to ensure services for individual children and young people placed out of the PCT area are consistent with the guidance on Establishing the Responsible Commissioner.
- Robust commissioning arrangements are in place where a child or young person is placed away from the responsible local authority to provide continuity of the health assessment and health planning process.
- Arrangements are in place to secure expertise from a designated doctor and nurse to provide strategic and clinical leadership and advice to the PCT commissioners and local authority. Where the designated professionals are



employed by a different NHS organisation this will need to be set out in a local agreement. More details of these roles are set out in the Practice Guidance.

- There is a named public health professional with responsibility for children in need issues including child protection as necessary. Looked after children are part of this wider group of children in need and should be considered as part of the Joint Strategic Needs Assessment.
- Systems are in place to ensure children and young people who are looked after are registered with GPs and have access to dentists near to where they are living, even if this is a temporary placement, and that primary care teams are supported where appropriate in fulfilling their responsibilities to looked after children.
- When children or young people looked after need to register with a new general practitioner (e.g. when they enter care or change placement), that arrangements can be made to “fast-track” the transfer of GP-held clinical records.
- When a child or young person moves placement or moves into the area from the area of another PCT, necessitating moving from one NHS waiting list to another, he/she is not disadvantaged by being placed at the bottom of the new list. Every effort should always be made to ensure that looked after children are seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service. The commitment for NHS patients in England to start their consultant-led treatment within a maximum of 18 weeks from referral includes patients who move home and between hospitals.
- Appropriate arrangements are in place for the transition from child to adult health services.
- There is effective co-ordination between health bodies, particularly at a strategic level. This should include joint working between public health, clinical health and CAMHS so as to ensure a social rather than purely medical model of promoting health.
- Public health programmes such as Change for Life reach looked after children and young people.
- Appropriate data sets are agreed locally, collected and reviewed annually.
- PCTs, together with colleagues in local authority services, should monitor and review arrangements and services against agreed targets and quality standards, to ensure a robust service is in place.

### 11.3 Provider organisations delivering services

11.3.1 Commissioners need to ensure the services for looked after children have sufficient clinical and strategic leadership and capacity to enable them to deliver their responsibilities set out in this guidance.

11.3.2 They should commission services from one or more providers which meet the following requirements:

- provision of clinical expertise and advice to commissioners as agreed locally;
- all looked after children get their health assessments undertaken and resulting health plans implemented as set out in paragraph 9.8;
- health professionals performing health assessments and contributing to health care planning have the appropriate skills and competencies by receiving appropriate training;
- arrangements for clinical supervision are made where the nursing staff are employed by the local authority;
- clinical governance and audit arrangements are in place to assure the quality of services for looked after children, including health assessments and health care planning;
- provider policies and procedures are in place and those providing care to looked after children are aware of local policy and procedures and their role;
- an annual report to inform the appropriate provider board and the commissioners;
- the collection and analysis of data to inform the profile of looked after children in the area for CYPP needs assessment;
- individual practitioners providing co-ordinated care for each child or young person.

### 11.4 Contribution of Primary Care Teams

11.4.1 Primary care teams have an important role to play in the identification of the individual health care needs of children and young people who are looked after. They often have prior knowledge of the child or young person looked after, of the birth parents and of carers, helping them to take a holistic and child-centred approach to health care decisions. They may also have continuing responsibility for the child or young person when they return home.

#### 11.4.2 Primary care teams' contribution is to:

- act as advocates for the health of each child or young person who is looked after;
- make sure timely, sensitive access to a general practitioner or other appropriate health professional when a child or young person who is looked after requires a consultation;
- make sure that referrals made to specialist services are timely, taking into account the needs and high mobility of many children and young people who are looked after;
- provide, when needed, summaries of the health history of a child or young person who is looked after, including their family history where relevant and appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments, subject to appropriate consents;
- maintain a record of the health assessment and contribute to any necessary action within the health plan;
- make sure that the clinical records make the "looked after" status of the child or young person clear, so that their particular needs can be acknowledged;
- regularly review the clinical records of looked after children and young people who are registered with them. In particular they should gather relevant information and make it available for each statutory review of the health plan;
- make sure the general practitioner-held clinical record is maintained and updated. It is a unique health record and can integrate all known information about health and health events during the life of any child or young person. This enables GPs, dentists, nurses, health visitors and others in primary care to have an overview of health priorities, and to know whether health care decisions have been planned and implemented;

To deliver the best possible medical care to the child or young person general practice needs to have the best possible access to the relevant medical records. This is best achieved by accepting the child or young person as a registered patient of the practice and seeking the urgent transfer of the medical records from the previous practice. Treating a patient as a temporary resident is not ideal as the medical record is not available to the treating practitioner. In these circumstances, the treating practitioner will normally wish to talk to the child or young person's registered practitioner to avoid treating the patient "blind". It should be remembered that temporary registration is for those who intend to be in an area for less than three months and where there is any doubt over the potential length of stay it would be advisable to opt for full registration.

## 11.5 Lead health professional

11.5.1 Whilst an increasing number of looked after children and young people have health assessments undertaken and health care plans developed, for some, little then happens to implement the plans between statutory reviews. Health care plans are not solely the responsibility of the health service, but rely on the social worker, foster carer / residential workers and NHS staff working together. By identifying one person who takes the lead for the NHS in working jointly with the social worker, foster carer / residential workers this should not only avoid this problem, but give these other workers a point of contact in the NHS to help navigate the NHS system where they encounter a problem. Disabled children and those with complex needs are likely already to have a key worker who could undertake this role, to avoid duplication. The lead health professional may be a different type of health professional for different children. This will be determined locally in response to the needs of the child and local service arrangements.

11.5.2 This lead health professional will:

- ensure the health assessments are undertaken (working with the designated health professionals for looked after children, depending on local arrangements);
- work with the child's social worker to co-ordinate the health care plan and ensure actions are tracked;
- act as a key conduit and contact point between the child or young person and their carer, where they have difficulties accessing health services;
- act as a key health contact for the child's social worker;
- work with the designated health professionals for looked after children, co-ordinate the individual health reviews.

## 11.6 The roles of the designated doctor and nurse

11.6.1 The designated doctor and nurse role is to assist PCTs in fulfilling their responsibilities as commissioner of services to improve the health of looked after children. Any job description should be jointly agreed by the PCT as commissioner of the local service for looked after children, the health organisation from which the doctor or nurse is employed, if different, and the relevant local authority. The designated role is intended to be a strategic one, separate from any responsibilities for individual children or young people who are looked after, although the professionals may also provide a direct service to children and young people.

11.6.2 There is unlikely to be a single model, and local PCTs will need to consider the range of duties for any post, whilst ensuring that the workload is realistic.

11.6.3 The **designated doctor** will:

- be a senior paediatrician (preferably, but not necessarily, a consultant community paediatrician);
- have undergone higher clinical/professional training in paediatrics and adolescent health;
- have substantial clinical experience of the health needs of looked after children – the designated doctor is likely to have worked or be working as a medical advisor to an adoption and/or fostering agency;
- be clinically active in community paediatrics in at least part of the geographical location covered by the post.

11.6.4 The **designated nurse** will:

- be a senior nurse or health visitor;
- have substantial clinical experience of the health and health care needs of children and young people;
- have undergone training in the specific needs of children and young people.

11.6.5 In addition to assisting PCT commissioners it is likely to be appropriate for the designated nurse to provide both a direct clinical service to looked after children and to support other nurses and health visitors who will be seeing these children and their carers. Further information about the roles of the designated doctor and nurse can be found in the Practice Guidance.

## 12 Securing delivery: performance management and inspection frameworks

### 12.1 OfSTED

12.1.1 A new programme of inspection for services for looked after children<sup>64</sup> took effect in 2009. This involves full inspection of safeguarding and services for looked after children in each local authority area at least once every three years, and will include assessors from the Care Quality Commission within the visiting teams.

<sup>64</sup> The term 'looked after children' includes all children being looked after by a local authority, including those subject to a care order under section 31 of the Children Act 1989 and those looked after on a voluntary basis through an agreement with their parents under section 20 of that Act.

12.1.2 These inspections will consider:

- quality of care and placement stability;
- access to, and attendance at, good schools;
- support for families and carers;
- the effectiveness of corporate parenting approaches;
- preparation for leaving care and adult life.

12.1.3 Local authorities will be required to evidence that they are supporting looked after children to “be healthy” as part of this inspection. Findings from inspections of services for looked after children will help determine Ofsted’s annual performance rating of council services for children and young people and will make an important contribution to area and organisational assessments including Comprehensive Area Assessments (CAAs).

12.1.4 Local authorities will need to report on performance against all national indicators as part of the CAA process. In the 2008-2011 National Indicator Set, there is one indicator, National Indicator 58, which specifically refers to the emotional health of looked after children. Some local authorities will have this as part of their Local Area Agreement (LAA). However, all local authorities will need to report on progress against all national indicators, whether or not it is a high-level indicator within their LAA. Other National Indicators relating to the placement stability and other outcomes for looked after children are also relevant.

## 12.2 Care Quality Commission

12.2.1 How well NHS and independent sector health organisations meet the health needs of looked after children is considered by the Care Quality Commission. This is currently measured against the Government’s standards for NHS healthcare and National Minimum Standards for independent healthcare.

12.2.2 The standards are, from 2010, being replaced by Regulations which will set out the regulated activities in respect of which a provider must be registered with the CQC and the registration requirements with which providers must comply. These Regulations will apply to providers in health and adult social care.

## 12.3 Role of Strategic Health Authorities

12.3.1 SHAs have statutory responsibilities set out in section 11 of the Children Act 2004 to make arrangements to ensure that the welfare of children is safeguarded when carrying out their functions.

12.3.2 SHAs therefore need to have systems in place to ensure through monitoring and performance management processes, that all the PCTs within their area have robust systems to manage their statutory responsibilities in relation to children who are looked after. This guidance will assist them in meeting that duty.

12.3.3 SHAs should also play a developmental, supportive role in helping PCTs to carry out their functions.

## Practice Guidance

*'As the corporate parent of children in care the State has a special responsibility for their wellbeing. Like any good parent, it should put its own children first. That means being a powerful advocate for them to receive the best of everything and helping children to make a success of their lives'* (Care Matters: Transforming the lives of children and young people in care, DfES 2006).

- 1.1 Central to young people's ability to fulfil their potential as they develop from childhood and through the teenage years is the need to be well – both physically and emotionally. **This practice guidance aims to offer information and guidance on some of the factors that commissioners and practitioners may wish to bear in mind when commissioning and delivering services in line with the statutory guidance.**
- 1.2 It provides information that practitioners will wish to take in to account in relation to:
  - The need for a holistic approach to health and wellbeing;
  - Access and engagement;
  - Care planning and placement quality;
  - Appearance, physical health and physical activity;
  - Health promotion (including sexual health, substance misuse and foetal alcohol syndrome);
  - Emotional health and CAMHS (including self-harm);
  - Health assessments – context, content and documentation;
  - The roles of designated health professionals;
  - Provision for those leaving care.

### A holistic approach to health and well-being

- 2.1 Childhood and young adulthood are critical stages in the development of behavioural patterns that will affect people's health in later years. Early intervention therefore lies at the core of driving forward a promotional approach to health and the reduction in inequalities.
- 2.2 Good health includes all aspects of health, including emotional well-being, dental health, healthy eating and physical activity. It includes the necessity of a child being



registered with a GP and should include an emphasis on primary prevention, alongside being involved in the Healthy Child Programme, which plays a key role in improving the health and well-being of children, as part of an integrated approach to supporting children. Playing and being involved in activities helps children and young people to make friends, be creative and imaginative, focus, concentrate, and have fun. These are important elements of healthy child development and are some of the building blocks of emotional health and well-being.

- 2.3 Good physical and emotional health and well-being are key contributors to broader outcomes such as improved learning and achievement and to the long-term prospects of young people as they move into adulthood. We know, for example, that children and young people with poor health are at greater risk of lower levels of educational attainment and of failing to achieve their full potential, which brings lifelong impacts.<sup>65</sup>
- 2.4 Good health goes beyond having access to health services. Improved health outcomes for looked after children require the focus of health care planning to be on health promotion and attention to environmental factors as well as physical, emotional and mental health needs. Children and young people need to understand their right to good health and to be able to access services. They need the knowledge and skills to communicate and relate to others and to take responsibility for themselves.
- 2.5 Young people who are looked after are recognised as being vulnerable to risk taking behaviour,<sup>66 67</sup> including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. These early risk-taking behaviours are very often indicators of poor emotional health and well-being and may be the forerunner of wider social exclusion such as homelessness and unemployment.
- 2.6 Children in care will spend a significant amount of their time in an education setting – nursery, school or college. Research evidence shows that these settings have a key role in promoting the well-being of children and young people, both through their teaching of health education and through their pastoral care of those in their charge. Those responsible for oversight of children in care should ensure that there are strong links between education settings and care staff and health professionals. Education staff are not health experts or social workers, but they are in a position to spot problems at an early stage and can offer a supportive environment in which to work with specialist staff to address a particular physical or emotional health

65 Department of Health (2004) National Service Framework for Children, Young people and Families

66 DFES (2006) Teenage Pregnancy Next Steps

67 Meltzer M., Gatward R., Corbin T., (2003) The Mental Health of Young People Looked After by Local Authorities in England and Wales. TSO

problem. All education settings should be supported in this role through good communications and appropriate staff development and should know where to go for expert help and how to maintain effective referral arrangements. This support should also pick up on particular issues around child protection and confidentiality of shared information.

- 2.7 Taking a holistic approach to health and well-being is essential to ensuring positive outcomes and the statutory guidance should be read within this context.

*A frequent barrier to effective multi-agency working is a lack of communication and understanding of the different roles and responsibilities. In Warwickshire all the agencies involved in the care of looked after children came together to develop an integrated care pathway. This inter-agency team produced a management tool – the Pathway – that allowed them to make sure looked after children’s health needs were being addressed consistently and that variations to the pathway such as not having a health assessment can be picked up and followed that up quickly.*

## Access and engagement

- 3.1 A key barrier to achieving health and well-being for looked after children is access to services. These difficulties can stem from frequent placement changes and school absence leading to missed primary health care services which are delivered through schools and appointments failing to catch up with the child. Children and young people may be reluctant to present themselves for services for fear of being stigmatised.
- 3.2 Furthermore, looked after children, their families and their carers have a vital role to play in ensuring that services which are provided meet their needs. Therefore the voices of children and their families should be at the heart of decisions both on the health care of an individual and in informing decisions relating to the commissioning of services.
- 3.3 A useful framework for ensuring both access and engagement is the national healthy care framework ([www.ncb.org.uk/healthycare](http://www.ncb.org.uk/healthycare)). This framework identifies six key entitlements for looked after children, that they:
- *feel safe, protected and valued in a strong, sustained and committed relationship with at least one carer;*
  - *live in a caring, healthy and learning environment;*
  - *feel respected and supported in his /her cultural beliefs and personal identity;*
  - *have access to effective healthcare, assessment, treatment and support;*

- *have opportunities to develop social skills, talents and abilities and to spend time in freely chosen play, cultural and leisure activities;*
- *be prepared for leaving care by being supported to care and provide for him/herself in the future.*

3.4 This provides a helpful framework for describing the quality of practice which is most likely to lead to positive outcomes, including positive health outcomes for the child. It also identifies the importance of the participation of children and young people in planning services and monitoring their effectiveness.

*Tower Hamlets provides free access to leisure facilities for all its children and young people in care. It provides monthly passes for anyone who uses the facility 6 or more times a month and for everyone else will pay on an as and when basis. This is extended to all children and young people regardless of where they are placed. It has also set up a bike scheme in conjunction with council partners in the environment department whereby children and young people can receive a bike and equipment on condition that they complete a cycling proficiency test.*

3.5 The Healthy Care audit tool and action planning cycle creates a process of continuous improvement focusing on the health and well-being of looked after children and young people. Using the audit tool will:

- Enable the participation of key stakeholders, including children and young people, their families and carers;
- Support effective commissioning;
- Ensure services are involved in advising on strategic and operational development;
- Support inspection processes;
- Clarify where to focus first;
- Produce immediate results and tangible benefits for children;
- Support the development of local partnerships and local momentum.

3.6 Local authorities are encouraged to establish Children in Care Councils which can play an important role in auditing services, providing feedback to managers and staff and informing future provision.

*To be successful, health improvement programmes need more than the reluctant consent of the young people. They require their active participation and empowerment as the primary custodians of their own health.*<sup>68</sup>

- 3.7 Engagement is at the centre of effective healthcare provision, which starts with the active promotion of health in the daily lives of children and young people. Young people frequently report dissatisfaction with the current health care provided, often finding accessing services problematic and seeing staff as not understanding their concerns. There is particular concern that traditional health services are not effective at targeting or meeting the needs of the most vulnerable young people, such as looked after children.
- 3.8 A number of schemes to help primary and community health care providers become better equipped and coordinated to meet the health needs of young people (aged 11-19) are being rolled out nationally and are outlined below.<sup>69</sup>

*'You're Welcome'* quality criteria<sup>69</sup> lay out principles that will help health services to be more responsive to young people's needs and be young people friendly. The criteria build on good practice and will support local commissioners and services in delivering on key local priorities for adolescents (e.g. reducing teenage pregnancy, improving uptake of chlamydia screening and smoking cessation services). One key criterion for achieving *'You're Welcome'* status focuses on accessibility. This criterion outlines that primary care trusts should have in place a strategy to promote easier access to services by marginalised young people, including looked after children and care leavers.

- 3.9 The Department of Health has supported the Royal Colleges' development of an adolescent health e-learning programme for doctors and nurses to ensure that they have the skills and knowledge to meet the needs of adolescents. The e-learning modules cover all aspects of adolescent health, including development, communication skills, consent and confidentiality issues, sexual health, substance misuse, obesity and eating disorders, mental health, and making health services young-person friendly. This is the first time that the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of General Practitioners (RCGP) have had such a holistic adolescent health programme within their core curriculum. Meeting the needs of vulnerable young people, including looked after children, is a core component of this work. This e-learning material is being used to improve training for all youth workers and extension to teachers is also being explored.

68 Chambers H., Howell S., Madge N., Olle H. Healthy Care: Building an evidence base for promoting the health and wellbeing of looked after children. NCB (2002)

69 Department of Health. *You're Welcome* quality criteria: Making health services young people friendly (2005)

- 3.10 In 2008/2009, the Department of Health separately commissioned an e-learning project covering the 0-5 strand of the Healthy Child Programme. This is currently being developed by e-Learning for Healthcare and the RCPCH in a partnership with the RCGP, the Royal College of Midwives and the Community Practitioners and Health Visitors Association and other stakeholder organisations. It will be available in 2010. It is also planned to develop a 5-11 strand.
- 3.11 The Healthy Child Programme (HCP) provides support for those responsible for commissioning services for children and young people as well as frontline professionals delivering those services. It is an evidence-based prevention and early intervention programme setting out the good practice framework for delivery of services from pregnancy to 19 years, to promote optimal health and well-being and reduce health inequalities. It is a universal progressive programme – i.e. it outlines a recommended universal service for all children and young people and their families, with additional services for those with specific needs and risks, including looked after children and young people. The HCP for pregnancy and the first five years of life (formerly the Child Health Promotion Programme) was updated in March 2008 to reflect the latest evidence. The HCP for five to 19 year olds was published in October 2009.

## Care planning and placement quality

- 4.1 We want all looked after children to have kind, understanding and committed carers- whether foster carers or residential staff- and we want to encourage that element of 'stickability' which research has shown to be key to the successful continuation of relationships<sup>70</sup>. The more engaged carers are in the child's life and the greater their role in decision-making, the more likely they are to develop that close bond which will lead to successful outcomes for the child.
- 4.2 This means that the child and the carer must be at the centre of all the activity. The work of the wider team around the child – the social worker, health professional, teacher – must be undertaken in a way which strengthens and supports the role of the carer rather than taking away responsibility.
- 4.3 Being valued and protected by an adult or parental figure is one of most important ways of teaching a child how to grow up to protect him or herself. Carers have a key role to play in promoting the safety of the children and young people they care for but it happens most effectively in the context of a stable relationship. Stability is the keynote of the Government agenda for looked after children and the *Care Matters* White Paper set out a range of actions for central and local government to promote stability in all aspects of the child's life.

70 Sinclair I., *Fostering Now Messages from Research*. Jessica Kingsley Publishers (2005)

- 4.4 Good quality placements are crucial to the health and well-being of looked after children. The *Care Matters* White Paper set out the key factors for ensuring a better choice of placements and a more positive placement experience:
- Ensuring a strong focus on stability;
  - Enabling local authorities to improve their commissioning of placements;
  - Improving foster carer support and training;
  - Better enforcement of the National Minimum Standards for residential care;
  - Piloting a 'social pedagogy' approach in residential care;
  - Ensuring that children in long term residential placements in education or health settings get the best possible support;
  - Improving practice in responding to children who go missing from care; and
  - Ensuring that local authorities deliver a better placement experience for children in care, including a new set of regulations in relation to visits.
- 4.5 Carers have a responsibility to provide the kind of home environment that actively promotes a healthy lifestyle. But equally they need to encourage young people appropriately to take some responsibility for their own health and well-being as part of growing up. This may mean providing health information or access to services, supporting their development and answering their questions. Providing them with a positive sense of identity and helping to build their self esteem and self efficacy will give them the confidence to do this.
- 4.6 Carers should ensure that children and young people in their care attend clinic/ health appointments and visit the dentist and optician on a regular basis accompanied by their carer or another trusted adult of their choice as appropriate. They have a key role to play in identifying the child's health needs; keeping records up to date in their Child Health Record Book (red book) where appropriate and ensuring that they contribute to the child's health and education plans as part of the overall care plan, in partnership with the agency, birth parents and other relevant people. They must be the child/young person's champion and advocate on their behalf, if necessary, to access and use the various health services.

*An increase of more than 25% has been achieved for dental checks for looked after children in Wigan Borough thanks to the new D Card scheme which guarantees looked after children and young people an appointment with a local NHS dentist for check ups and treatment. Before the scheme started many foster carers had to take children out of the borough to see an NHS dentist or to the community clinics. The scheme is provided by Ashton, Leigh and Wigan Primary Care Trust. The scheme works with three dental practices spread across the borough commissioned to see children and young people referred by the scheme – a specially designed 'D Card' is presented at the practice and the child will be seen and treated within 4 weeks. The practices involved have received training about the needs of looked after children.*

- 4.7 Lack of clarity about where responsibility lies often hampers the efforts of carers to promote children's health. To make sure carers are clear about their roles and responsibilities, the local authority looking after the child should ensure that appropriate delegations are in place through the placement planning process and recorded within the Placement Information Record or Placement Plan.
- 4.8 Clarity about where responsibility lies between the local authority and provider is particularly important when meeting the needs of disabled children living away from home in the short or long term. Attention must be given to ensuring the safe installation and use of any equipment and adaptations which may be necessary.
- 4.9 For young people in residential care, it is vital that they feel valued and respected for who they are. The Government is piloting social pedagogy in children's homes as a means of improving the quality of children's daily experiences. Social pedagogy provides a theoretical and practical framework for understanding children's upbringing. It focuses on forming relationships through engagement with children on practical tasks and on working in groups as well as creative and practical subjects, such as art, drama, woodwork, music or gardening – media through which they can relate to children. Arts and practical subjects are also valued for their general therapeutic effect; they can help children enjoy life and feel good about themselves.

*A child needs to have opportunities to develop personal and social skills, talents and abilities and to spend time in freely chosen play, cultural and leisure activities.*

- 4.10 Personal and social skill development is fundamental to a successful childhood and adulthood. Many of these skills are derived from secure attachments and successful pre-school experiences and some looked after children will have lacked opportunities to acquire these basic skills. Carers, social workers and health and education practitioners have a vital role to play in identifying gaps and working with the child or young person to find ways to fill them. Examples would be in noticing that a child has difficulty in sustaining friendships, being picked for a team, being

able to take turns or expressing him or herself in class. Such opportunities for new and enhancing experiences can also address some of the health promotion gaps which also affect the health, safety and well-being of this population of children.

## Physical health and physical activity

5.1 Physical activity, outdoor play, active travel and other unstructured free time activity enable children and young people to bring together ideas, feelings, relationships and physical experiences and provide opportunities to promote good physical health. Play, active travel and creative activities, including sports and other leisure activities can happen:

- In the home/ foster home/ residential care setting;
- In the local community (parks, adventure playgrounds, playing fields, swimming pools);
- As part of organised activities (such as after school groups, dance classes, play schemes, football teams, Brownies and cubs);
- As part of an everyday journey or special visit, for example to an art gallery, theatre, nature reserve, wildlife park or museum;
- At school, before and after the school day and during break times.



The Chief Medical Officer recommends that all children and young people aged over 5 should achieve a total of 60 minutes or more of at least moderate intensity physical activity each day. At least twice a week this should include activities to improve bone health (activities that produce high physical stresses on the bones), muscle strength and flexibility<sup>71</sup>.

Schools and community partners have a key role to play in the provision of physical activity, as through the PESSYP (Physical Education and Sport Strategy for Young People) they work towards providing 5 hours per week of PE and sport for all aged 5 to 16 and a minimum of 3 hours per week for 16 to 19 year olds. Carers, however, should ensure that looked after children are able to access this provision through support such as transport and encouragement to be physically active.

To enable looked after children to meet the 60 active minutes daily recommendation, carers should be supported to provide opportunities for physical activity, active travel and active play, sport and hobbies outside school, particularly during weekends and school holidays – as well as ensuring that children in their care take the opportunities for active play, physical education and sport offered in school. Some young people will need support from carers to develop and sustain their interest in an activity or to build more physical activity into their lives; children are more likely to be physically active if they see that physical activity is part of the ordinary lives of their carers. Foster carers have found that ‘taster’ sessions can be particularly helpful to these children and young people.

## Eating well

- 5.2 In a healthy care environment, children and young people are encouraged to eat well. A healthy diet is key to current and future health and well-being. What we eat can make a big difference to our health and well-being. Eating healthily can help us maintain a healthy weight, and reduce our risk of getting diseases like heart disease, diabetes and cancer.
- 5.2.1 Those involved in the care of looked after children should be encouraged and supported in demonstrating a commitment to the principles of healthy eating, including through modelling this in their own eating. Staff and carers are well placed to support looked after children in eating a healthy and varied diet, which should be provided in care settings to cultivate “good” eating habits. A healthy balanced diet contains a variety of types of food, including lots of fruit, vegetables

71 [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4080994](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080994)

and starchy foods such as wholemeal bread and wholegrain cereals; some protein-rich foods such as meat, fish, eggs and pulses; and some milk and dairy foods. The 'eat well plate' makes healthy eating easier to understand by showing the types and proportions of foods we need to have a healthy and well balanced diet.

5.2.2 The top 8 tips for eating well are:

1. Base meals on starchy foods such as bread, cereals, rice, pasta and potatoes.
2. Try to eat at least 5 portions of a variety of fruit and veg every day.
3. Eat more fish including a portion of oily fish each week.
4. Cut down on saturated fat and sugar.
5. Try to eat less salt – no more than 6g a day.
6. Get active and try to be a healthy weight.
7. Drink plenty of water.
8. Don't skip breakfast.

5.2.3 In addition – whether through a focus on foster homes or working with vulnerable families to prepare for when children return to their own families – whole family participation in a healthy diet should also be encouraged, to ensure foster children are not treated differently. Spin off benefits can include helping to tackle child behaviour problems exacerbated by the inappropriate use of confectionery, snacks and sugary drinks to reward or appease behaviour.

5.2.4 It is important to recognise however that many children will not be used to a healthy and varied diet. Time, imagination and patience will be needed to support them to adapt as part of the adjustment which comes with entering care.

### Some Resources

- The Food Standards Agency's 'eatwell' website – <http://www.eatwell.gov.uk> – includes information on healthy eating for different age groups, including the 'eatwell' plate.
- <http://www.5aday.nhs.uk>
- The Caroline Walker Trust has resources on 'Eating well for under 5s in child care' and 'Eating well for looked after children and young people' – <http://www.cwt.org.uk/index.html>
- The Government's *Healthy Weight, Healthy Lives* Obesity strategy aims to ensure everyone is able to maintain a healthy weight – with an initial focus on children.
- Change4Life Campaign – <http://www.nhs.uk/Change4Life> – gives practical advice on, and resources to help carers encourage, healthy eating and physical activity.
- From April 2008, tackling child obesity became a national priority for PCTs, working with their local partners. *The NHS Operating Framework* for 2007/08 and 2008/09 set out the Vital Signs indicator on Obesity among primary school children and how PCTs must have an annual obesity plan – SHAs must agree an annual plan and then monitor through risk-based performance management.
- *Healthy Care* (2003) aims to ensure that children & young people in care live in an environment that promotes positive health and well being and gives them opportunities to develop life skills to enable them to live independently and healthily. Good nutrition is integral to this in terms of understanding and skills. ([www.ncb.org.uk/healthycare](http://www.ncb.org.uk/healthycare))

## Oral health

- 5.3 Oral health is vital to children's social success as well as physical health. Irregular and missing teeth can make children less attractive socially- a particularly important issue for teenagers. It is too easy to think that these issues are not important in comparison with the other issues in these children's complicated lives.
- 5.3.1 Carers can support the adoption of healthy lifestyles which should include actions to maintain oral health. These would include the provision of a well-balanced diet in which sugared food and drinks are restricted in daily frequency to four episodes a day. The habit of twice daily tooth brushing with family fluoride toothpaste should be instilled as soon as the first teeth appear and this process should be supervised

until children are eight years old. In some cases these practices will be new to children and may need to be introduced gradually.

- 5.3.2 Many looked after children enter care with dental problems. All children should have regular dental check ups and efforts should be made to maintain continuity with the same clinician and prescribed courses of treatment should be completed. In cases where looked after children have special needs that make attendance at a high street general dental practice difficult, efforts should be made to seek specialist dental care via the local PCT.
- 5.3.3 While a child may not start to see a dentist in his or her own right until the age of 2 or 3 it is recommended that carers of babies and very young children take them to their own dental check ups so that they become used to having teeth checked at an early age.

## Health promotion

### Promoting healthy relationships and sexual health

- 6.1 Both young women and young men in and leaving care are more likely than their peers to be teenage parents. One study found almost half of young women leaving care became pregnant within 18-24 months and another reported that a quarter were pregnant or young parents within a year of leaving care.
- 6.1.1 This increased vulnerability to pregnancy is due to care leavers, and young people in and on the edge of care, being disproportionately affected by key risk factors for teenage pregnancy: experience of abuse, poor mental health, low educational attainment, school absence, contact with the police and poverty. Unaccompanied asylum seeking children (UASC) may have additional negative experiences, including bereavement and sexual violence, which can impact on their sexual health.
- 6.1.2 It is therefore critically important that children in care and care leavers are helped to gain the self esteem and skills needed to develop loving, respectful and safe relationships. This will include having the confidence to delay early sex until they are ready to make safe and positive choices and, if and when they do become sexually active, to use effective contraception and condoms to prevent pregnancy and sexually transmitted infections. Support around teenage pregnancy and sexual health should be provided to all young people in and leaving care, regardless of their sexual orientation or preference and should not be affected by individual practitioner's personal views.

- 6.1.3 All local authorities with their PCTs have a teenage pregnancy strategy in place to reduce the under 18 conception rate. The under 18 conception rate and chlamydia screening are both indicators in the Local Government National Indicator Set and also Tier 2 Vital Signs in the NHS Operating Framework. Actions to tackle teenage pregnancy and reduce chlamydia should be integrated into the Children and Young People's Plan, with accountability held by the Children's Trust and Local Strategic Partnership.
- 6.1.4 All areas have received guidance on the ten key factors for effective local strategies to reduce teenage pregnancy rates<sup>72</sup>. The guidance highlights the vulnerability of children in care and care leavers and asks local areas to address their needs both through the universal provision of high quality sex and relationships education in school and easy access to contraception and sexual health services – and through targeted work providing more intensive support. The Teenage Pregnancy Unit has also published a Self Assessment Toolkit designed to help local areas review and revise their strategies against the guidance. This recommends using local data on the percentage of young women and young men in care or who are pregnant to monitor the impact of the strategy on this vulnerable group.
- 6.1.5 In addition, the Teenage Pregnancy Unit guidance for social care practitioners – *Enabling young people to access contraceptive and sexual health information and advice*, sets out the key principles for supporting children in care and care leavers to look after their sexual health and provides answers to FAQs from social workers, foster carers and other social care practitioners. This guidance will be revised and reissued to coincide with the publication of this practice guidance.

#### Key elements of sex and relationship work

- **Information** – children and young people are entitled to clear, relevant, age appropriate information which is accurate and non-judgmental.
- **Skills** – children and young people are entitled to learn and practice key life skills that should include: emotional, social, communication, negotiating, practical and decision-making skills.
- **Attitudes, values and beliefs** – by exploring and challenging attitudes, values and beliefs, children and young people can be helped to develop a positive attitude to sexual health and well-being.

**Key aspects of a teenage pregnancy strategy that should be in place to support looked after children and care leavers to prevent early pregnancy and sexually transmitted infections (STIs)**

Looked after children should receive good quality Sex and Relationship Education (SRE) as part of PSHE in schools and out of school settings that includes knowledge and skills on: delaying early sex, developing trusting and consensual relationships, the effective use of contraception to prevent pregnancy and consistent use of condoms to prevent STIs.

In addition, intensive SRE/PSHE programmes for looked after children or care leavers at particular risk – may be commissioned and delivered through school, youth settings or in residential settings.

The commissioning of contraception and sexual health (CASH) services should include a needs assessment of children in care and care leavers to ensure specialist advice is easily accessible. This may include the provision of CASH services within residential homes or other outreach services to meet local need. Children in care and care leavers should be included in the monitoring and evaluation of services as set out in the *You're Welcome* quality criteria for young people friendly health services.

All social workers, foster carers and looked after children nurses should receive SRE training to give them the confidence and competence to have supportive discussions with children and young people and make referrals to CASH services when necessary. Training should be part of the local workforce strategy and provided as part of induction and INSET.

Looked after children and care leavers should be prioritised for involvement in positive activity programmes to help raise their self esteem and aspirations.

## **Pregnant teenagers, teenage mothers and young fathers**

- 6.2 Young people in care or care leavers who become pregnant should be offered non-judgemental information – and where necessary more in-depth counselling – on their options of keeping the baby, abortion or adoption. Whatever choice the young person makes, they should be supported to access a health professional for onward referral to NHS funded abortion or antenatal care.
- 6.2.1 Although some manage very well, for those who continue the pregnancy, research shows that outcomes for them and their children are disproportionately poor:

- Poor child health outcomes (60% higher rates of infant mortality and 25% increased risk of low birth weight);
- Poor emotional health & well-being (teenage mothers are 3 times more likely to experience post-natal depression than older mothers); and
- Increased risk of NEET, living in poverty and experiencing social exclusion.

6.2.2 These poor outcomes may be even starker among teenage mothers and young fathers who are in care or leaving care because of their prior negative experiences.

6.2.3 It is therefore essential that young people in care or care leavers who are continuing the pregnancy or who are expectant fathers are provided with dedicated support through a Lead Professional, coordinating specialist advice from a multi-agency team linked to Targeted Youth Support and Children's Centres. Support arrangements are for local decision, but should be in line with *Teenage Parents Next Steps: guidance for LAs and PCTs* (2007). Dedicated support should start as early as possible in the antenatal period, continue postnatally and include, for example, support around relationships and emotional health, re-engaging with education, and the on-going use of effective contraception to prevent repeat pregnancies – estimated at 20% of births conceived to under 18s. Actions to improve outcomes for teenage mothers and young fathers – including those in and leaving care – should be integrated into the Children and Young People's Plan.

## Smoking

*Support for smoking cessation is being provided to foster carers and looked after young people by Health Trainers. They visit the carer and looked after young person at home to discuss why they want to give up smoking and help them plan how and when to do it – this might involve using nicotine patches or other aids and also includes being supportive and encouraging. The service is provided by Ashton, Leigh and Wigan Primary Care Trust.*

6.3 Smoking is the main cause of preventable death and the main cause of health inequalities and most smokers start to smoke before the age of 18. One out of two smokers die early as a result of smoking, losing on average 16 years of life. Those who have grown up in an environment where they are exposed to tobacco smoke are more likely to start smoking early and to find it more difficult to quit smoking later in life. Many young people come into the care system as smokers. Others become smokers whilst being looked after.

6.3.1 There are very few health and social care professionals who do not treat or meet people with conditions caused by or exacerbated by smoking. Helping these patients to stop smoking is often the most effective and cost-effective of all the

interventions they receive. Despite this, however, rates of intervention by health and by social care professionals remain low.

- 6.3.2 Since giving stop smoking advice need only take a few minutes, all professionals should be encouraged to systematically deliver very brief or brief interventions to all smokers at every opportunity. Stop smoking advice need only take a few minutes using the Ask Advise Act (AAA) model for the provision of very brief or brief advice and referral of smokers to the local NHS Stop Smoking Service.
- 6.3.3 A healthy care environment should have a clear policy for addressing these risks to the health of looked after children. This policy should have a strong emphasis on pro-active efforts to protect looked after children from taking up smoking the first place. There should also be an emphasis on protecting looked after children from second-hand smoke and providing an environment they can grow up in where smoking is actively discouraged. Where looked after children already smoke they should be encouraged to give up. A range of support is available at <http://smokefree.nhs.uk/>

## Substance misuse

- 6.4 Many looked after young people use drugs for recreational reasons, just like other young people. But there is also evidence that looked after young people may use drugs, including alcohol to 'forget bad things', reflecting their often difficult and traumatic personal histories.<sup>73</sup>
- 6.4.1 In addition, where children and young people are abused through prostitution, alcohol and other drugs they are often used in the grooming and enticement process. There is a close connection between the uses of alcohol and substances as a significant factor in young people's sexual behaviour and as with other aspects of their lives, children and young people learn from the behaviour of those around them.
- 6.4.2 All professionals working with looked after children should understand the referral pathways for treatment. It is also advised that strategic plans such as the Young People Treatment plans should consider the needs of looked after children and young people and that the Substance Misuse Partnership considers whether the needs of looked after children and young people are being met.

73 Big Step Social Inclusion Partnership. The Health of Young People in Care and Leaving Care in Glasgow. The Big Step (2002)



## The Health Assessment

- 7.1 The health assessment when a child is first looked after is not an isolated event but should be part of continuous activity to ensure the provision of high quality healthcare and positive discrimination for health which is managed through a clear process. It provides an opportunity for information to be gathered about the child's state of health at a point in time but it can only be effective if it is part of a continuous process of monitoring and promoting the child's health by committed carers and schools.
- 7.1.2 Flexibility should be the key to carrying out an effective health assessment which will:
- be child focused;
  - take account of the particular needs of children who are looked after and their families, including attention to issues of disability, race, culture and gender;
  - be carried out at a time and venue convenient to the child or young person and their carers and parents;
  - be sensitive to the child or young person's needs, wishes and fears;
  - include information from all those involved with the care of the children, particularly the birth parents or other previous carers;
  - allow sufficient time and preparation for the child to be given a clear understanding of the process and what is involved, so that they have the confidence to fully participate;
  - be carried out in a place that facilitates the child or young person's participation.
- 7.1.3 Without such an approach any assessment or health care plan is unlikely to result in an improvement in the health of the child or young person. A negative experience will also adversely influence their future use of health services.

## Timing

- 7.2 Before a child or young person looked after receives a health assessment, it is essential to bring together as much relevant information as possible and this information fast-tracked to the health professional undertaking the assessment. This will include information held:
- by children's services derived from an assessment undertaken in accordance with the Assessment Framework, which includes the child's personal history and family history if it is known;

- by community dental services or family dentists;
- by community health services;
- on the child health computer system, especially immunisation status to date;
- on any parent held or child held record;
- on the GP-held record;
- within any database in local Accident and Emergency Departments;
- within local hospital record systems, especially where the child is known to have been in contact with services;
- any contact with child and adolescent mental health services.

7.2.1 An effective local process which includes the social worker obtaining consent from the birth parents before requesting the health assessment can greatly speed up this preparatory phase. In the case of GP-held records, a summary report should be requested from the GP holding them. Steps should also be taken to fast-track the records to any GP with whom the child is known to have subsequently become registered (this should be done by the PCT of the previous GP).

7.2.2. Collating this information and organising the transfer of records to the appropriate place or person is a time-consuming activity. Some local authorities and health bodies have joint funded an administrative post to undertake this activity. Such posts have been cost effective in releasing professional time to be available for direct clinical work. However this work is organised, clear local protocols should identify where responsibility lies.

## **Objectives of Health Assessments and the Planning Process**

7.3 The objectives of the health assessment and planning process are to:

- assess health risk and provide an opportunity to redress past health neglect, collate health history including peri-natal history;
- ascertain and advise on relevant family history;
- review immunisation status and missed child health screening episodes including dental and oral health;
- assess current health and mental health concerns;
- review and advise on known existing health problems and risk factors;
- ascertain outstanding appointments and places on waiting lists;

- identify unrecognised health needs;
- identify mental health, behavioural and emotional problems;
- recognise developmental or learning concerns;
- plan appropriate action and ensure recommendations are carried through;
- discuss life style issues;
- plan follow up.

### **Assessment content recommendations**

- 7.4 Local arrangements may vary, but there should be a clear core content for the written health assessment. This assessment should be detailed and take place after available information on the child's health history has been collected and collated.
- 7.4.1 The aim should be to enable the child to have his or her health needs assessed holistically and to develop a plan to meet these needs without imposing unnecessary requirements which can be seen as a further invasion of privacy and which set them apart from the rest of the population.
- 7.4.2 A health assessment should be seen as an opportunity to see and talk with the child or young person, review the child or young person's overall health, development and well-being. Attention should also be paid to the child or young person's behavioural and emotional development, including evidence of health risk taking behaviours. Information relating to the child's attendance, behaviour and achievement at school should also be taken in to account as these factors can be related to self-esteem and health outcomes.
- 7.4.3 Information will be obtained from discussions with carers and the child and from a physical examination when undertaken. It should be recognised that there may be differential rates of development for some children, for example disabled children, across developmental dimensions. The assessment should provide the opportunity to talk about health worries and answer any questions the child or his or her carer may have and to advise where further information can be obtained.
- 7.4.4 The health practitioner carrying out the assessment has a duty of clinical care to the child, which includes making any necessary referrals for investigation and treatment of conditions identified at the assessment. Even when the placement is brief the practitioner should follow up concerns. If the child returns home every effort should be made to continue to implement the health care plan.

- 7.4.5 It should be ascertained at the time of this assessment whether the child is already receiving or awaiting medical treatment locally or elsewhere. Every effort should be made to ensure that being looked after does not disrupt existing arrangements or cause him or her to lose a place on a waiting list.
- 7.4.6 The content of the assessment should be age sensitive and developmentally appropriate. The recommended content for the different stages of childhood are outlined in boxes on pages 67, 68 and 69.
- 7.4.7 The assessment should take special consideration of conditions that may be more prevalent in looked after children and which may be otherwise misdiagnosed. In particular, the possibility that a child may be experiencing symptoms related to foetal alcohol syndrome should be considered when there is a history of maternal alcohol misuse. Symptoms are not always physically obvious and foetal alcohol syndrome may manifest itself in ways that could present as conduct or behavioural disorders.
- 7.4.8 The health plan will specify who should undertake review assessments of the child's health. In many situations it may be appropriate for a suitably trained nurse to do this. Information missing at the time of the assessment (or needed as a result of the assessment) should be obtained before the health plan is agreed.
- 7.4.9 Clear explanations should be given to the child or young person about any further consultations, including dental and oral health examinations, treatment or care needed. Explanations should include the reasons for this and the choices available. The appropriateness of plans should be kept under review and amended and updated as necessary.

## Age-appropriate recommended content of the health assessment

### **UNDER 5s**

For under fives, the focus will be on:

- attachment behaviour;
- physical health;
- growth;
- diet;
- immunisations;
- teeth;
- monitoring developmental milestones, in particular the development of speech and language, gross and fine motor function, vision and hearing, play and pre-literacy skills, social and self-help skills.

### **AGES 5–10**

For primary age children the focus will be on:

- physical health and management of specific health conditions e.g. asthma;
- communication skills;
- ability to make relationships and to relate to peers;
- mental and emotional health, including depression, conduct disorders;
- progress at school;
- exercise and diet and understanding of a healthy lifestyle;
- maintenance of personal hygiene;
- awareness of basic safety issues, including road safety;
- provision of a healthy balanced diet;
- where appropriate, to recognise and cope with the physical and emotional changes associated with puberty;
- access to accurate simple information about sexual activity;
- immunisation;
- dental health;
- attachment behaviour.

**ADOLESCENCE AND LEAVING CARE – 11–18**

For secondary school age children and young people the focus will be on:

- ability to take appropriate responsibility for their own health, including management of specific health conditions e.g. asthma, diabetes;
- communication and interpersonal skills;
- educational and social progress;
- lifestyle, including diet and physical activity;
- dental and dermatological health;
- mental and emotional health, including depression and conduct disorders;
- understanding of issues relating to sexuality and sexual activity, including its role in relationships; contraception; sexually transmitted infection and the particular risks of early sexual activity;
- access to sources of information and advice about a range of health issues, including the risks of alcohol, tobacco and other substance use and access to sources of advice on modifying health risk behaviours. Assessment should be made of whether referral to specialist treatment for substance misuse is appropriate;
- ensuring that immunisations are up to date;
- for care leavers to have a full copy all social care health records (including genetic background and details of illness and treatments) and be equipped to manage their own health needs.

## Emotional health

*Mental health influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, to communicate and to form and sustain relationships. It also influences our ability to cope with change, transition and life events<sup>74</sup>*

What young people think promotes and maintains their mental health:<sup>75</sup>

- Feeling safe – both physically and emotionally;
- Being able to talk to an adult of their choice in confidence;
- Access to sports centres and youth clubs that can provide interesting and meaningful activities;
- Personal achievement;
- Being praised;
- Generally feeling positive about oneself.

- 8.1 Many looked after children have experienced neglect, harm and distress. They are particularly vulnerable to poor mental health and poor emotional health and well-being. Some may need the support of CAMHS services for a shorter or longer period of time while others will make significant improvements from good quality care but all children are in need of skilled, supportive care from foster carers or residential staff.
- 8.1.2 Further analysis of the ONS survey carried out by Tamsin Ford et al.<sup>76</sup> found that even when looked after children were compared to children in a community sample from the most deprived socio-economic groups, they still showed significantly higher rates of mental health disorders. The authors suggest that this is largely due to adverse factors impacting on children prior to entry into care. They also identified significantly higher rates of developmental disorders, such as autism and ADHD, which may have gone previously undiagnosed. Other studies also indicate that behaviour and mental health problems in children, along with a number of other factors in the child and carer, are linked to increased risk of placement breakdown.
- 8.1.3 Unresolved mental health problems in childhood can cause continuing difficulties for children, carers and families. They may lead to further problems in adult life

74 Department of Health (2001) Making it Happen- A guide to delivering mental health promotion. London, DH

75 Quoted in Healthy Care briefing Mental health. NCB (2005)

76 Ford, T. et al. (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.



such as homelessness, poor educational outcomes and employment prospects, unsatisfactory personal relationships and even contact with the criminal justice system.

- 8.1.4 There are a number of factors which create risk and protective factors for children's mental health. Some of these risk factors will remain present throughout a child's life, such as past abuse or genetic factors. However the impact of these risk factors will be mediated by resilience factors for the individual child and access to appropriate services. Resilience in children can be promoted by ensuring that they have the opportunity to form consistent relationships with adults and children and to achieve in both education and leisure activities. Good planning and support for carers can also promote positive attachments and stable placements. Evidence from research <sup>77</sup> indicates that children with a higher number of risk factors gain greater benefit from positive parenting than children with fewer risk factors.
- 8.1.5 It is important that dedicated CAMHS services are available for looked after children and young people where there is an identified local need. Evidence suggests that looked after children and young people have greater difficulty in accessing mainstream CAMHS services because they may not have the more traditional 'diagnoses' which fit referral criteria.<sup>78 79</sup> The 2008 CAMHS review reported that there was a shortfall of staff with the skills and confidence to deal with mental health issues.
- 8.1.6 Recommendations from the 2008 CAMHS review relating to all groups of vulnerable children state that:
- their mental health needs will be assessed alongside all their other needs, no matter where the need is initially identified;
  - an individualised package of care will be available to them so that their personal circumstances, and the particular settings in which they receive their primary support, appropriately influence the care and support they receive;
  - for those experiencing complex, severe and ongoing needs, these packages of care will be commissioned by the Children's Trust and delivered, where possible, in the local area. Effective regional and national commissioning will occur for provision to meet rare needs.'<sup>80</sup>

77 Scott S, Spender Q, Doolan M, Jacobs B and Aspland H. (2001) Multicentre controlled trial of parenting groups for child antisocial behaviour in clinical practice. *British Medical Journal* 323 194-197

78 ([www.dcsf.gov.uk/CAMHSreview](http://www.dcsf.gov.uk/CAMHSreview))

79 Kerfoot (2005) *Children looked after by the state*. In Williams and Kerfoot (eds) *Child mental health Services: Strategy, planning, delivery and evaluation*. Oxford: Oxford University Press

80 [www.dcsf.gov.uk/CAMHSreview](http://www.dcsf.gov.uk/CAMHSreview)

- 8.1.7 In practice for looked after children, this means that all children entering care should have their emotional health and well-being assessed, both through use of the Strengths and Difficulties Questionnaire and also using information from and observations of the child or young person, their family and their current carers.
- 8.1.8 In order to support children's positive mental health and to help identify difficulties early on, all foster carers and residential staff should have access to training in promoting emotional well-being and the early identification of mental health difficulties in children at different developmental stages. They also should have training and help in supporting and caring for children with behavioural and mental health needs, in their own home or setting, for example through packages such as 'Fostering Changes', which has been developed by the South London and Maudsley Trust.<sup>81</sup> DCSF is funding a national roll out of this programme as part of the Care Matters agenda. Professionals working with looked after children, including carers, should also have access to training appropriate to their needs and to consultation from CAMHS professionals.
- 8.1.9 Once a child's or young person's needs have been identified, then some children and their carers will require the input of CAMHS professionals. This may be to provide consultation to the child's carer or placement or to provide direct evidence based interventions with the child, based on his or her needs. This happens most effectively when CAMHS provides dedicated resources to work with looked after children and their carers, with staff who are trained and experienced in working with looked after children and their carers. Targeted CAMHS for looked after children should work closely alongside the child's social worker, carers and other professionals such as looked after children nurses and paediatricians. Where possible these services should follow the child, if the child is moved out of area and they should also work flexibly in terms of location and times of appointment offered.

*In Hartlepool the introduction of the strengths and weaknesses questionnaire was used to improve CAMHS services for children in care. SDQs were completed by foster carers (100%) and teachers (75%) and showed a high correlation between the scores of foster carers and teachers for the same children. An analysis of the forms was carried out by the designated looked after children psychologist in CAMHS. Agreement has been reached between the LA and health service on a fast track referral to CAMHS for intervention or support of any children whose score indicated particular difficulties.*

81 Pallett C., Blackeby K., Yule W., Weissman R., and Scott S., Fostering Changes: How to improve relationships and manage difficult behaviour. BAAF (2005)

- 8.1.10 Children and young people with the highest levels of need may require a complete package of care, which addresses their mental health, placement and sometimes educational needs, for example through the Multidimensional Treatment Foster Care programme or through specialist residential care. These arrangements should be jointly commissioned, through the local Children's Trust and reviewed on a regular basis. A small group of young people in care and care leavers may require inpatient care. In this case staff should ensure that care plans and pathways plans and reviews work closely alongside use of the Care Programme Approach, to reduce unnecessary additional meetings for young people and professionals and to ensure that clear plans are in place for aftercare.
- 8.1.11 The Multisystemic Therapy programme can provide intensive support to children on the edge of care and their families or to children who have recently returned home from care.
- 8.1.12 Where children's and young people's needs can only be met by placing them out of the local area in residential placements it is important that the placement actually provides the therapeutic input promised and the child or young person does not require additional CAMHS services, which are often not available.

## Self-harm

- 8.2 Deliberate self-harm is more common amongst looked after children than the general population. Children's services professionals are advised to incorporate the NICE guideline on the management of self-harm into protocols for the health care of looked after children.
- 8.3 It should be noted that:
- self-harm can range from occasional self-harm with no associated intent to cause serious injury and minimal risk to high intent to cause serious harm which may be one off, infrequent or repeated;
  - that external appearances of the self-harm are insufficient to establish intent, or risk or indeed allow understanding of motives;
  - that in the absence of other coping strategies some self-harm may be a form of coping rather than an intention to commit suicide or seriously harm the self.
- 8.4 Professionals should refer to the NICE Guidelines for further details  
<http://guidance.nice.org.uk/CG16>

## The role of designated health professionals

**The designated doctor and nurse will work together to fulfil the following functions:**

### *Advisory role*

- provide advice to the PCT, and thus to the Children's Trust, on questions of planning, strategy and the audit of quality standards in relation to health services for looked after children;
- work with PCTs to monitor performance of local health services for looked after children and young people;
- ensure expert health advice on looked after children is available to children's social care, the PCT, residential children's homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff;
- advise colleagues in health and children's social care on issues of medical confidentiality, consent and information sharing.

### *Policy and procedures*

- take a strategic overview of the service;
- ensure robust clinical governance of local NHS services for looked after children;
- contribute to local children and young people's plans;
- ensure there is a system to check the implementation of individual health plans.

### *Liaison*

- maintain regular contact with the local health team undertaking health assessments on looked after children;
- liaise with children's social care and other PCTs over health assessments and personal health plans for out of area placements.

### *Monitoring and information management*

- ensure the quality of health care assessments carried out;
- ensure full registration of each looked after child – and all care leavers – with a GP and dentist;
- ensure that sensitive health promotion is offered to all;

- provide an analysis of the range of health neglect and need for health care for local looked after children – i.e. casemix analysis;
- ensure implementation of health plans for individual children;
- contribute to the production of health data on looked after children;
- ensure an effective system of audit is in place;
- review the patterns of health care referrals and their outcomes;
- evaluate the extent to which looked after children and young people’s views are informing the design and delivery of the local health services for them.

#### *Annual report*

- the delivery of health services for children and young people looked after should be evaluated annually by the designated doctor and nurse. It should consider the above and the effectiveness of health care planning for individual children and young people looked after, and describe progress towards relevant performance indicators and targets;
- it should also include the results of any independent local studies of the accessibility of health assessments to the children and young people themselves, to foster carers, parents, social workers and to health professionals;
- the report will be presented to the Chief Executive of the PCT Board who commissioned it and the Director of Children’s Services.

#### *Clinical governance and audit*

- The performance of health professionals undertaking health assessments should be monitored regularly as part of local arrangements for clinical governance and audit. Aspects to be monitored include the stages of the health assessment process, the quality of information retrieval and transfer, of clinical record keeping and the timeliness of referrals. It is the responsibility of the PCT commissioning the service to ensure that these arrangements are in place.

### **Training**

- responsibility for planning local training for GPs, paediatricians and nurses undertaking health assessments for looked after children;
- participating (as appropriate) in local undergraduate and postgraduate paediatric training to ensure health including mental health of looked after children is addressed;
- playing an active part in the planning of multi-disciplinary training;

- ensuring they themselves are up to date with developments in the field by attending appropriate meetings and reading relevant publications.

## Leaving care

*Bradford's Leaving Care Service provides a range of health and well being services for care leavers including:*

- *A weekly health drop in run by the leaving care nurse on two sites in the city, and one to one work with young people outside of the drop in sessions.*
- *A parenting group for care leavers who are pregnant or are parents offers 10 sessions covering topics to do with parenting and practical life skills such as money, housing and continuing education and training.*
- *A cook and eat group for young care leavers runs at a local youth cafe in partnership with the youth service. The young people get a chance to practice healthy eating and take part in other inclusive activities for young people at the cafe.*
- *A weekly football group for all care leavers and which includes some young men who are unaccompanied asylum seekers.*
- *A weekly dance group.*
- *A transition group for 15 year olds which focuses on developing emotional and independent living skills, including relationship and practical skills including safety and hygiene, budgeting and healthy eating. The group also enjoys leisure and sports activities such as canoeing or bowling.*
- *A sexual health mentoring project.*
- *Training is provided for all Leaving Care Service staff in areas including condom distribution and chlamydia screening.*

- 9.1 Preparing to leave care is critically important for all looked after young people. The Children (Leaving Care) Act 2000 requires all eligible, relevant and former relevant children to have a Pathway Plan which will focus on arrangements for the young person's successful transition to independence. The Pathway Plan will take account of the assessed health needs of the young person and set out clearly how these are to be met. Particular attention must be given to the young person's need for support in taking responsibility for his/her own health and in accessing appropriate services, including information and advice. A healthy lifestyle also requires that proper attention is given to social, recreational and sports activities.

- 9.2 Multi-agency approaches are particularly crucial for care leavers as at this stage health needs cannot be separated from wider needs. There is an important health promotion and health advisory role for the health services in supporting care leavers in registering with a GP and accessing a dentist when they move into independence. The young person's personal adviser will have a key role in getting care leavers registered with the health services.
- 9.3 Young care leavers value supportive and friendly health professionals, want to remain with the same GP and like young people's clinics. It is important that services are accessible and to and used by young people friendly. Over use of A&E can result from not knowing how to make appointments.
- 9.4 Care leavers consistently take a holistic view of health when asked about their views on what helps them to be healthy and what impacts adversely. The five most important factors cited in one study<sup>82</sup> were:
- Feelings about life
  - Housing
  - Close personal relationships
  - Care experience
  - Depression
- 9.5 While *Care Matters* sets out a policy agenda to enable young people to remain in care for longer, many still leave care at a young age. They experience loneliness and isolation as they lose the supportive relationships which they had while they were in care. Such a transition time can reawaken issues about identity, family relationships and the hurt they carry about having been in care. This puts them at high risk for mental health problems if the support and help are not available at such a difficult transition time.
- 9.6 Mentoring may offer an important experience for care leavers who value it for helping them with relationship problems, building confidence and improving emotional wellbeing.
- 9.7 Preparation for independence is one of the developmental tasks of childhood but it is most successfully done in the context of a supportive family who will provide a long term safety net when things go wrong. It is vital to identify someone in the young person's social or family network who can provide this safety net in the context of a relationship.

82 Saunders L and Broad B (1997) *The Health Needs of Young People Leaving Care*. De Montfort University

9.8 Some care leavers will need particular support as part of the transition planning. These include:

- Young people with emerging mental illness and personality disorder
- Young people who will not require specialist services but who will need a pathway planning package to reflect their delayed maturation

9.9 It is also important that attention is paid to the need for continuity when younger children leave care, either to return to their birth family or for adoption. Consistency of care should be ensured wherever possible and it should be recognised that children's health needs do not cease because they have ceased to be looked after, for whatever reason.



# Annex A: Regulations

2007 No. 559

NATIONAL HEALTH SERVICE, ENGLAND

## The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) (Amendment) Regulations 2007

*Made*

26th February 2007

*Laid before Parliament*

2nd March 2007

*Coming into force*

1st April 2007

The Secretary of State for Health makes the following Regulations in exercise of the powers conferred by sections 16D, 17, 18 and 126(4) of the National Health Service Act 1977(1):

### **Citation, commencement, interpretation and application**

1.—(1) These Regulations may be cited as the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) (Amendment) Regulations 2007 and shall come into force on 1<sup>st</sup> April 2007.

(2) In these Regulations, “the principal Regulations” means the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002(2).

(3) These Regulations apply in relation to England.

### **Amendment of regulation 2 of the principal Regulations**

2. In regulation 2 of the principal Regulations (interpretation), in paragraph (1), in the appropriate alphabetical position, insert—

““the 1989 Act” means the Children Act 1989;”(3);

““adult” means a person who has attained the age of eighteen;”;

““child” means a person under the age of eighteen;”;

““children’s home” has the same meaning as in the 2000 Act;”;

““young people” means persons who have attained the age of twelve but are under the age of twenty.”.

### **Amendment of regulation 3 of the principal Regulations**

3.—(1) Regulation 3 of the principal Regulations (functions of the Secretary of State exercisable by Strategic Health Authorities and Primary Care Trusts) shall be amended as follows.

(2) In paragraph (2)(b), after “Strategic Health Authorities but” insert “, subject to paragraph (2A),”.

(3) After paragraph (2), insert—

“(2A) Subject to regulation 6, the Secretary of State’s functions relating to the health service under section 3(1) of the National Health Service Act 2006(4) (services generally) are to be exercisable by Strategic Health Authorities for the purpose of securing, by arrangement with any person or body, the provision of any service specified in Schedule 5.”.

- (4) In paragraph (7)(a), for “paragraph (7B)” substitute “paragraphs (7B), (7E) and (7G)”.
- (5) After paragraph (7A), insert—
- “(7AA) For the purposes of paragraph (7A), an arrangement includes an arrangement made jointly by the placing PCT and a local authority.”.
- (6) After paragraph (7B), insert—
- “(7C) Paragraph (7E) applies where—
- (a) under arrangements made on or after 1st April 2007—
- (i) by a Primary Care Trust in exercise of its functions under paragraph (7)(a);
- (ii) by a local authority; or
- (iii) jointly by a Primary Care Trust in exercise of its functions under paragraph (7)(a) and a local authority,
- a child to whom paragraph (7D) applies is provided with services which consist of or include the provision of accommodation situated in the area of another Primary Care Trust or a Local Health Board(5); and
- (b) the child—
- (i) is thereby resident in such accommodation; and
- (ii) does not fall under the responsibility of the originating Primary Care Trust under paragraph (7)(a)(i).
- (7D) This paragraph applies to a child who—
- (a) is looked after by a local authority within the meaning of section 22 of the 1989 Act;
- (b) is a relevant child within the meaning of section 23A of the 1989 Act(6);
- (c) qualifies for advice and assistance under section 24(1A) or (1B)(7) of the 1989 Act;
- (d) is provided with accommodation at a school to which he is admitted in accordance with a statement of special educational needs made under section 324 of the Education Act 1996(8) that names the school; or
- (e) requires accommodation in a care home(9), a children’s home or an independent hospital(10) to meet his continuing care(11) needs.
- (7E) The originating Primary Care Trust shall continue to exercise the functions referred to in paragraphs (1) and (2) for the benefit of a child referred to in paragraph (7C).
- (7F) Subject to regulation 3A, in paragraphs (7C) and (7E) “the originating Primary Care Trust” in relation to a child means the Primary Care Trust which—
- (a) makes, in respect of that child, an arrangement referred to in paragraph (7C)(a)(i) or (iii); or
- (b) was responsible for exercising the functions under paragraph (7)(a) on behalf of that child immediately before a local authority makes, in respect of that child, an arrangement referred to in paragraph (7C)(a)(ii).
- (7G) G) Where a Primary Care Trust has made an arrangement referred to in paragraph (7C)(a)(i) or (iii) by virtue of which a child is, immediately before he attains the age of eighteen years, provided with—
- (a) accommodation in a care home, a children’s home or an independent hospital situated in the area of another Primary Care Trust, and
- (b) nursing and another service which is a planned service(12), as part of the health service, to meet his continuing care needs, when the child attains the age of eighteen years that arrangement shall, for the purposes of these Regulations, be treated as an arrangement which falls within paragraph (7A).”.
- (7) After paragraph (10), add—
- “(11) In this regulation, “local authority” means—
- (a) a county council;

- (b) a district council for an area for which there is no county council;
- (c) a London borough council;
- (d) the Common Council of the City of London; or
- (e) the Council of the Isles of Scilly.”.

#### **Transitional provisions**

4. After regulation 3 of the principal Regulations insert—

#### **“3A Application of regulation 3 to local authority arrangements made prior to 1<sup>st</sup> April 2007**

(1) Paragraph (2) applies where—

- (a) before 1st April 2007 a local authority has made an arrangement which, had it been made on or after that date, would be an arrangement which meets the requirements of regulation 3(7C)(a) and (b); and
- (b) on or after 1st April 2007, that local authority has, under those arrangements, provided the child with accommodation in the area of a Primary Care Trust or Local Health Board different to the one in which accommodation was being provided immediately before that date.

(2) In a case to which this paragraph applies, “the originating Primary Care Trust” shall be—

- (a) the Primary Care Trust in whose area the placing local authority is situated; or
- (b) if there is more than one such Primary Care Trust, the Primary Care Trust which was responsible for exercising the functions under paragraph (7)(a) of regulation 3 on behalf of the child immediately before the commencement of the placing local authority’s provision of accommodation to that child.”.

#### **Amendment of Schedule 1 to the principal Regulations**

5. In Schedule 1 to the principal Regulations, in the heading to Part 2, for “the Purpose of Performance Management Only” substitute “Specified Purposes Only”.

#### **Addition of Schedule to the principal Regulations**

6. After Schedule 4 to the principal Regulations, add:—

Regulation 3(2A)

#### **“SCHEDULE 5 SECRETARY OF STATE’S FUNCTIONS UNDER SECTION 3(1) OF THE NATIONAL HEALTH SERVICE ACT 2006 EXERCISABLE BY STRATEGIC HEALTH AUTHORITIES FOR THE PURPOSE OF SECURING THE PROVISION OF SERVICES: SPECIFIED SERVICES**

1. Alstrom syndrome service
2. Bladder exstrophy service
3. Choriocarcinoma service
4. Complex tracheal disease service
5. Diagnostic service for amyloidosis
6. Diagnostic service for primary ciliary dyskinesia
7. Diagnostic service for rare neuromuscular disorders service
8. Craniofacial surgery service
9. Epidermolysis bullosa service
10. Extra corporeal membrane oxygenation service for adults
11. Extra corporeal membrane oxygenation service for children

12. Extra corporeal membrane oxygenation and ventricular assist devices as bridge to heart transplant service for children
13. Heart and lung transplantation service
14. Liver transplantation service
15. Lysosomal storage disorder service
16. Mental health service for deaf children: inpatient service
17. Mental health service for deaf children consisting of therapy and professional support provided by video-link
18. Ocular oncology service
19. Ophthalmic pathology service
20. Osteo odonto keratoprosthesis service for corneal blindness
21. Pancreas transplantation service
22. Persistent hyperinsulinaemic hypoglycaemia of infancy service
23. Primary malignant bone tumours service
24. Pseudomyxoma peritonei service
25. Pulmonary hypertension service for children
26. Pulmonary thromboendarterectomy service
27. Rare mitochondrial disorders service
28. Reconstructive surgery in adolescents for congenital malformation of the female genital tract service
29. Retinoblastoma service
30. Secure forensic mental health service for young people
31. Secure forensic mental health and learning disability service for young people
32. Severe combined immunodeficiency and related disorders service
33. Severe intestinal failure service
34. Severe obsessive compulsive disorder and body dysmorphic disorder service
35. Small bowel transplantation service for adults
36. Small bowel transplantation service for children
37. Specialist liver disease service for children
38. Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders
39. Vein of Galen malformation service
40. Ventricular assist devices as bridge to heart transplant service for adults".

Signed by authority of the Secretary of State for Health

*Mr Ivan Lewis*  
Parliamentary Under Secretary of State  
Department of Health

26th February 2007

# Annex B: Principles of Confidentiality

Confidentiality, information sharing and consent are three key issues which arise in the provision of effective health care to looked after children. This guidance summarises some important elements but it should be read in conjunction with more detailed guidance issued by the Department of Health<sup>83</sup>

Common Law, the Human Rights Act 1998 and the Data Protection Act 1998 provide the main legislative framework governing the way in which confidential information is used. In summary disclosure is allowed where:

- Appropriate consent has been given (see below for further details); or
- The information is required by statute or court order; or
- There is an overriding duty to the public (e.g. the prevention, detection or prosecution of serious crime).

Whenever information is disclosed it should be limited to the minimum necessary for the purpose and restricted to those who need to know.

The NHS and local authorities should have in place protocols which establish the framework for information sharing at an intra and inter-agency level. These should reflect the HM Government guidance on information sharing published in 2008<sup>84</sup>, and the NHS Confidentiality Code of Practice 2003.

A lack of protocols for inter-agency information sharing may have major implications for the care of looked after children. A number of children who become looked after may not return to their birth families but will become permanently part of new foster or adoptive families or will move into independence without retaining links with birth families. The transfer of information about a child's health status and history becomes very important. Accurate information about health history, current/ongoing medical conditions may be vital to securing the right placement for a child.

For this reason obtaining consent from the child or adult to information sharing is a vital first principle to promoting the health of looked after children.

83 Confidentiality: NHS Code of Practice (2003) [http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/PatientConfidentialityAndCaldicottGuardians/DH\\_4084181](http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/PatientConfidentialityAndCaldicottGuardians/DH_4084181)

84 Information sharing: guidance for practitioners and managers <http://www.everychildmatters.gov.uk/resources-and-practice/IG00340/>

Where disclosure of a child's information might reveal information about other individuals (e.g. parents, family) consent should be sought from these individuals as well. Where it is not practicable to seek consent or where the individual is not competent to give consent, it is important to consider whether disclosure would be justified in the public interest e.g. to protect others from a risk so serious that it outweighs the individual's right to privacy. Decisions to disclose information in the public interest must be taken on a case by case basis, and should always be fully documented.

In obtaining consent to seek information from other parties or to disclose information about the child a key consideration will be determining whether the child is competent to give consent or whether consent should be sought from a person with parental responsibility.

The same issues arise in relation to consent to information sharing as in consent to treatment, namely:

*'Young people aged 16 or 17 are regarded as adults for the purposes of consent to treatment and are therefore entitled to the same duty of confidence as adults. Children under 16 who have the capacity and understanding to take decisions about their own treatment are entitled also to decide whether personal information may be passed on and generally to have their confidentiality respected. . . . In other instances, decisions to pass on personal information may be taken by a person with parental responsibility in consultation with the health professionals involved.'*

## Children aged 16 and 17

Once young people reach the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care. This means that in many respects they should be treated as adults – for example if a signature on a consent form is necessary, they can sign for themselves.

However, it is still good practice to encourage competent children to involve their families in decision making. Where a competent child does ask for their confidence to be kept, it must be respected unless disclosure can be justified on the grounds of 'public interest' e.g. that there is reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm.

Efforts should be made to persuade the young person to involve their family, unless it is believed that it is not in their best interest to do so. If a decision is taken to disclose, the justification should be noted in the child's records.

## Children and young people aged 15 and under

Unlike 16 or 17 year olds, children and young people under 16 are not automatically presumed to be legally competent to make decisions about their healthcare. However, the courts have stated that under 16s will be competent to give valid consent to a particular intervention if they have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (sometimes known as "Gillick competence"). In other words, there is no specific age when a child becomes competent to consent to treatment: it depends both on the child and on the seriousness and complexity of the treatment being proposed.

'Competence' is not a simple attribute that a child either possesses or does not possess: much will depend on their relationship and trust between doctors, other health professionals and the children and their family or carer. Children can be helped to develop competence by being involved from an early age in decisions about their care.

If a child under 16 is competent to consent for himself or herself to a particular intervention, it is still good practice to involve the family in decision making unless the child specifically requests that this should not happen and cannot be persuaded otherwise. As with older children, a request for confidentiality must be respected unless the child is suffering or likely to suffer significant harm without disclosure.

## Significant harm

*Working Together to Safeguard Children*<sup>85</sup> provides guidelines in cases where there are concerns that the child is or may be at risk of significant harm.

## Parental responsibility

The Children Act 1989 (amended by regulations<sup>86</sup>) sets out who has parental responsibility including:

- The child's parents if married to each other at the time of conception or birth;

85 Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children, HM Government, 2006 – <http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/>

86 The Parental Responsibility Agreement (Amendment) Regulations 2005

- The child's parents if they were not so married but the father is named on the birth certificate
- The child's mother, but not father if the father is not named on the birth certificate *unless* the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;
- A step-parent who has acquired parental responsibility via a parental responsibility agreement
- The child's legally appointed guardian – appointed either by a court or by a parent with parental responsibility in the event of their own death;
- A person in whose favour a court has made a residence order concerning the child;
- A local authority designated in a care order in respect of the child (but not where the child is being looked after under section 20 of the *Children Act*, also known as being 'accommodated' or in a 'voluntary care');
- A local authority or other authorised person who holds an emergency protection order in respect of the child.

## Foster carers and residential social workers

Foster carers and residential social workers who provide day to day care for children and young people who are looked after are unlikely to hold parental responsibility. It is possible for those with parental responsibility – the birth parent(s) or the local authority – to give authority to someone who cares for the child on a regular basis to give consent under defined circumstances such as emergency treatment or routine treatments such as coughs and colds. It is important that these matters are explicitly addressed in the Health Plan.

## Requirements for consent

The patient or third party will need to understand the reasons why particular information needs to be shared so that they can give **informed** consent. Under the Data Protection Act 1998 it is important that explanations include:

- Clarity about the purpose of approaching other individuals or agencies;
- Reasons for disclosure of any information, for example about the referral or details about the child or family members;
- Details of the individuals or agencies being contacted;
- What information will be sought or shared;



- Why the information is important;
- What it is hoped to achieve;

Choices that are available to the patient or third party in relation to release of their personal information.

## Annex C: Immunisation and guidance for the vaccination of children with unknown immunisation status

The routine childhood immunisation schedule can be found via the link below:

[www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListDate/Page/1204031508623?p=1204031508623](http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListDate/Page/1204031508623?p=1204031508623)

In addition to this schedule other vaccinations such as BCG, Hepatitis B and HPV (human papillomavirus vaccine) are not routine for **all** children, but targeted to those with specific needs for protection. Further information is available via the following link:

[www.immunisation.nhs.uk/Immunisation\\_Schedule](http://www.immunisation.nhs.uk/Immunisation_Schedule)

Where a child or your person presents with an inadequate immunisation history, every effort should be made to clarify what immunisations have been given in the past using the following routes:

- Personal Child Health Record (PCHR/"red book");
- GP records;
- Health visiting and school nursing records;
- PCT Child Health Information Systems (CHIS)
- Child Health Departments
- Child Protection Teams

Children coming to the UK from abroad may have no or incomplete records of immunisations received previously. Details of recommended immunisation schedules for other countries can be found at:

[www.who.int/vaccines/globalsummary/immunization/countryprofileselect.cfm](http://www.who.int/vaccines/globalsummary/immunization/countryprofileselect.cfm).

There will be vaccines offered in the UK that are not available in other parts of the world, and children arriving to UK should be immunised in accordance with the routine immunisation schedule for this country.

In the event of the relevant data not being available via any of these routes, then a discussion with either a District Immunisation Co-ordinator, a paediatrician with a special interest in immunisation, or a Consultant in Communicable Disease Control (CCDC) would be able to help make a decision as to which immunisations a child should be offered, dependent on his/her age.

The Health Protection Agency has produced an algorithm that is helpful where either: children born overseas arrive in the UK and need further immunisation, or where UK-born children have missed some or all of their routine immunisations. The document, *"Vaccination of individuals with uncertain or incomplete immunisation status"* is available at [www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1194947406156](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947406156)

## Annex D: Immunisations and specific considerations for asylum seeking children and refugees

Many asylum seeking and refugee children who are looked after will have arrived in this country unaccompanied. Some may have parents or other relatives in this country who are unable to care for them because of illness or other reasons. A few may have been orphaned since arrival. Refugee children coming from countries with a high prevalence of HIV infection and where rates of vertical transmission are also high, may be orphaned when parents die of an HIV-related illness, and are also at significant risk of being infected themselves. (Hall and Elliman, 2002)

Many refugee children come from cultural and religious backgrounds with which those in the statutory sector responsible for providing care may be unfamiliar. The children, who may speak little or no English, will often have witnessed and suffered events outside the experience of social workers, doctors and teachers in this country. While refugee children may be psychologically distressed, and some may understandably exhibit signs of Post Traumatic Stress Disorder, it is important that their resilience and resourcefulness is also acknowledged and respected.

Unaccompanied refugee children are unlikely to have medical records from their country of origin and any medical history they themselves are able to give is likely to be incomplete. Their immunisation status may be unknown and a course of primary immunisation may need to be undertaken. Children may have had no previous child health surveillance and may well not have undergone neonatal screening for congenital abnormalities or inborn errors of metabolism. Children may suffer from malnutrition, and depending on country of origin, conditions to consider include tuberculosis, hepatitis B and C, malaria, schistosomiasis and HIV/AIDS. It should also be remembered that response to stress might manifest itself with physical signs.

**Those undertaking health assessments on refugee children require access to good local interpreting services or link workers familiar with the child's culture and able to advocate on their behalf.** Expertise on refugee health is developing both within Paediatrics and Primary Care. The Kings Fund has worked with the respective Colleges to produce advice for both Paediatricians and GPs. There are a number of non-governmental organisations active in projects to assist young refugees. Assessments and services will also need to take account of the medium and long-term planning needs.



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