DRAFT

Department for Education

Department of Health

Promoting the health and welfare of looked-after children

Statutory guidance for local authorities, clinical commissioning groups and NHS England

[ ] 2015

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Summary

About this guidance

This is joint statutory guidance from the Department for Education and the Department of Health. It is for local authorities, clinical commissioning groups (CCGs) and NHS England and applies to England only.

This guidance is issued to local authorities, CCGs and NHS England under sections 10 and 11 of the Children Act 2004 and they **must** have regard to it when exercising their functions.

It is also issued under section 7 of the Local Authority Social Services Act 1970. This requires local authorities in exercising their social services functions to act under the general guidance of the Secretary of State. Local authorities **must** comply with this guidance unless there are exceptional reasons that justify a departure.

This guidance replaces the *Statutory Guidance on Promoting the Health and Well-being of looked-after children*, which was issued in November 2009 to local authorities, Primary Care Trusts and Strategic Health Authorities.

This guidance should be read in conjunction with:

The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review

The Children Act 1989 Guidance and Regulations Volume 3: Transition to Adulthood

The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services

The Children Act 1989 Guidance and Regulations Volume 5: Children's Homes[1]

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Who Pays? Determining responsibility for payments to providers August 2013

Payment by Results Guidance 2013-14

NICE public health guidance 28: Looked-after children and young people

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[1] The Department for Education is currently reviewing requirements in relation to children's homes. Subject to consultation new Children's Homes Regulations, including Quality Standards and an accompanying guide, will be introduced in April 2015.

NICE quality standard for the health and wellbeing of looked-after children and young people

Looked-after children: knowledge, skills and competences of health care staff: intercollegiate framework May 2012

Expiry or review date

This guidance will be revised only if it is considered no longer fit for purpose.

What legislation does this guidance refer to?

- The Children Act 1989 and associated regulations[2]
- The Children Act 2004
- The Mental Capacity Act 2005 – Deprivation of Liberty Safeguards
- The National Health Service Act 2006
- The Mental Health Act 2007
- The Health and Social Care Act 2012
- The Care Act 2014
- The Children and Families Act 2014

Who is this guidance for?

This guidance is for:

- senior managers responsible for local authority children's services, including Directors of Public Health
- staff in clinical commissioning groups (CCGs) and NHS England
- designated and named professionals for looked-after children
- frontline managers with responsibilities for looked-after children
- children's services social workers
- supervising social workers
- managers and staff of services for care leavers
- Lead Members for Children's Services in local authorities
- commissioners of placements and other services for looked-after children
- Virtual School Heads
- Independent Reviewing Officers
- Personal Advisers for care leavers
- any other professional who is involved in the delivery of services and care to looked-after children

[2] The Care Planning, Placement and Case Review (England) Regulations 2010 http://www.legislation.gov.uk/uksi/2010/959/contents/made

Main points

- Local authorities have a duty to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health.
- The local authority that looks after the child must arrange for them to have a health assessment as required by The Care Planning, Placement and Case Review (England) Regulations 2010 and to have an individual health plan, which forms part of the child's overall care plan.
- When a child starts to be looked after, changes placement or ceases to be looked after the responsible authority should notify, among others, the CCG (or local health board in the case of a child looked after by a local authority in England but living in Wales) and the child's registered medical practitioner (GP).[3] If the child is moved in an emergency, the notifications should happen as soon as possible.
- CCGs and NHS England have a duty to cooperate with requests from local authorities to undertake health assessments and help them provide support and services to looked-after children.
- Local authorities, CCGs and NHS England must cooperate to commission health services for all children in their area. The health needs of looked-after children should be considered in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).
- Every local authority should have agreed local mechanisms with CCGs to ensure that they comply with responsible commissioner arrangements when making placement decisions for looked-after children and can resolve any funding issues that arise.[4]
- If a looked-after child or child leaving care moves out of the CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing the child's healthcare and the new providers to ensure continuity of healthcare. CCGs should ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care for the child.

[3] The person to notify in the CCG could be the designated nurse, who should in turn inform the named professional and the local looked-after children health team.

[4] *Who Pays? Determining responsibility for payments to providers.*

Supporting all looked-after children: joint responsibilities of local authorities, clinical commissioning groups and NHS England

Context

1. Most children become looked after as a result of abuse and neglect. Although they have many of the same health risks and problems as their peers, the extent of these is often greater because of their past experiences. They are, for example, more likely to experience mental health problems and a greater proportion of looked-after children have special educational needs. Delays in identifying and meeting these needs have far reaching effects on all aspects of their lives, including their chances of reaching their educational potential.

Overarching principles

2. Parents want their children to have the best start in life, to be healthy and happy and to reach their full potential. As corporate parents, those involved in providing local authority services for the children they look after should have the same high aspirations.

3. Local authorities have a duty under the Children Act 1989 to safeguard and promote the welfare of the children they look after, wherever they are placed. Directors of Children's Services, Directors of Public Health and Lead Members for Children's Services have a responsibility to ensure there are systems in place so that duty is properly discharged.

4. This must be done in accordance with the relevant Regulations.[5] These Regulations set out the requirements governing the development and review of a looked-after child's care plan. That plan includes their health plan.

5. The NHS has a major role in ensuring the timely and effective delivery of health services to looked-after children. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and The NHS Constitution For England make clear the responsibilities of the NHS to them. In fulfilling those responsibilities the NHS contributes to meeting the health needs of looked-after children in three ways: commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child.

[5] The Care Planning, Placement and Case Review (England) Regulations 2010

6. Under the Children Act 1989, CCGs and NHS England have a duty to comply with requests from a local authority to help them provide support and services to looked-after children.

7. Local authorities, CCGs and NHS England can only carry out their responsibilities to promote the health and welfare of looked-after children they cooperate. They are required to do so under section 10 of the Children Act 2004.[6]

8. The Health and Social Care Act 2012 places a legal duty on CCGs to work with local authorities to promote the integration of health and social care services.[7] The Government's Mandate to NHS England includes an explicit expectation that the NHS, working together with schools and children's social services, will support and safeguard looked-after children (and other vulnerable groups) through a more joined-up approach to addressing their mental and physical health needs.

9. Effective channels of communication between all local authority staff working with looked-after children and the NHS, along with clear lines of accountability, are needed to ensure that the health needs of looked-after children are met in a timely way.

10. Staff working with looked-after children in the NHS should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different. They should in particular:

- ensure looked-after children get access to universal services as well as targeted and specialist services where necessary
- receive supervision, training and support.

11. Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning and their operational delivery of CAMHS services. This also applies to children placed for adoption.

12. Looked-after children should be able to participate in decisions about their health care. Arrangements should be in place to:

- promote a culture that takes account of the views of looked-after children, according to their age and understanding, in identifying and meeting their physical, emotional and mental health needs

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[6] Under the Children Act 1989 'relevant partners', which are required to cooperate with local authorities in making arrangements to improve children's wellbeing in their area, are: district councils, where there are two-tiers of local government, clinical commissioning groups, NHS England, Young Offenders Institutions, police and probation services, schools, further education colleges and sixth form colleges.

[7] Section 14Z1(2) of the National Health Service Act 2006 inserted by section 26 of the Health and Social Care Act 2012.

- help others, especially Independent Reviewing Oficers (IROs), social workers, carers and schools, to understand the importance of listening to and taking account of the child's wishes and feelings about how to be healthy.[8]

Planning health services for looked-after children

13. The starting point for planning health services for looked-after children should be the statutory Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). The statutory guidance on JSNAs and JHWSs states that health and wellbeing boards will need to consider the needs of vulnerable groups such as looked-after children and adopted children.[9] The information gathered as part of that process should be used to identify gaps in provision to meet the physical and mental health needs of looked-after children and inform strategic commissioning priorities.

14. CCGs and the officers in the local authority responsible for looked-after children's services should:

- recognise and act on the greater physical and emotional health needs of looked-after children
- give equal importance (parity of esteem) to the mental and physical health of looked-after children and follow the principles in the national document Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis[10]
- agree multi-agency action to meet the health needs of looked-after children in the area
- ensure that sufficient resources are allocated to meet the identified health needs of the looked-after children population, based on the range of data available about their health characteristics
- take into account the views of looked-after children, their parents and carers, to inform, influence and shape service provision, including through Children in Care Councils and local Healthwatch where they are undertaking work in this area
- arrange the provision of accessible and comprehensive information to looked-after children and their carers.

[8] In this guidance the term 'carer' means foster carer or residential care worker.

[9] Health and wellbeing boards comprise: a representative from each CCG whose area falls within or coincides with the local authority area, the director of children's services, the director of public health, the director of adult social services and a representative from the local Healthwatch organisation.

[10] https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

15. Though they may use other screening tools to measure emotional wellbeing, local authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional wellbeing of individual looked-after children.[11] SDQ scores can be aggregated to help quantify the needs of the local looked-after children population and should be used by local authorities and CCGs as they develop their JHWSs.[12] More information about the use of the SDQ for individual looked-after children can be found in Annex A.

Commissioning health services

16. As the main commissioners of health services for looked-after children and children in need, CCGs should have appropriate arrangements in place to meet the physical and mental health needs of looked-after children.

17. Services for individual children placed out of the CCG area should be consistent with the responsible commissioner guidance *Who Pays? Determining responsibility for payments to providers* (see pages 12 and 13).

18. CCGs should ensure:

- they can access the expertise of a designated doctor and nurse for looked-after children (see page 13). Where a designated professional is employed by a different NHS organisation, this will need to be set out in a local agreement
- looked-after children are always registered with medical practitioners (GPs) and have access to dentists near to where they are living
- when looked-after children need to register with a new GP (e.g. when they enter care or change placement), the transfer of GP-held clinical records is 'fast-tracked'
- when looked-after children move placement or move into another CCG area, they are not disadvantaged by being placed at the bottom of a new NHS waiting list for treatment. Looked-after children should be seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service

[11] The SDQ is a brief behavioural screening questionnaire about 4-16 year olds. It exists in three parts: one for the carer, another for the child's teacher and a third part for the child. While the Department for Education requires local authorities to provide SDQ data to be completed for looked-after children by their foster carer or residential care worker, local authorities should not see this as purely a data collection exercise by central government with which they must comply.

[12] The NSPCC/Rees Centre University of Oxford report in the Impact and Evidence Series, *What Works in Preventing and Treating Poor Mental Health in Looked-After Children?* found that 'Use of the Strengths and Difficulties Questionnaire (SDQ) with looked-after children has been shown to provide a good estimate of the prevalence of mental health conditions…'

- appropriate arrangements are in place for looked-after childen and care leavers moving from child to adult health services.

19. Commissioners, whether they sit within the responsible local authority or in health, should commission services which meet the following requirements:

- health professionals contributing to the care planning cycle for looked-after children should have the appropriate skills and competences and receive relevant continuing professional development
- providers have arrangements in place for the training and clinical supervision of all professionals contributing to the healthcare of looked-after children, including where nursing staff are employed by the local authority
- clinical governance and audit arrangements are in place to assure the quality of health services for looked-after children.

The responsible commissioner

20. NHS England guidance *Who Pays? Determining responsibility for payments to providers* provides the framework for establishing responsibility for commissioning an individual's care within the NHS.[13] Local authorities and CCGs should have agreed local mechanisms to ensure this guidance is followed when making placement decisions for looked-after children and for resolving any funding disputes that may arise. This is essential to avoid delays in looked-after children being assessed for, and accessing, the services they need.

21. Where a CCG or a local authority, or both where they are acting together, arrange accommodation for a looked-after child in the area of another CCG, the "originating CCG" remains the responsible CCG for commissioning the secondary healthcare services that CCGs have responsibility for commissioning. That is the case even where the child changes his/her GP practice. The "originating CCG" is the CCG that makes such an arrangement, or the responsible CCG immediately before a local authority makes such an arrangement. The originating CCG should notify the CCG for the area in which the child is placed.

22. NHS England expects that any disputes will be resolved locally, ideally at CCG level, with reference to the guidance in *Who Pays?* In cases that cannot be resolved at CCG level, Area Teams of NHS England should be consulted and should arbitrate where necessary.

23. CCGs should understand the flows of looked-after children both in and out of the CCG area, and agree local arrangements to ensure children living outside the area

[13] The sections of that guidance of particular relevance to looked-after children are paragraphs 29-31 and paragraphs 71-75.

continue to have their statutory health needs assessment and that services are commissioned to meet the needs identified.

24. Arrangements for primary healthcare are determined by GP registration. As the responsible commissioner, the originating CCG should make arrangements for the child's statutory health assessment(s) to be undertaken.

25. Where a child is initially placed, the local authority looking after them has a shared responsibility with the relevant CCG or NHS Trust in the area where the child is living to ensure that a full health assessment takes place and that a health plan is drawn up and implemented.

26. If a looked-after child or child leaving care is moved out of a CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing healthcare and new providers to ensure continuity. The needs of the child should be the first consideration.

27. CCGs should ensure that a child is never refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.

The role of the designated doctor and nurse

28. Designated doctors and nurses have an important role in promoting the health and welfare of looked-after children. The role of the designated doctor and nurse is:

- to assist CCGs in fulfilling their responsibilities as commissioners of services to improve the health of looked-after children
- intended to be strategic, separate from any responsibilities for individual looked-after children, although they may also provide a direct service to those children.

29. Any job description should be jointly agreed by the CCG 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.

30. Model job descriptions and person specifications can be found in the Royal Colleges' intercollegiate framework. In line with NHS England's Accountability and Assurance Framework, CCGs should have appropriate systems in place for discharging their responsibilities for safeguarding.[14] That includes securing the expertise of designated doctors and nurses for looked-after children. There is unlikely to be a single model, and local CCGs should consider the range of duties for any post, whilst ensuring that the workload is realistic.

[14] Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework

Planning and providing services to promote the health of individual looked-after children

The care planning framework

31. Meeting in equal measure the emotional, mental and physical health needs of every looked-after child, and taking account of their wishes and feelings in doing that, is as central to effective care planning as education or where a child lives.

32. As an integral part of care planning, the child's social worker must make arrangements to ensure that every looked-after child has:

- their physical, emotional and mental health needs assessed
- a health plan describing how those identified needs will be addressed to improve health outcomes
- their health plan reviewed in line with care planning requirements set out in Regulations or at other times if the child's health needs change.

Information sharing

33. Local authorities and CCGs should ensure that there are effective arrangements in place to share information about a child's health, that balance the need to know with the sensitive and confidential nature of some information. Fear about sharing information should not get in the way of promoting the health of looked-after children.[15]

34. The lead health record for a looked-after child should be the GP-held record. The initial health assessment and health plan and subsequent ones should be part of that record.

Health assessments, plans and reviews: local authority and NHS responsibilities

Health assessments

35. Local authorities are responsible for making sure a health assessment on their physical, emotional and mental health needs is carried out for every child they look after,

[15] The NHS and local authorities should have in place information sharing protocols that reflect the HMG guidance *Information sharing: guidance for practitioners and managers,*available at https://www.gov.uk/government/publications/information-sharing-for-practitioners-and-managers. The Health and Social Care Information Centre brings together helpful resources and guidance on information governance at http://www.hscic.gov.uk/infogov

regardless of where that child lives. The Care Planning, Placement and Case Review (England) Regulations, 2010 [Regulation 7] require the local authority that looks after them to arrange for a registered medical practitioner to carry out an assessment of the child's state of health and provide a written report of the assessment. This should be done before the child is placed or, if that is not practicable, as soon as possible.

36. The health assessment should address the areas specified in Schedule 1 of the care planning regulations. These areas are:

- the child's state of health, including physical, emotional and mental health
- the child's health history including, as far as practicable, his or her family's health history
- the effect of the child's health history on their development
- existing arrangements for the child's medical and dental care appropriate to their needs, which must include
    - routine checks on the child's general state of health, including dental health
    - treatment and monitoring for identified health (including physical, emotional and mental health) or dental care needs
    - preventative measures such as immunisation[16]
    - screening for defects of vision or hearing
    - advice and guidance on promoting health and effective personal care
- any planned changes to the arrangements
- the role of the appropriate person, such as a foster carer, residential social worker or teacher, and any other person who cares for the child in promoting their health.

37. CCGs have a duty to comply with requests from local authorities for help in the exercise of their functions to make sure this happens in line with statutory requirements on local authorities.[17]

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[16] Comprehensive information on immunisation including the current routine childhood vaccination schedule is available at https://www.gov.uk/government/collections/immunisation. An algorithm that is helpful where either children born overseas arrive in the UK and need further immunisation, or UK-born children have missed some or all of their routine immunisations, is available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347559/PHE-algorithm-September-2014.pdf. For the health needs of unaccompanied asylum seeking children, there is an expert paper available on the National Institute for Health and Care Excellence (NICE) website at http://www.nice.org.uk/guidance/ph28/evidence/looked-after-children-ep23-unaccompanied-asylum-seeking-children-john-simmonds-and-florence-merredew2.

[17] Section 27 of the Children Act 1989

The principles of a good health assessment and planning

38. CCGs and local authorities acting together should work within the following principles when undertaking health assessments for looked-after children.

39. Health assessments should:

- not be an isolated event but, rather, be part of the dynamic and continuous cycle of care planning (assessment, planning, intervention and review) and build on information already known from health professionals, parents and previous carers. That includes routine health checks received through the universal healthy child programme 0-5 years and 0-19.[18]
- be child-centred and age appropriate (further information about the content of age appropriate assessments is at Annex A) and carried out with sensitivity to the child's wishes and feelings and fears, so that the child feels comfortable. For example, they do not necessarily need to include a physical examination (if the child is competent to refuse to be examined). They should take account of any particular needs, including attention to issues of disability, race, culture and gender and if they are unaccompanied asylum seekers.[19] Health assessments should also be carried out as far as possible at a time and venue convenient to the child, their carers and parents.
- give the child clear expectations about any further consultations or treatment needed. Explanations should include the reasons for this and the choices available, and the appropriateness of plans kept under review as necessary
- pay particular attention to health conditions that may be more prevalent in looked-after children (such as foetal alcohol syndrome) and which may otherwise have been misdiagnosed.

40. To ensure the child's health plan is of high quality, the health assessment should use relevant information drawn together beforehand and fast-tracked to the health professional undertaking the assessment. This will include information held:

- by children's social services and derived from an assessment undertaken in accordance with *Working Together to Safeguard Children*. This includes the child's personal and family history if known
- by community dental services and family dentists

[18] The outcomes of these checks are normally notified to parents. For looked-after children they should be notified to the main carer and the child's social worker. For children accommodated under section 20 of the Children Act 1989 the child's parents should also be notified.

[19] When undertaking the statutory health assessment, designated health professionals (as part of the multi-agency contribution to local authority led age assessments where they are necessary) may be requested to comment on the age of a looked-after child who is an unaccompanied asylum seeker.

- on the Child Health Information System (CHIS), especially immunisation status to date
- on any parent-held or child-held record
- on the GP-held record[20]
- within any database in local hospital emergency departments or within other local hospital record systemns, especially where the child is known to have been in contact with services
- on any contact with child and adolescent mental health services (CAMHS).

41. The health assessment should:

- make effective use of the SDQ. For this reason, local authorities should be supported by CCGs and Mental Health Trusts to ensure the process is carried out in a way that best reflects the child's needs. SDQs should be built into the health assessment process and used when new placements start. Further information about SDQ requirements in relation to the health assessment is included in Annex A
- involve birth families as far as possible, so that an accurate picture of the child's physical, emotional and mental health can be built up
- work in harmony with any other assessments and plans such as an Education, Health and Care Plan where the child has special educational needs
- involve a named health professional to coordinate the assessment and actions set out in the health plan developed from that assessment.

42. The health practitioner carrying out the assessment has a duty of clinical care to the child. That includes making the necessary referrals for investigation and treatment of conditions identified at the assessment. Even if the placement is brief, the practitioner should follow up concerns and if the child returns home, every effort should be made to continue to implement the health plan.

43. Health asessments should also reflect the criteria set out in Annex H of the Payment by Results Guidance 2013-14.

Who should carry out the health assessment?

44. It is the responsibility of the authority that looks after a child to arrange their health assessment in partnership with health professionals. The responsible CCG and, if

[20] In the case of GP held records, a summary report should be requested from the GP holding them. Steps should be taken to fast-track the records to any GP with whom the child is known to have subsequently become registered.

different, the CCG in the area where the child is placed should reach agreement quickly as to which CCG's staff will carry out health assessments.

45. Factors that should determine any decision about which CCG undertakes the health assessment are:

- the need to ensure they are satisfied with the quality of health assessment and follow-up to the actions that are identified
- the distance at which the child is placed. If a child is placed far from home, the responsible CCG should consider if it is more practicable to commission the receiving CCG
- knowledge about the availability of local services that can meet the child's needs.

46. The Department of Health, with NHS England, Monitor, the Royal Colleges and other partners, has developed a mandatory national currency and tariff for statutory health assessments for looked-after children placed out of area. Details are set out in the current National Tariff Payment System.[21]

The health plan and health reviews

47. The first health assessment and report should result in a health plan, which is available in time for the first review by their Independent Reviewing Officer (IRO) of the child's case. That case review must happen within 20 working days from when the child started to be looked after.[22]

48. The local authority that looks after the child must make arrangements for a registered medical practitioner or a registered nurse or registered midwife under the supervision of a registered medical practitioner to review a looked-after child's state of health and provide a written report of each review addressing the matters specified at paragraph 37 above.

49. The review of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months after the child's fifth birthday.

50. The local authority that looks after a child must take all reasonable steps to ensure that they receive the health care services they require as set out in their health plan. Those services include medical and dental care treatment as well as advice and guidance on personal health care and health promotion issues.

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-Revised_26_Feb_14.pdf

[22] Regulation 33(1) of the Care Planning, Placement and Case Review (England) Regulations 2010

Mental health services

51. Child and Adolescent Mental Health Services (CAMHS) play a crucial role in assessing and meeting any needs identified as part of the SDQ screening process and via other means. CCGs should ensure that 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.

Special educational needs (SEN)

52. The majority of looked-after children have special educational needs. Of those, a significant proportion will have a statement or a learning difficulties assessment. From 1 September 2014 statements were replaced by Education, Health and Care (EHC) plans, with the transition process to be complete by 2016.

53. To support children and young people with SEN or disabilities, including those who are looked after or leaving care, local authorities and CCGs must commission services jointly. This SEN provision applies to children and young people from birth to age 25.

54. Local authorities are also placed under a duty to publish a Local Offer, which sets out in one place all information about provision across education, health and social care, for children and young people with SEN or disabilities. Local authorities which place looked-after children in another authority need to be aware of that authority's Local Offer if the child has SEN or disabilities.

55. Local authorities and health professionals should ensure that:

- they follow the requirements set out in the Special Educational Needs and Disability Code of Practice 0 to 25[23]
- the child's EHC plan works in harmony with their care plan to tell a coherent and comprehensive story about how the child's health needs in relation to accessing education are being met. Health and education professionals should consider how to co-ordinate assessments and reviews of the child's EHC plan to ensure that, taken together, they meet the child's needs without duplicating information unnecessarily.

56. Further information can be found in the Code itself and in the Guide for health professionals on the support system for children and young people with special educational needs and disabilities.

[23] Information about looked-after children who have SEN is included in chapter 10.

The role of social workers and others in promoting health

57. Social workers have an important role in promoting the health and welfare of looked-after children. In particular they should:

- take action to liaise with relevant health professionals if actions identified in the health plan are not being followed up
- support foster carers, or the appropriate person in the children's home where a child is placed, to promote the child's physical and emotional health on a day-to-day basis. That should include providing them with information on the child's state of health, including a copy of the child's latest health plan[24]
- ensure that there is clarity for carers, GPs and dentists about what health care decisions have been delegated to carers.

58. Social workers and health professionals should give carers information on how to contact designated and named health professionals for each child in their care, and on how to access services, including CAMHS consultations, that the child needs.

59. Social workers should also ensure:

- that foster carers and residential care staff know it is their responsibility to make sure a child attends their health assessment and all other medical appointments
- that the children their authority looks after, including teenage parents, have access to available positive activities such as arts, sport and culture, in order to promote their sense of wellbeing.

60. Social workers and other local authority professionals should ensure that information about any health needs or behaviours which could pose a risk of harm to the child, the carer or members of his/her family or household is passed to the carer at the time of the placement. At the same time, the carer should receive information about the support that will be available to the child and carer to address or manage these difficulties.

61. Fostering service and children's homes providers should work with foster carers and residential care staff to make sure they provide information about the child's health needs (including completed SDQs) for the planning and review process.

[24] Where the child is 'competent'in line with Fraser Guidelines their consent should be obtained. An NSPCC factsheet on Gillick competency and Fraser Guidelines is available at http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/.

The role of Independent Reviewing Officers

62. The Independent Reviewing Officer (IRO) should, as part of the child's case review, note any actions and updates to ensure that that the health plan continues to meet the child's needs. Any deficiencies in the quality of the health plan or its delivery should be brought to the attention of the appropriate level of management within the local authority, using the local dispute resolution process if necessary. IROs should ensure that looked-after children are involved in the review of their care plan and its component parts. Further information can be found in the Independent reviewing officers' handbook.

The contribution of primary care teams

63. Primary care teams have an important role in identifying the individual health care needs of looked-after children. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions. They may also have continuing responsibility for the child when he/she returns home.

64. Primary care teams should:

- ensure timely access to a GP or other appropriate health professional when a looked-after child requires a consultation
- provide 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
- maintain a record of the health assessment and contribute to any necessary action within the health plan
- make sure the GP-held clinical record for a looked-after child is maintained and updated and that health records are transferred quickly to their new GP when the child moves into another CCG area, leaves care or is adopted.

65. Treating a patient as a temporary resident is not ideal, as the medical record is not available to the treating medical practitioner. If this cannot be avoided, the treating practitioner will normally wish to talk to the child's registered medical practitioner to avoid treating the patient "blind". 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.

Health professionals and the role of named health professionals for looked-after children

66. All healthcare staff who come into contact with looked-after children should work within the Royal Colleges' intercollegiate framework. This framework identifies the competences that enable healthcare staff to promote the health and welfare of looked-after children. They are a combination of the skills, knowledge, values and attitudes that are required for safe and effective practice.

67. All staff should have access to appropriate continuing professional development opportunities, supervision and support to facilitate their understanding of the clinical aspects of child welfare and information sharing in relation to looked-after children.

68. The named health professional will act as a principal health contact for children's social care and should have specialist knowledge of the health needs of looked-after children or know how to access it. [25] Working with the designated professionals for looked-after children, named health professionals should

- coordinate the provision of local health services for individual looked-after children and the input into health assessments and their reviews for individual looked-after children
- ensure the timeliness and quality of health assessments for looked-after children and ensure actions taken to implement the health care plan are tracked
- act as a key conduit and contact point for the child and their carer, where they have difficulties accessing health services.

Placement out of authority

69. Social workers must notify the relevant CCG, in accordance with relevant Regulations, when a child is placed out of authority.[26] They should ensure that arrangements are made to secure health provision for the child. When a child starts to be looked after, changes placement or ceases to be looked after, the local authority must notify in writing:

- the CCG for the area in which the child is living
- the CCG and the local authority for the area in which the child is placed.

[25] A model job description and person specification for the named professional role can be found in the Royal Colleges' intercollegiate framework.

[26] Regulation 13, The Care Planning. Placement and Case Review (England) Regulations 2010

70. Unless the placement is made in an emergency, a local authority must inform the relevant CCG and local authority in writing of its intention to place a child in its area. It should state whether the placement is intended to be long or short term. In cases of emergency placements where prior notification is not possible, it should be done within five working days or as soon as reasonably practicable.

71. The Care Planning, Placement and Case Review (England) Regulations 2010 require local authorities making distant placements to consult with children's services in the area of placement and the Director of Children's Services of the responsible authority to approve these placements.[27] The process for making distant placements and who should be consulted is described in statutory guidance on out of authority placements of looked-after children.

72. In making a judgement about the suitability of an out of authority placement for a child, the responsible authority should assess, with input from health services, the arrangements which it will need to put in place to enable the child to access services such as primary and secondary health care.

73. Where the child will require specialist health services such as Child and Adolescent Mental Health Services (CAMHS), the CCG (or local health board in Wales) that commissions secondary healthcare in the area authority should be consulted, so that the responsible authority can establish whether the placement is appropriate and able to meet the child's needs. The designated nurse for looked-after children in the area authority will also be a valuable source of advice and information.

Children living in children's homes

74. As well as their responsibilities as corporate parents of children living in children's homes, local authorities have additional responsibilities if they are the provider of the home.

75. A local authority should be confident when placing a child in a children's home that, if the home offers specialist health care such as therapeutic care, the professional care provided will meet the assessed health needs of the individual child.

76. The local authority, as a corporate parent, the child's social worker and health professionals should work with children's home staff to secure the health services that each child needs. In particular, social workers and other relevant officers in the authority responsible for a looked-after child should work with the home to:

- agree the specific responsibilities of the home towards supporting the health needs of every child at the time the placement is made

[27] The following must also be consulted: the child's IRO, the child's relatives and parents where appropriate, the CCG (or local health board in Wales) that commissions secondary health care if the child requires secondary health services and the Virtual School Head.

- ensure that these responsibilities are recorded in the child's placement plan. This must include recording permission from a person with parental responsibility for the child for staff to administer first aid and non-prescription medication, and clearly agreed responsibilities for the administration of prescription medication
- be confident that staff in the home have sufficient understanding of relevant local health provision, including the functions of the designated doctor and nurse for looked-after children in their area, and can support children to navigate these services, advocating on their behalf where necessary and appropriate.

Children in custody

77. Local authorities and the NHS should ensure there are arrangements in place to support the children they look after who are in custody. More information about meeting the health needs of looked-after children in custody is provided in Annex B.

Transitions from care

78. Some children who cease to be looked after – whether returning home, adopted or with a Special Guardianship Order or making the transition to adulthood – will have continuing health needs that require ongoing treatment. Health professionals and social workers should ensure that there are suitable transition arrangements in place so that the child's health needs continue to be met. In particular, they should ensure that prospective adopters and care leavers have information about what health services, advice and support are available locally to meet their needs.

Children placed for adoption

79. Children placed for adoption remain looked after until the adoption order is made. Research shows that their needs do not change overnight once they are adopted. Local authorities should ensure there is consistent and sustained health care in place to support each child during the transition from care to a permanent home. This will help inform post-adoption support for the child and the child's new parents and enable continuity of services.

80. At a strategic level:

- local authorities should have robust arrangements in place for the timely commissioning of timely health assessments so that prospective adopters have the information they need to support the child placed with them
- local authorities and CCGs should cooperate to make sure adoption panels secure access to timely medical advice, so as to avoid delays in making an application for

a placement order. Panels require comprehensive health information and good health advice in order to make decisions without unnecessary delay

- local authorities and CCGs should work together to ensure that information in health records is not lost once the child ceases to be looked after.

81. At an operational level, at an early stage where adoption is the planned permanence option for a looked-after child, social workers should:

- comply with the requirements for health assessments and reviews set out in the Adoption Agency Regulations 2005
- build on the health assessments and information already included in the child's health plan
- request health assessments that include the requirements for any further medical reports necessary for the purposes of placement order proceedings, for example, in relation to any on-going mental health needs and therapeutic services that need consideration to support bonding and attachment with the child's prospective new parents.

82. The local authority should be ready to file the medical (and other) reports required under Rule 29 of the Family Procedure (Adoption) Rules 2005 and Annex B of the Practice Direction which supplements Rule 29(3), in accordance with the Court timetable.

Care leavers

83. Local authorities and the NHS should ensure that there are effective plans in place to enable looked-after children aged 16 or 17 to make a smooth transition to adulthood, and that they are able to continue to obtain the health advice and services they need. In particular:

- there should be an emphasis on partnership working between the young person and their personal adviser, and the doctors and nurses involved in their health assessments[28]
- personal advisers should have access to information and training about how to promote physical and mental health
- CAMHS transitions should be planned at least six months in advance of a transition to adult services.

84. Care leavers should have a full copy of all social care health records (including genetic background and details of illness and treatments) and be equipped to manage their own health needs.

[28] From their 16th birthday, the authority responsible for looking after the child must appoint a personal adviser for eligible children to work with them and prepare a pathway plan.

85. Young people leaving care should be able to continue to obtain health advice and services. Personal advisers should work closely with looked-after children's health teams involved in health assessments. Leaving care services should ensure that health and access to positive activities are included as part of the young person's pathway planning.

86. 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 who 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, are identified and facilitated as appropriate.

Annex A

Age-appropriate recommended content of the health assessment

The content of the health assessment should be age-sensitive and developmentally appropriate. The recommended content for the different stages of childhood is outlined below.

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 school age children, the focus will be on:

- physical health and management of specific health conditions eg 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, 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.

Assessment for emotional and behavioural difficulties: using the SDQ

In order to identify and take steps to meet any potential mental health needs, as a minimum, the Strengths and Difficulties Questionnaire (SDQ) should be used to screen for any problems related to a looked-after child's emotional wellbeing. The SDQ is a clinically validated screening tool that provides information to help social workers form a view about the emotional wellbeing of individual looked-after children. Local authorities, usually through the child's social worker, should ensure that:

- SDQ questionnaires are given to carers to complete and that they receive guidance and support on how to use them

- an SDQ is completed by the main carer for each looked-after child between the ages of 4 and 16 inclusive, preferably so that it is available to inform the child's statutory health assessment
- information in the completed questionnaires is collected and the child's average SDQ score worked out and available to inform the child's health assessment. This should help the social worker and health professionals to decide whether to triangulate the scores with an SDQ completed by the child's teacher or (if the child is in the relevant age bracket) the child, and whether the child needs to be referred for further diagnostic assessment of their mental health
- if the child's SDQ scores suggest there are underlying problems, this should trigger a fuller diagnostic assessment. The SDQ should be used as evidence to support a referral to local targeted or specialist mental health services, where appropriate.

When decisions about placement choices are being made and where changes of placement occur, social workers, working in partnership with health professionals, should consider referral for specialist mental health assessment and treatment where it is appropriate. The SDQ should help inform these decisions. Professionals should ensure this information is shared securely and appropriately where changes of placements, including from care to adoption, occur.

The SDQ is in three parts. The data return for the Department for Education relates only to the part completed by the carer. However, where the SDQ questionnaire completed by the carer suggests the child's score is outside of the normal range the social worker or health professional should arrange for the child and the child's teacher to complete the SDQ questionnaires designed for them. If triangulation of those SDQ scores confirms the carer's score, consideration should be given to using a diagnostic tool to enable an appropriate intervention to be identified.

Annex B

Custody

If a young person who has previously been accommodated under section 20 of the 1989 Act is remanded in custody he or she is no longer looked after under this section of the 1989 Act. This is because the child is no longer being voluntarily accommodated by a local authority. However, looked after status may need to be resumed on release or, depending on the child's age, he or she may be a 'relevant' care leaver. Prior to release, the authority that will be responsible for the child's future care, along with the assigned young offenders institution (YOI), should:

- make arrangements with the local authority secure children's home (LASCH), secure training centre (STC) or YOI to ensure that the child's needs have been re-assessed to inform arrangements for their future accommodation and care
- ensure that the assessment includes up-to-date information about the child's educational needs so that the PEP can be revised as part of the new care/pathway plan

Under section 104(1) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPOA), children remanded to youth detention accommodation become looked-after children. During the period of remand the child will have a detention placement plan. That plan should include information about the arrangements made by staff in the youth detention accommodation for the child's health.

Children who offend and receive custodial sentences remain looked-after if they were under a care order immediately prior to conviction. The authority therefore has a continuing responsibility to review their health plan as part of the care plan and to ensure the child's access to education and training is consistent with their statutory entitlements. In these cases the local authority should:

- have procedures in place to know where these young people are placed and how long they are likely to be held
- have access to information about the child's health
- ensure that the health needs of the individual are being met
- ensure that there is proper planning to maintain the continuity of healthcare once the young person is released from custody

Where a looked-after child is placed in secure accommodation for their own welfare (section 25 of the 1989 Act), local authorities should liaise directly with the secure unit to ensure that they meet their statutory responsibilities to promote the health and welfare of the child.

Annex C [under development]

Terms used in this guidance

Distant placement: Regulation 11(5) of the Care Planning, Placement and Case Review Regulations (England) 2010 as amended defines a distant placement as meaning 'a placement outside the area of the responsible authority and not within the area of any adjourning local authority'. Distant placements must be approved by the responsible authority's DCS.

Eligible children: a looked-after child who is aged 16 or 17 and has been looked after by a local authority for a period of 13 weeks, or periods of 13 weeks, which began after he reached 14 and ended after he/she reached 16.

Originating authority/responsible authority: the local authority that looks after the child

Placement out of the authority's area: a placement out of the authority's area is one that is a placement in foster care, a children's home, or in 'other arangements' located outside the boundary of the responsible authority. An out of authority placement may be in an adjourning local authority's area or it may be a 'distant' placement.

Further information [under development]

Useful resources and external organisations

- NSPCC Face to Face service
- What works in preventing and treating poor mental health in looked-after children? (August 2014). This is part of NSPCC's Impact and Evidence series co-produced with the Rees Centre, University of Oxford
- Strengths and Difficulties Questionnaires
- Attachment Aware Schools project
- The mental health of young people looked after by local authorities in England Howard Meltzer, 2003
- Looked-after children and young people NICE public health guideline 28
- NICE pathways: Looked-after babies, children and young people overview
- NICE local government briefings: Looked-after children and young people (June 2014)
- NICE Quality Standard for the health and well-being of looked-after children
- Research in practice: Fostering and adoption learning resources in relation to health

Other relevant departmental advice and statutory guidance

- Special educational needs and disability code of practice: 0 to 25 years
- Mental health and behaviour in schools: departmental advice
- Statutory guidance on adoption

Other departmental resources