

PHOTO REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES

PHOTO REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES

Promoting the Health of Looked After Children



Contents

Foreword	vii
Acknowledgements	viii
Preface	ix
Scope and purpose of the guidance	ix
The role of guidance	ix
The policy context	x
Issues to be addressed	xi
1. Introduction	1
1.1 Wellbeing	1
1.5 An integrated approach	2
2. Legislative Framework	4
2.1 The United Nations Convention on the Rights of the Child	4
2.2 The Children Act 1989	4
2.5 The Care Standards Act 2000	5
3. Evidence from Research and Experience	6
3.4 Epidemiology	6
3.9 The nature of health problems in looked after children	7
3.16 The annual health assessment	8
3.18 Implementing health care decisions	8
3.21 A whole system problem but not unique to this country	9
4. Principles of Good Health Care	10
5. The Roles and Responsibilities of Councils	11
5.1 Duties to children	11
5.2 Strategic level	11
5.4 Turning data and information into action	12
5.7 Placements outside the boundary of the local authority	12
5.12 Operational level	13
– Management and delivery of services	13
5.14 Care planning and reviews	14

6.	The Roles and Responsibilities of the NHS	16
6.6	Care Trusts	17
6.7	Children's Trusts	17
6.9	Role of Strategic Health Authorities	18
6.11	The Responsible Commissioner	18
	– Looked after children	18
	– Boarding school pupils, special school pupils	19
6.19	Contribution of Primary Care Teams	19
6.20	The roles of the designated doctor and nurse	20
	– Advisory role	20
	– Policy and procedures	21
	– Liaison	21
	– Monitoring and information management	21
	– Annual report	21
	– Clinical governance and audit	22
	– Training	22
7.	Joint Planning across Health and Social Services	25
7.2	Contraception and sexual health services	25
7.8	Young people and drugs – providing effective services	26
8.	Health Assessment, Planning, Intervention and Review	29
8.1	Assessment	29
8.6	Collating information before health assessment	30
8.9	Approach to the assessment	31
8.12	Assessment content recommendations	32
8.21	Care plans and health plans	32
8.24	Providing services: implementing the health plan	33
8.27	Reviews	33
9.	The Parenting Role	36
9.4	Education	36
9.9	Leisure, hobbies and sport	37
10.	Children in Special Circumstances	39
10.1	Disabled children	39
10.6	Black and minority ethnic children	39
10.11	Asylum seeking children and refugees	40
10.15	Care leavers and transition to independence	41
10.18	Children cared for in secure settings	41
11.	Health Promotion	44
11.1	Context	44
11.2	Promoting health and achieving wellbeing	44
11.5	A healthy care setting	44
11.10	Definition of promoting health in care	45
11.12	Planning	45
11.13	Participation	46
11.15	Partnership	46
11.16	Training and support	47

12.	Mental Health	49
12.1	Mental health and emotional wellbeing	49
12.8	A primary level of service-tier 1	50
12.14	Community based child and adolescent mental health services	51
13.	Confidentiality, Information Sharing and Consent	54
13.1	Confidentiality	54
13.8	Consent	55
13.10	Children aged 16 and 17	55
13.12	Children and young people aged 15 and under	56
13.15	Significant harm	56
13.16	Parental responsibility	56
13.17	Foster carers and residential social workers	57
13.18	Requirements for consent	57
Appendix 1	Children Act (Miscellaneous Amendments) (England) Regulations 2002	58
Appendix 2	Suggested information collection	66
Appendix 3	Vaccination of children with unknown immunisation status	67
Appendix 4	The content of a health assessment	68
Appendix 5	Flow chart for health care of an individual child (East Berkshire)	70
Appendix 6	Project Development Group Membership	73
Appendix 7	References	74

Foreword

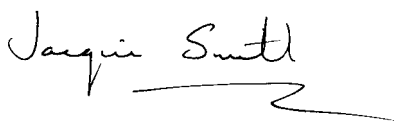
Within the objectives, which the Government has set for Children's Social Services is a clear commitment to improving the life chances of children and young people who are looked after away from home. Growing up as fit and well as possible is key to being able to benefit from educational and other life enhancing opportunities, yet the circumstances in which looked after children find themselves make it harder for them to access a range of health services, including mental health services.

Improving the health of looked after children is a multi-agency responsibility involving Councils and health agencies. This guidance therefore sets out the responsibilities on all agencies to work together to provide services which meet the needs of these children and young people. It also sets out the values and principles which should underpin the delivery of services.

To achieve these improvements to the health of looked after children the statutory requirements have been amended to provide a more robust framework, yet one which has the flexibility to meet the needs of an individual child.

The guidance draws directly upon the views and experiences of children and young people who are looked after, upon a wealth of research about their health needs and outcomes and upon the thoughtful responses to the extensive consultation exercise conducted about these proposals. This consultation exercise, following the publication of the draft document *Promoting Health for Looked After Children*, identified a number of structural and practical barriers to the achievement of good health for this population of children which the guidance seeks to address. Two key barriers are the lack of parents who are able to advocate on behalf of the child to ensure any needs they have are recognised and met and the rate of movement between placements which many looked after children and young people experience. This guidance is therefore intended to provide a foundation for local policy and practice development across a range of health, care and education services.

The value of this guidance will be measured in the degree to which it contributes to real improvements to the health and emotional wellbeing of looked after children.

A handwritten signature in black ink, reading 'Jacqui Smith', with a long, horizontal, wavy line extending from the end of the name.

Jacqui Smith

Acknowledgements

This guidance is the product of a close collaboration between colleagues in the Department of Health and in the field. The response to the consultation exercise was very constructive and positive and resulted in a continuing dialogue with many practitioners developing innovative practice models to address the health inequalities experienced by this population of children and young people.

The Department is especially indebted to the children and young people who have shared their views and experiences, to the Councils who enabled their young people to participate in the consultation exercise and to the Children's Society who shared the findings from their own consultation exercise. The approach reflected in the guidance has been informed by many models of good practice found in the field especially the service offered to looked after children and young people in Sunderland by Dr Jan Welbury and colleagues and in Southampton by Dr Cathy Hill and colleagues. Particular thanks are also given to Dr Cathy Hill and Professor David Hall for their permission to use material from the forthcoming publication 'Health for all Children' for the section on research and evidence. Many other professionals from a range of disciplines have also contributed good practice examples cited in the guidance. Finally, thanks goes to the Quality Protects Health Group for their continuing support and advice.

The development of this work has reflected a collective commitment to improve the health of looked after children and young people.

Preface

Scope and purpose of the guidance

This document sets out a framework for the delivery of services from health agencies and Councils with Social Services Responsibilities (CSSRs) which will promote and improve 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 is therefore relevant for a range of agencies in the statutory, voluntary and independent sectors, including education and leisure services.

The document:

- sets out the revised legislative framework for safeguarding and promoting the health of looked after children and young people;
- describes the evidence from research and experience about levels of unmet health need and the rationale for the service delivery model;
- sets out the role and responsibilities of different agencies;
- outlines the principles of good health care;
- describes the framework for assessment, planning, intervention and review of the health needs of looked after children and young people;
- provides guidance on the health needs of children and young people in specific circumstances;
- describes the legal framework governing confidentiality, consent and information sharing.

The role of guidance

The guidance supports the development of an effective and flexible system which will address health inequalities and the assessment of health needs, obtain and manage the information required to produce individual health plans for all looked after children and young people and enable these plans to be implemented.

The guidance therefore provides a set of underpinning principles on which services should be based and outlines key roles and responsibilities of all relevant agencies. It emphasises both the importance of strategic planning and inter-agency partnerships as well as the overarching responsibility to provide effective corporate parenting and accessible services.

It represents a shift away from a health care system based on annual 'medical' towards a more holistic assessment of an individual child and young person's health care needs. These assessed needs refer to both physical and mental health including health promotion.

All the processes and procedures outlined in this document are designed to improve outcomes for children, not to provide detailed prescription of activities for agencies on individual children. Implementation of this guidance will, however, require effective partnerships to be in place at both strategic and individual case level in relation to service delivery, information sharing, confidentiality and consent.

To be successful in improving health outcomes for this vulnerable population any guidance, structures or plans must have as its central focus a partnership process which builds on the views and priorities of the children and young people themselves. Therefore this guidance starts with the views of children and young people.

Messages from Children and Young People

- Young people value the idea of seeing and keeping their own health records.
- Young people's experience of medical examinations is negative - the event is often impersonal, lacking in explanations and without recognisable outcomes for them.
- Policies and procedures should be established to ensure that the needs of the system do not intrude on a child's appropriate need for personal privacy.
- Young people feel angry at the failure of professionals to respect the confidentiality of their health information.
- Information and advice should cover: sexual health, fitness, stress, depression, contraception, drugs, skin and hair care and how to use a GP practice.
- Better information, advice and support should be available for mental health services.

The policy context

The vision described in *Building a Strategy for Children and Young People* (Children and Young People's Unit, 2001) makes specific reference to the need for excellent joined up public services which strive to meet the individual needs of children, young people and their families.

To deliver this vision the Government has set up a Children's Taskforce, and is developing a National Service Framework (NSF) for children of which a key stream is Children in Special Circumstances which includes children who are looked after. The NSF will provide a key context for improving the health of children by setting in place new national standards for service delivery www.doh.gov.uk/nsf/children.htm.

The Children's NSF will be concerned with children's overall wellbeing, not just with their health in clinical terms and its work will be informed by the indicators for children developed by the Children and Young People's Unit referred to above.

Within social care services one of the key Government Objectives for Children's Social Services is:

- to ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care.

The Department of Health Public Service Agreement (PSA) targets now include a target on child mental health, which is to:

- *improve life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010*

Issues to be addressed

This guidance therefore outlines the ways to improve:

- the participation of children and young people in developing services to meet their needs;
- the assessment of the child or young person's health needs which recognises the inequalities which they have experienced;
- the standards both in the design and delivery of health care services including arrangements for clinical governance;
- effective parenting for these vulnerable children.

1. Introduction

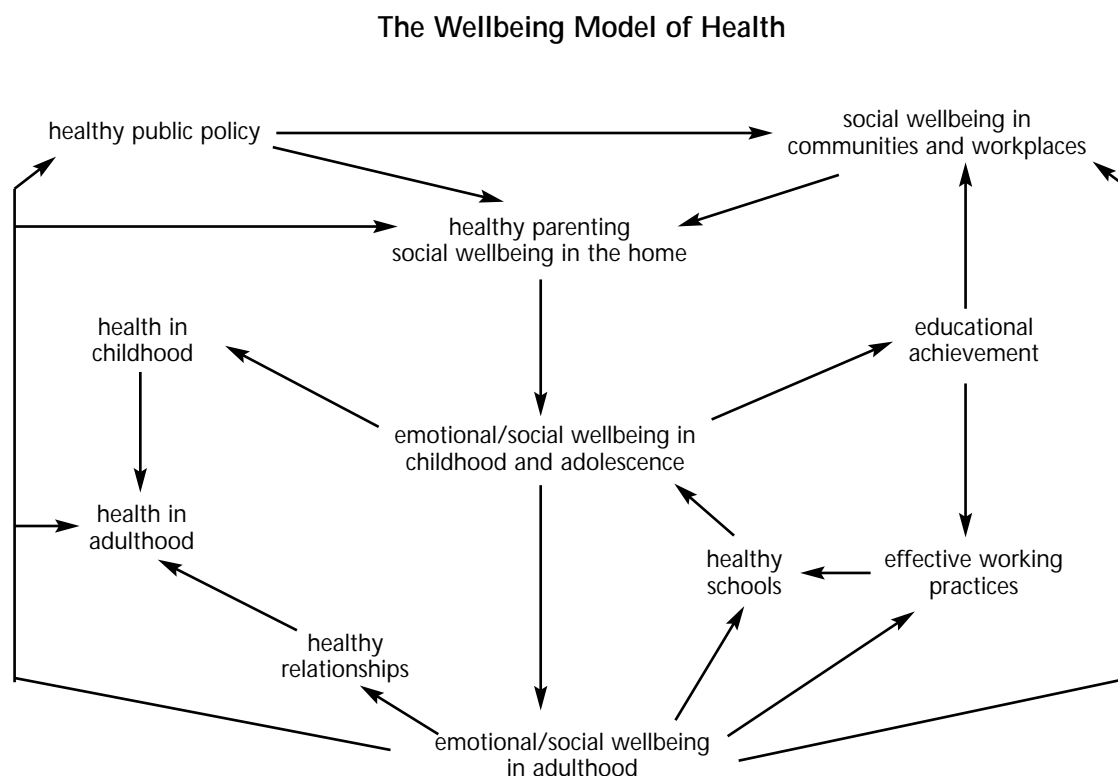
Wellbeing

- 1.1 Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs however, often remain unmet. As a result, many children and young people who are looked after experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes.
- 1.2 The aspirations for all children outlined in the Consultation document *Building a Strategy for Children and Young People* issued by the Children and Young People's Unit, are set clearly in a context of both combating social exclusion and promoting good outcomes. The aspiration for wellbeing is that:

'Children and young people should develop healthy lifestyles and opportunities to achieve optimum health and wellbeing, within the context of high quality preventive and treatment services – if and when they need them. Children and young people should have the resilience, capacity and emotional wellbeing that allows them to play, learn, relate to other people, and resolve problems in life.' (Children and Young People's Unit, 2001)
- 1.3 The International Classification of Functioning, Disability and Health (ICIDH-2) offers the following definition of wellbeing:

'Wellbeing is a general term encompassing the total universe of human life domains including physical, mental and social aspects, that make up what can be called a "good life". Health domains are a subset of domains that make up the total universe of human life.'
- 1.4 In adopting this definition the guidance therefore refers to health in the context of the role of health in relation to other domains of wellbeing. Stewart-Brown (2000) provides an important model of wellbeing, centred on the emotional wellbeing of children, which is reproduced at **figure 1**. In particular the model illustrates the interconnectedness of different domains in contributing to wellbeing in childhood and adulthood:

Figure 1



(Buchanan A. Hudson B.)

An integrated approach

1.5 This guidance is primarily directed towards improving the health of children and young people looked after away from home. These children and young people may be:

- accommodated under a voluntary agreement with their parent(s) consent, or their own consent if aged 16 or 17;
- in care on a Care Order or Interim Care Order under Section 31 of the Children Act 1989;
- accommodated under Section 21(2)(C)(i) of the Children Act 1989 (remanded to Local Authority care);
- on an Emergency Protection Order under Section 44 of the Children Act 1989.

1.6 Nevertheless the issues facing children and young people who are looked after described earlier are faced equally by wider groups of children in need and marginalised children. Children looked after have usually already been identified as children in need in the community and some will have been in need of protection. Most will return to their families in the same communities when they cease to be looked after or return to those communities as care leavers, while a few will eventually be adopted. It is therefore important that arrangements are in place to ensure that outstanding actions from a health care plan are implemented and reviewed once children leave care by whatever route.

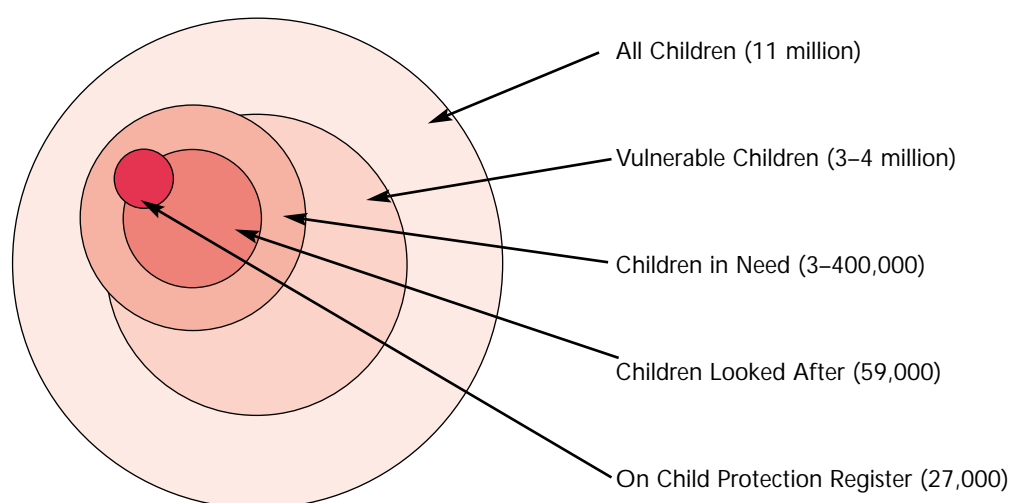
1.7 Many children in need will have health needs arising from:

- living in families affected by drugs, alcohol and domestic violence;
- special needs or a disability;
- experience of trauma, abuse and/or neglect;
- coming from highly mobile families.

They may also have experienced poorer access to services including universal services such as dental services, immunisations, routine child health surveillance and health promotion because of language or cultural barriers.

- 1.8 Whenever the child first comes to professional attention the approach to health assessment should be holistic and include a comprehensive review of health needs including dental and oral health, hearing and sight. Thus if first seen for child protection concerns the focus should not just be on a medical examination for evidence of abuse but should also consider the same issues covered in the health assessment of a looked after child, using the opportunity to recognise a range of unmet health needs and consider ways of meeting them.
- 1.9 The domains and dimensions of the *Framework for the Assessment of Children in Need and their Families* will, in future, be used for the assessment of all children in need and their families, including those living with their families, in need of protection, looked after, care leavers and children being placed for adoption. The Assessment Framework and the Looking After Children System have been brought together to create the **Integrated Children's System** which will provide a common framework for assessment, intervention, planning and review for all children in need. (Department of Health, forthcoming)
- 1.10 When this system is fully implemented all children in need, including those looked after, will have a core assessment which will provide key baseline information on the child's health needs and strengths from which to monitor future progress.

Figure 2 below demonstrates the relationships between some populations of children in need.



Summary

- the document sets out a framework for the delivery of services from health agencies and social services to promote the health of looked after children;
- a holistic model of health is taken, including the contribution of a range of agencies;
- responding to the health needs of looked after children should be seen as part of a continuum of meeting the needs of vulnerable children, to ensure continuity before, during and after the period they are looked after;
- the Integrated Children's System using the dimensions and domains of the Assessment Framework should be used to assess and meet these identified needs.

2. Legislative Framework

The United Nations Convention on the Rights of the Child

2.1 This guidance reflects the principles contained within the United Nations Convention on the Rights of the Child ratified by the UK Government in 1991. Specifically:

- **Article 3:** the best interests of the child should be a primary consideration when action is taken concerning children;
- **Article 23:** a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community;
- **Article 24:** the right of any child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health;
- **Article 25:** the right of a child placed by competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement;
- **Article 39:** all appropriate measures to be taken to promote the physical and psychological recovery and social reintegration of a child victim of any form of abuse and neglect.

The Children Act 1989

2.2 This guidance is particularly informed by the requirements of the Children Act 1989 which 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 to safeguard and promote the wellbeing of children looked after by them.

2.3 This legislation places specific duties on Councils with Social Services Responsibilities (CSSRs) to promote the health of looked after children. In view of the evidence of high levels of unmet health needs in this population the Arrangements for Placement of Children (General) Regulations 1991a and the Review of Children's Cases Regulations 1991b have been amended to provide a more robust but also more flexible framework.

2.4 The revised regulatory framework is attached in its entirety at **Appendix 1**. The key changes are:

- the **first** health assessment is required to be undertaken by an appropriately qualified registered medical practitioner;
- **review assessments** may be carried out by an appropriately qualified registered nurse/midwife;
- the requirements for a health authority health assessment on children aged under five are now twice yearly;

- the notifications are now required both to the PCT in the area from which the child is leaving and the PCT area to which the child is moving.

The Care Standards Act 2000

- 2.5 Regulations and standards developed to support the Care Standards Act 2000 (Department of Health, 2000a) outline the responsibilities of agencies and carers in promoting the health of children who are looked after.

Summary

The guidance is in accordance with the UN Convention on the Rights of the Child. It contains revisions made to the regulatory requirements. The key changes are:

- the first health assessment is required to be undertaken by an appropriately qualified registered medical practitioner;
- review assessments may be carried out by an appropriately qualified nurse;
- the review health assessment requirements for children aged under five are now twice yearly;
- notification is now required to both the PCT in the area from which the child is leaving and the PCT area to which the child is moving.

3. Evidence from Research and Experience

- 3.1 Knowledge and understanding about children's welfare – and how to respond to the presenting needs of vulnerable children – develop over time, informed by research, experience and the critical scrutiny of practice. Sound professional practice within both the health and social care fields about the impact of poor parenting and early trauma on health and how to intervene to improve health and other important related outcomes for looked after children will be derived from evidence. Such evidence will be derived from a thorough assessment of a specific child or young person's health and development, the family circumstances and environment.
- 3.2 This section presents some evidence from the views and experiences of children and young people of current provision and some of its unintended consequences. It goes on to summarise available research findings on the epidemiology and nature of the health problems in looked after children.
- 3.3 **Figure 3** shows the views of children and young people about the system of health checks based on medical examinations. These views were co-ordinated as part of a consultation exercise undertaken by The Children's Society (Children's Society, 2000). The in-depth consultation was conducted with 14 children.

Figure 3

Views of Current System of Health Checks (medical examination)			
Number who thought statutory health checks were useful for young people who were looked after.	Number who were unsure if statutory health checks were useful for young people who are looked after.	Number of young people who felt statutory health checks were not useful for young people who were looked after.	Number of young people who said statutory health checks made them feel angry.
9	3	2	2
Number of young people who felt confused about statutory health checks.	Number of young people who felt statutory health checks were "boring".	Number of young people who felt statutory health checks were "ok/no problem".	Number of young people who felt "happy" about statutory health checks.
3	2	3	2
Number of young people who felt "unsure/not bothered" about statutory health checks.	Number of young people who have never attended for statutory health check.	Number of young people who received a personal letter for their statutory health check.	Number of young people who did not receive a personal letter for their statutory health check.
2	1	2	12

Epidemiology

- 3.4 Looked after children and young people are amongst the most socially excluded of all children. A series of Government reports have highlighted the health neglect, unhealthy life-style and the mental health needs that characterise children and young people living in care. Looked after children are the epitome of the inverse care law – their health may not only be jeopardised by abusive and neglectful parenting, but care itself may fail to repair and protect health. Indeed it may even exacerbate damage and abuse.

- 3.5 An analysis of some of the data provides a profile of children and young people who are looked after.
- 3.6 During the 12 months to 31 March 2001, a total of 81,200 of England's children had been looked after (Department of Health, 2001a). This figure excluded children in agreed short-term respite placements*. Of these 81,200 children, a little over half, (43,600) were looked after continuously and fewer than a third were new entrants (24,500), of whom 18,200 had no previous history of care. This longitudinal perspective gives a clearer insight into population need than the commonly quoted snapshot view (59,900 children looked after on 31 March 2001). Hence, while approximately 1,200 of England's children will be looked after on any particular day, during a year approximately a third as many again will experience the care system. This dynamic picture is more relevant when planning local service provision. In a PCT serving a 100,000 total population approximately 160 children would be expected to experience being looked after in a year, of whom approximately 50 would be new entrants.
- 3.7 As at March 2001 boys are in a slight majority (55%) and children aged 10 and over are more likely to be looked after. The ethnic origin of 81% of looked after children are reported as White British, the remaining 19% being from a variety of other ethnic backgrounds. (Department of Health, 2001) There is evidence that the latter group is more likely to have adverse health experiences and particular needs in care. When children receiving respite care are excluded, disability was reported as the main 'need for service' code for almost 4% of children who were looked after at 31 March 2001. This figure can be regarded as an under-estimate of the total number of looked after children with a disability, as it only identifies those where the disability was the primary reason that they receive service provision from social services. Further information is available at www.doh.gov.uk/cin/cin2001.htm
- 3.8 Children enter the looked after system for a variety of reasons. Most have experienced parental neglect (by omission or commission) or abuse. Sixty six per cent are looked after under court orders. While the majority of children are looked after by foster carers there is a growing trend for children to be subject to a care order but living at home (11%) or placed with family or friends approved as foster carers (17% of foster placements). A minority of children live in residential homes (13%). Almost uniquely these are older children – only 2% of children in residential care are under 10 years of age. An important overall trend is that children are entering care at a younger age and staying for longer periods.

The nature of health problems in looked after children

- 3.9 Until recently there has been no systematic monitoring of health progress and outcomes in looked after children. Evidence from studies suggests neglect of routine immunisations and screening, lack of appropriate care for known acute/chronic health conditions, and failure to diagnose health and mental health problems.
- 3.10 However, these studies describe small, unrepresentative, uncontrolled samples and are unable to distinguish problems preceding or consequent on the child's care experience. The study by Jackson et al (2000) found that in a comparison of 119 children looked after with 364 non-looked after population controls, the looked after group fared worse for routine dental care, immunisation status and health threatening behaviour. Emotional and behavioural problems were more prevalent and despite a high level of mental health referral, few children received treatment. Hill et al (2000) studied the records of 49 children over 1–2 years in care and found that less than 50% of health care plan recommendations had been carried out.
- 3.11 Evidence from a longitudinal study of looked after children (Skuse, Macdonald and Ward, 2002) shows that 52% appeared to have an identified physical or health condition of sufficient gravity to require outpatient treatment. Fifteen per cent of the sample had two such conditions.

* A further 11,800 children were looked after in England during the year ending 31 March 2001 solely under an agreed series of short term breaks.

- 3.12 Research evidence also shows a high prevalence of mental health problems in children and young people entering care (Dimigen et al, 1999) and particularly those in residential placements (McCann et al, 1996). This indicates the need for children to access specialist CAMHS but, as importantly, the need for carers and other professionals to receive training and consultation from these services.
- 3.13 In 1999 The Office for National Statistics (ONS) undertook a national survey which gives background to the prevalence of mental disorders in children and young people in the general population (ONS 2000). For example among children aged 5-15 years, 5% had clinically significant conduct disorders; 4% were assessed as having emotional disorders e.g. anxiety and depression and 1% were rated as hyperactive. The less common disorders (autistic disorders, tics and eating disorders) were attributed to 1/2% of the sampled population. A national survey of the prevalence of mental disorders of looked after children are currently in preparation. (Meltzer et al, forthcoming)
- 3.14 More rigorous methodology has been possible in America where states have more sophisticated health monitoring of foster care children and an enhanced ability to study health care utilisation through Medicaid claims. These have shown high use of health care, particularly mental health care compared to socio-economically deprived children in control groups.
- 3.15 The Social Services Inspectorate report on services for care leavers in 1997 reported that:

“There was generally no difficulty in accessing primary healthcare services. However, the young people did not know how to get advice about healthy living, safe sex and their emotional development. There were particular problems in obtaining mental health services.” (Department of Health, 1997a)

This finding is confirmed by the findings from a research project to improve the health of young people leaving care which found worryingly high levels of a wide range of mental health problems. The incidence of depressive illness is particularly high. (Broad, 1997)

The annual health assessment

- 3.16 The regulatory framework provides for an annual health assessment of each child over five or young person who is looked after, supported by statutory reviews of their care for which social services are responsible. The objective of these arrangements is to ensure that health needs are properly assessed and appropriate health care interventions provided. Historically, however, the coverage of these assessments has been at best patchy with large regional variations.
- 3.17 Health assessments have been regarded as annual “medicals”, with undue emphasis on the performing of a physical examination with inadequate attention being paid to personal history, birth and family histories, growth and development, emotional health and dental and oral health. Issues such as health promotion and the concerns of children and young people themselves have often been overlooked. Several studies such as Butler and Payne (1997) and Mather et al (1997) have shown that important information about a child’s current and past health is missing or unavailable such as recording of immunisation status and the current or previous GP.

Implementing health care decisions

- 3.18 When they do take place, health assessments frequently identify the need for investigation or specialist referral. (Jackson et al, 2000) (Hill, 2000) However, looked after children experience frequent moves in and out of the care system or between a series of placements. During the year 2000, 18.1 per cent of looked after children moved through three or more different placements. (The national target for

2001 is 16 per cent). This mobility means that health care decisions tend not to be implemented or to be seriously delayed. Although many looked after children have significant mental health or emotional and behavioural problems, Jackson's study showed that as few as 2% may receive the treatment they need or be offered professional support to their carers.

- 3.19 A health care system based on annual "medicals" has made many children and young people feel disengaged from their own health issues. A survey by The Who Cares? Trust showed that 40% of children under 11 felt that they had not received enough health information and advice, and around half of those in children's homes and secure units considered that they put their health at risk in some way. (Who Cares? Trust, 1998)
- 3.20 McGuire et al (1997) found that the requirement to have an annual "medical" is regarded as stigmatising by many children and young people (especially if they are carried out at school or during school time) and this leads many to refuse attendance.

A whole system problem but not unique to this country

- 3.21 The problems described above and which this guidance seeks to address are those of a health system in England and Wales which is not working well enough to meet the needs of children and young people who are looked after. These systemic problems are not unique to the United Kingdom. Similar difficulties in managing information and health care decisions have been described in Western Australia. (Clare, 2000)

4. Principles of Good Health Care

- 4.1 Health assessments and health plans will promote the current and future health of the child or young person who is looked after and not focus solely on the detection of ill-health. Health assessments will cover a range of issues beyond those of physical health which include developmental health and emotional wellbeing.
- 4.2 The individual child or young person should be at the centre of the process of health assessment, planning, intervention and review. Each child or young person must be given the opportunity at all stages to express their wishes and concerns and these should be listened to. Health professionals should conduct health assessments in a way that enables and empowers children and young people to take appropriate responsibility for their own health.
- 4.3 Health assessments and services for children and young people who are looked after should be sensitive to age, gender, disability, race, culture and language. They should be non-discriminatory and promote equality of access to services.
- 4.4 The Council with Social Services Responsibilities (CSSR) must fulfil the role of an active concerned parent in promoting and monitoring the child or young person's health and development and should, where possible and appropriate, actively involve the child or young person's birth parents.
- 4.5 Children and young people who are looked after should have "timely" access to services in accord with their significantly increased need for health care compared with their peers, and the access problems caused by their greater mobility.
- 4.6 The child or young person's informed consent to all health care and treatment should be actively sought and recorded in a way appropriate to the child or young person's age and understanding.
- 4.7 Assessments should be conducted within a standardised and systematic framework. A protocol should be used to assess physical health, but consideration should also be given to the use of validated and reliable instruments with which to assess development, disability, learning difficulty and the need for mental health services.

5. The Roles and Responsibilities of Councils

Duties to children

5.1 Councils have a duty to promote the welfare and ensure the wellbeing of **all** children who are looked after by them. This means that Councils must put in place arrangements to ensure that every child who is looked after has:

- a. his/her health needs fully assessed;
- b. 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
- c. his/her health plan reviewed

in accordance with regulations and best practice to ensure delivery of a high quality service which meets the needs of the children and young people.

This requires Councils to make plans at a strategic level to ensure local delivery of these arrangements and at operational level to act as an advocate for each child in their care.

Strategic level

5.2 Strategic service planning to improve the health of looked after children will take place within the local structures for planning and delivering co-ordinated services for children and young people. The relevant guidance is Children's Services Planning: Guidance issued jointly by the Department of Health and Department for Education and Employment in 1996 and Co-ordinated Service Planning for Vulnerable Children and Young People in England issued on 8 May 2001 (www.doh.gov.uk/scg/childplan.htm).

5.3 Strategic planning requires a number of elements to be in place:

- clear objectives and priorities;
- an agreed planning cycle;
- a coherent framework;
- reliable management information systems;
- effective consultative mechanisms;
- robust monitoring and quality assurance systems;
- active participation of children and young people;
- integration with other planning mechanisms and specific initiatives for children who are looked after;

- new ways of joint working, which utilise the new opportunities for joint funding and breakdown some of the organisational boundaries that hinder progress;
- effective mechanisms for service delivery.

Strategic planning is a corporate responsibility and to be effective it requires that a senior manager within the authority has designated responsibility for this function.

Turning data and information into action

- 5.4 Councils should continue to develop mechanisms to identify and quantify need, to set clear objectives and priorities to facilitate better targeting of resources and more effective delivery of services. Reliable information should inform and lead to action and improvement. Practice and research have shown that the collection and publication of hard information at a local level about the position regarding the health of looked after children has provided the impetus for action.
- 5.5 CSSRs and the NHS should have in place protocols which establish the framework for information sharing at an intra and inter-agency level.

The protocol should set out:

- who has access to what information, and how data security is ensured;
 - arrangements for seeking consent to information sharing;
 - how children, parents and other third parties are informed of, and allowed to challenge, information that is kept on them;
 - how carers contribute to and receive information;
 - mechanisms for sharing information between social services and PCTs.
- 5.6 The protocol should also cover arrangements for informing, and gaining information from other councils. Councils need both to monitor the position of children from their area placed outside the authority, and similarly to advise other Councils who have sent children into their authority.

Placements outside the boundary of the local authority

- 5.7 Placements outside the boundary of the CSSR are known to create additional problems in meeting the needs of the child and in ensuring access to health services which are required. Such placements should not be made without first making arrangements to secure appropriate health services for the child. (See paragraphs 6.11–6.18 for details of the Responsible Commissioner arrangements including the continued implementation of a current health plan.) This requires effective liaison between relevant personnel in Councils and health services to make these arrangements.
- 5.8 Notification of placements required under the Arrangements for Placement of Children (General) Regulations 1991/2002 are particularly important when children are placed out of authority to ensure fast transfer of records, and identification of health needs and continuity in any current treatment.

- 5.9 CSSRs should have agreements and protocols with relevant health service providers, which enable arrangements for meeting the child's health needs to be made prior to placement. Councils will need to monitor closely the arrangements to ensure that the child's health needs are being met. The review process provides the mechanism for this, and the Council should consider direct reporting arrangements to the designated senior manager on every child placed outside the area after each review to ensure that the needs of this group are not lost. Regular reports should also be provided to elected members to enable them to fulfil their corporate parenting responsibilities. Consideration of the availability of local health resources relevant to an individual child's needs must be a key consideration in identifying an appropriate placement.
- 5.10 At present CSSRs and PCTs are required to monitor, for all looked after children and young people:
- proportion who have a health assessment each year;
 - proportion who have seen a dentist each year;
 - immunisation rates.
- 5.11 Over time further performance indicators will be developed which can demonstrate improvements to the health of looked after children and performance monitor the effectiveness of service delivery.

Operational level

Management and delivery of services

- 5.12 Councils should ensure that a senior manager within children's social services has specific responsibility for the health of looked after children. The post-holder should have responsibility for:
- effective liaison with health and health related services;
 - ensuring clear lines of communication between organisations and within the Council;
 - ensuring that staff and carers have the appropriate skills and knowledge including positive mental health promotion;
 - ensuring that staff and carers receive regular supervision and can access consultation where appropriate;
 - policy and procedures within Councils which are child centred and which promote the achievement of the health of looked after children;
 - ensuring clear policies, procedures and protocols are in place which set out the roles and responsibilities of staff and carers and which are informed by best practice and research, are up-to-date, and comply with legislation;
 - the operation of effective management information systems for monitoring performance against government and local objectives;
 - ensuring that each looked after child has a named social worker;
 - arrangements for ensuring that all looked after children are offered and take advantage of a health assessment which is carried out by an appropriate team of health professionals who are sensitive and alert to their particular needs and within appropriate time-scales;

- ensuring that all looked after children have a care plan and a health plan, which are made and reviewed within statutory time-scales;
- establishing effective reporting arrangements when a child does not have a health assessment or a written health plan as required;
- resolving difficulties or problem areas in the system;
- ensuring speedy resolution of health issues for individual children i.e. a fast-track procedure to prevent delay in resolving disputes or difficulties between authorities and other relevant parties which may impact on the child's health;
- ensuring that the notifications to other Councils and PCTs are made when children and young people move.

5.13 Responsibilities of the social worker in ensuring that the child's health needs are met will include:

- initiating a health assessment with the child or young person, parent and/or relevant family member, carer and relevant health professionals;
- developing a health plan from the assessment;
- checking and securing the availability of appropriate services to meet these needs when making arrangements for his/her placement;
- informing the individuals and authorities as set out in the Arrangements for Placement of Children (General) Regulations 1991/2002 before the placement is made;
- ensuring that care plans and health plans are made and reviewed, in accordance with the statutory requirements. Where this does not happen, the social worker should report this to a designated manager within the department.

Care planning and reviews

5.14 The Children Act 1989 and accompanying regulations and guidance provide a clear framework for making arrangements for the placement of children. Four key processes can be identified as follows:

- assessment;
- planning;
- intervention; and
- review.

These are set out in detail in Chapter 8.

Summary

- Councils should put in place arrangements to ensure that every child who is looked after has:
 - a. his/her health needs met
 - b. a health plan, which sets out how the health needs identified in the assessment will be addressed
 - c. his/her health plan reviewed
- corporate parenting means acting as the advocate for each child in the care of the Council to ensure that he/she accesses the health services they need;
- to achieve this, Councils will need to work in partnership with Primary Care Trusts at both strategic and operational levels to ensure effective delivery of health services;
- Councils should continue to develop mechanisms to identify and quantify need, to enable clear objectives to be set, and resources to be targeted;
- each local authority has a duty to establish and maintain a protocol for sharing relevant information about care placements and health, both within the local authority boundary and outside it;
- placements outside the boundary of the CSSR should not be made without first making arrangements to secure appropriate health services for the child;
- Councils need to have a system in place to monitor whether children's health needs are being met. The review process is the normal mechanism for doing this on an individual basis, but the system needs to capture children placed outside the area;
- Councils should ensure that a senior manager within social services has specific responsibility for the health of looked after children;
- the individual child's social worker is responsible for ensuring each stage of the health assessment, plan, implementation and review is initiated and where any problems are encountered, report these to the designated manager.

6. The Roles and Responsibilities of the NHS

- 6.1 The NHS has a clear role in ensuring the timely and effective delivery of health services to looked after children and young people. Under the Children Act 1989 and amended legislation Primary Care Trusts (PCTs) and Strategic Health Authorities (StHAs) have a duty to comply with requests from the CSSR to help them to provide support and services to children in need. For this duty to be discharged effectively for looked after children there must be local NHS involvement at the strategic level and in relation to the provision of care to individual children and their carers.
- 6.2 PCTs should ensure they participate in local inter-agency planning through contributing to the local strategic plan.
- 6.3 PCTs, with CSSRs should therefore examine local arrangements to promote the health, including dental health, of children and young people who are looked after. Services should be co-ordinated across agencies integrated where appropriate and information transfer actively managed. This is discussed further in section 13 of this guidance.
- 6.4 A service level agreement should be in place where the designated professionals are employed by a different trust. This should include a minimum quality and performance standard, signed off both by social services and the local PCT.
- 6.5 **As commissioners of health services for looked after children/young people and other children in need, Chief Executives of PCTs should:**
- ensure that the health of children and young people who are looked after is an identified local priority;
 - ensure that structures are in place to plan, manage and monitor the delivery of health care to all children and young people who are looked after;
 - in collaboration with social services, identify a designated doctor and nurse to provide strategic and clinical leadership and advice to a defined geographical population. Where the boundaries of the CSSR and PCT are co-terminus (as with the majority of London Boroughs) arrangements will be more straightforward. Where the boundaries are not co-terminus arrangements must be made to ensure complete and coherent coverage of a CSSR either by the designated doctor and nurse from several PCTs working closely together to an agreed protocol or by one PCT undertaking the designated functions on behalf of several PCTs;
 - ensure that clinical governance and audit arrangements are in place to assure the quality of health assessments and health care planning;
 - ensure that there is a named public health professional who will input into children in need issues including child protection as necessary. Looked after children are part of this wider group of children in need;
 - ensure that health professionals performing health assessments and contributing to health care planning have received appropriate training;

- where a child or young person is placed away from the responsible CSSR ensure systems are in place to provide continuity of the health assessment and health planning process;
- ensure that systems are in place to ensure children and young people who are looked after are registered with GPs and 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), ensure systems are in place to “fast-track” the GP-held clinical records and dental records;
- through the commissioning process ensure that, 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;
- ensure that arrangements are in place for the transition from child to adult health services;
- ensure that an appropriate data set is collected and reviewed at least annually (a suggested data set is provided at Appendix 2);
- together with colleagues in local authority services, monitor and review the arrangements and service against agreed targets, to ensure a robust service is in place.

Care Trusts

- 6.6 Care Trusts are NHS bodies which work in both health and social care. Some groups of children have complex needs and the integration of services is vital to improving the care they receive. This is particularly important for children with disabilities, special needs and children and adolescents with mental health problems. The Care Trust model can enable the services for children from acute health, community health and social services to be combined, along with other key services for children with disabilities. Another possibility could be based on the commissioning and providing model, focusing on child and adolescent mental health services. In this instance, the links between these services and other key services such as education would need to be effective and carefully thought-out.

Children's Trusts

- 6.7 Children's Trusts will enable local partners to jointly plan, commission, finance and deliver services for children. The Trusts are intended to ensure children and their parents receive better co-ordinated services geared to meeting individual needs, rather than being centred on organisational structures and agency boundaries.
- 6.8 The range of services that could be included in Trusts is very wide, and will need to be decided locally by local partners to fit what is needed and what works for local circumstances. Services to be included might span (for example) combinations and variations from the list below:
- services for disabled children;
 - children with special educational needs;
 - child protection;

- identification, referral and tracking of children at risk;
- speech and language therapy;
- child and adolescent mental health services; and
- areas where social care, health and education services need to work together.

Role of Strategic Health Authorities

- 6.9 The role of Strategic Health Authorities is to ensure through monitoring and performance management processes, that all the PCTs and Trusts within their area have robust systems to implement this guidance, and to implement any subsequent changes issued by the Department of health.
- 6.10 Strategic Health Authorities also have a developmental, supportive role in helping PCTs to carry out their functions.

The Responsible Commissioner

Looked after children

- 6.11 Children who are looked after by Local Authorities are usually placed with foster carers or in a residential home for children. The responsible PCT should be established by the usual means identified in paragraph 9 of the guidance on *Establishing the Responsible Commissioner* consultation document (Department of Health, 2002a) (i.e. the name and address of the GP with which the child is registered or, the address of the foster carer or children's home).
- 6.12 When a child is first placed by a Local Authority they have 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. When time allows, the relevant PCT should be informed in writing by the responsible Local Authority of its intention to place a child in its area and should be advised whether the placement is intended to be long or short term. Some placements need to be arranged urgently and prior notification will not always be possible. In these cases the relevant PCT must be notified within two weeks.
- 6.13 If a looked after child moves, arrangements should be made, in discussion between those currently providing the health care and with the new PCT and relevant specialist services to ensure continuity of health care. Continuity in some circumstances may involve continued care from the original provider until a handover can be arranged. Any changes in the health care commissioning responsibilities must not be allowed to disrupt the ultimate objective of providing high quality, timely, care for the individual child or young person. It is important to ensure a smooth hand-over of clinical care where that is the agreed best plan for the child. A new assessment should not always be necessary.
- 6.14 When a child who is looked after reaches the age of eighteen, the responsible PCT is determined by the name and address of the GP with whom the child is registered. If this is not possible, then the usual address of the child on his or her eighteenth birthday will identify the responsible PCT unless the child is attending a special school.
- 6.15 Where 'looked after' children attend boarding or special school, the rules set out in paragraphs 45–47 of the guidance on *Establishing the Responsible Commissioner* will apply.

Boarding school pupils, special school pupils

- 6.16 Pupils attending boarding schools are considered to be resident at the location of the school and not at their parents' or guardians' address and the school will be responsible for organising the provision of primary care services through local PCT(s), therefore the responsible commissioner will be determined as the PCT that the school is attached to.
- 6.17 Pupils attending or boarding at special schools (a special school is a day or boarding school that caters exclusively for children with special needs, including learning difficulties and other special educational needs) are the responsibility of their 'home' PCT (derived from the name and address of their registered GP before placement), except for the provision of general primary care services which will be the responsibility of the host PCT. This will also apply to children placed by social services or through joint funding arrangements between PCTs, social services and local education authorities.
- 6.18 Where a pupil is attending a special needs college, who has been placed out of area by a PCT, Local Authority or Local Education Authority reaches the age of 18 the responsible commissioner will be determined as the 'home' PCT until the placement has ended i.e. until the age of 21.

Contribution of Primary Care Teams

- 6.19 Primary care teams have an important role to play in the identification of the 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.

Primary care teams should:

- act as advocates for the health of each child or young person who is looked after;
- ensure 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;
- ensure 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;
- ensure 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;

- the general practitioner-held clinical record is unique 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.

The roles of the designated doctor and nurse

- 6.20 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. In many places such an arrangement has already been developed. Any job description should be jointly agreed by the PCT who is acting 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 CSSR(s). 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.
- 6.21 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.
- 6.22 The **designated doctor** will:
- be a senior paediatrician (preferably, but not necessarily, a consultant community paediatrician);
 - have undergone higher professional training in paediatrics;
 - 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.
- 6.23 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.
- 6.24 As with the designated doctor, this appointment is in part to assist the PCT in fulfilling its responsibilities as commissioner of services to improve the health of looked after children. Additionally it is likely to be appropriate for the designated nurse to provide both a direct clinical service to looked after children and to support nurses and health visitors who will be seeing these children and their carers.

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

Advisory role

- providing advice to the PCT on questions of planning, strategy and the audit of quality standards in relation to health services for looked after children;
- working with PCTs to monitor performance of local health services for looked after children and young people;
- ensuring that expert health advice on looked after children is available to social services, PCTs, residential children's homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff;

- advise colleagues in health and social services 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;
- develop policies and procedures and ensure those providing healthcare to looked after children are aware of local policy and procedures and their role;
- contribute to local children'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 social services and other PCTs over health assessments and personal health plans for out of borough 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 care 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 NHS Plan targets and other relevant performance indicators.
- 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 who commissioned it, the Director of Social Services and available to the Strategic Health Authority and regional offices for monitoring purposes.

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 should 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;
- such performance management arrangements are already required to be in place for designated professionals responsible for child protection where 'designated professionals are to be performance managed in relation to their functions by the PCT Director of Public Health'. (Department of Health, 2002)

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 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.

Summary

The Chief Executive of Primary Care Trusts should:

- ensure they participate in local inter-agency children's services planning;
- ensure that the health and wellbeing of children and young people who are looked after are an identified local priority;
- ensure that structures are in place to plan, manage and monitor the delivery of health care to all children and young people who are looked after;
- in collaboration with the local social services, should identify a designated doctor and nurse to provide strategic and clinical leadership, and advice to a defined geographical population;
- where the designated professionals are employed by a different trust, ensure a service level agreement is in place, setting out a minimum quality and performance standard;
- ensure clinical governance and audit arrangements are in place;
- ensure health professionals performing health assessments and contributing to health care planning have received appropriate training;
- ensure systems are in place to ensure children and young people who are looked after are registered with a GP and dentist near to where they are living, even when this is a temporary placement;
- ensure systems are in place to fast track the GP records and dental records when a looked after child is newly registered;
- ensure systems are in place for children moving into the area, to wait no longer than a child already in that area who has an equivalent need;

- ensure arrangements are in place for the transition from child to adult services;
- ensure an appropriate data set is collected and reviewed at least annually;
- together with local authority colleagues, monitor and review the local arrangements and service, against agreed targets, to ensure a robust service is in place.

The Strategic Health Authority should:

- ensure PCTs have robust systems to implement this guidance and any subsequent guidance, through monitoring and performance management processes;
- provide support and development to PCT's to help them fulfil their role.

Responsible Commissioner

- when a child is placed outside the CSSR boundary, they remain the responsibility of the home CSSR;
- when a child moves from one PCT area to another, the new PCT area is responsible for meeting the child's health needs;
- the child should be fully registered with a GP in the new area they are living in, as soon as possible;
- the placing CSSR is responsible for ensuring a health assessment is undertaken and a health plan drawn up;
- it is recommended that the designated doctor from the area the child moves from, undertakes this on their behalf, liaising with the designated doctor and other health services in the new area as appropriate;
- the first health plan should make it clear who will be clinically responsible for reviewing the plan, and for follow up assessments;
- it is recommended that the designated doctor for the placing authority, retains a monitoring function to ensure the child's health needs are being met;
- the child should have access to all services locally as soon as he/she moves, unless it is clinically more appropriate for he/she to attend specialist services where they are already known;
- when a child has complex health needs, the availability of suitable local services should be considered before placement. The existing health plan should continue to be implemented;
- where a looked after child attends boarding or special school, the rules set out in paragraphs 45–47 of the Responsible Commissioner Guidance apply.

Contribution of Primary Care Teams

The primary care team have an important role to play, particularly in many instances in providing continuity before, during and after the child is looked after. They should:

- act as advocates for the health of each looked after child/young person;
- ensure timely, sensitive access to an appropriate member of the team;
- ensure referrals to specialist services are timely to address the inequalities of looked after children;

- provide timely summaries of health information;
- maintain a record of the health assessment, and contribute to any action in the health plan as necessary;
- ensure clinical records identify the “looked after” status of the child/young person, so that their particular needs can be acknowledged;
- regularly review the clinical records and contribute information to each review of the health plan.

Roles of the designated doctor and nurse

- assist the PCTs in fulfilling their responsibilities as commissioners of services to improve the health of looked after children;
- advise the PCT on, and contribute to, planning, strategy and audit of quality standards for health services for looked after children;
- provide expert advice;
- take a strategic overview of the service, and monitor the quality;
- ensure robust clinical governance arrangements within NHS services;
- develop and ensure awareness of relevant policies, procedures and roles;
- maintain regular contact with health staff undertaking health assessments;
- liaise with social services and other PCT’s for out of authority placements;
- produce an annual report;
- ensure all staff are appropriately trained.

7. Joint Planning across Health and Social Services

- 7.1 There are two key areas where services need to be commissioned, planned and delivered across health and social care agencies.

Contraception and sexual health services

- 7.2 The Government's Teenage Pregnancy Strategy aims to halve the under 18 conception rate by 2010, with the NHS Plan setting an interim target of a 15% reduction by 2004. Reducing the under-18 conception rate is also a Department of Health Public Service Agreement (PSA) target and is part of the Public Service Agreement for local government. The provision of effective contraception and sexual health services for young people, and help to develop the necessary skills to resist peer pressure to have early or unwanted sex are key strands of the strategy.

Many health and social care professionals will already be aware of their local teenage pregnancy strategy and teenage pregnancy co-ordinator. For those who do not, however, details can be obtained from the Teenage Pregnancy Unit on **020 7972 5098**, e-mail **MB-Teenage-Pregnancy Unit@doh.gsi.gov.uk** or through the website **www.teenagepregnancyunit.gov.uk**.

- 7.3 All young people, including those who are looked after or are care leavers, can face a range of obstacles to accessing contraception and sexual health services including embarrassment, confidentiality, location and opening hours, the atmosphere of many places and confusion about the legality of seeking contraception if under 16. In delivering contraceptive and sexual health services it is vital that those factors including the location, opening times, and confidentiality are addressed. The criteria for commissioning and providing effective services are set out in *Best Practice Guidance On The Provision of Effective Contraception and Advice Services for Young People*. (Department of Health Teenage Pregnancy Unit, November, 2000b).
- 7.4 Particular attention should be paid to boys and young men who currently form a small percentage of attendees of these services. In addition, many young people from black and minority ethnic groups face multiple disadvantage which may impact on their capacity to access services. Further information is contained in *Guidance for Developing Contraception and Advice Services to Reach Boys and Young Men* (Department of Health Teenage Pregnancy Unit, April 2001c) and in *Guidance for Developing Contraception and Advice Services to Reach Young People from Black and Minority Ethnic Groups* (Department of Health Teenage Pregnancy Unit, April 2001d).
- 7.5 Social work professionals and foster carers have a key role, and professional duty, to ensure that looked after young people (including under 16 year olds) and care leavers are encouraged to seek contraceptive and sexual health advice if it appears that they are, or are likely to be, sexually active. Further information about the proactive role that they can play in supporting young people to access early advice is set out in *Guidance for Field Social Workers, Residential Social Workers and Foster Carers on Providing Information and Referring Young People to Contraceptive and Sexual Health Services* (Department of Health Teenage Pregnancy Unit December, 2001e). This guidance has been distributed to Chief Executives, Directors and Assistant Directors of Social Services. Copies of the Guidance are available from **www.teenagepregnancyunit.gov.uk**

- 7.6 Many vulnerable young people may, through lack of self-esteem, feel less able to make their own choices about early or unwanted sex. Social work professionals and foster cares should therefore offer young people support to develop assertiveness and negotiating skills to help them resist any pressure to have early or unwanted sex.
- 7.7 Teenage pregnancy co-ordinators have developed service publicity for young people and a checklist of local services to help professionals working with young people to make quick and appropriate referrals. Details of local services to which social work professionals and foster carers can refer young people to are also available from:
- fpa (England) 020 7837 4044
The Brook Helpline 0800 0185 023 (freephone)
www.fpa.org.uk
www.ruthinking.co.uk

Young people and drugs – providing effective services

- 7.8 Feedback from children and young people indicates that they want honest and credible information on drugs, including alcohol, tobacco, solvents and volatile substances, prescribed and non-prescribed medication and illegal drugs. They want opportunities to increase their knowledge and understanding and develop the skills they need to access support and cope with situations that they may face in the future. (Drug Education Forum, 2000)
- 7.9 All children and young people are entitled to drug education and support and the National Healthy School Standard (NHSS) offers an important model for the delivery of effective drug education in schools, within the context of Personal, Social and Health Education (PSHE) and Citizenship. Children and young people do not think about drugs in isolation but relate it to other issues and concerns in their lives. PSHE and Citizenship provides an important context within which a range of health issues including emotional health and wellbeing, (including bullying), mental health, drug misuse (including alcohol and tobacco), sexual health and healthy eating can be discussed in an integrated way.
- 7.10 Research into drug taking by young people in general indicates that the majority of young people who experiment with drugs will not experience harm. However a significant minority will go on to develop problematic drug use. There is evidence to suggest that looked after young people are a group who are particularly vulnerable to developing drug misuse problems. Research indicates that looked after children engage in more drug use and at a younger age than other children and young people. Their levels of solvent and alcohol use have been highlighted as being of particular concern. Anecdotal evidence also indicates that the perception of some professionals is that looked after children who use drugs are at risk of progressing to more chaotic drug use at times of stress and crisis, and highlights the importance of them having access to credible information and effective support.
- 7.11 Looked after children may be less likely to access drug education and support at school and it is crucial that other opportunities are available for them to receive the information and support that they need.
- 7.12 The Government's 10-year national drugs strategy *Tackling Drugs to Build a Better Britain* highlights parent and carer involvement as an important factor in the success of drug education provision. Parents, carers and extended family are often anxious about drugs and their effects and sometimes feel that they lack confidence and skills in discussing drugs with their children and siblings. Parents, carers and families need support if they are to fulfil this role effectively.

- 7.13 Residential care workers and foster carers have an important role in providing support that complements drug education provision in schools and ensuring that looked after children are aware of local services and that they feel confident and equipped to access them.
- 7.14 On behalf of the Department of Health, DrugScope has produced policy guidance for Councils. The document aims to assist elected members, managers, practitioners and parents/carers with responsibility for looked after young people, to develop and implement local policy and good practice. (DrugScope, 2002)
- 7.15 The Drug Education Forum (DEF) and National Children's Bureau (NCB) Residential Care Unit in collaboration with Councils is producing practice guidance for residential care workers and foster carers. This will offer concise and practical support to enable them to provide effective support to looked after children on drugs. An important part of this project is the opportunities that NCB and DEF will develop with local partners for looked after children and young people to participate in the development of policy and practice.
- 7.16 The Department of Health also provides funding to Adfam, a national charity, to support its work with friends and families of drug users. Department of Health funding is enabling them to set up family support groups in areas where none exist, and train people to run and support these groups.
- 7.17 At local level the range of partners can work together to ensure the provision of effective drugs education and services for children and young people, including looked after children. Local planners such as Drug Action Teams (DATs), Local Healthy Schools Programmes and Primary Care Trusts (PCTs) can ensure that the needs of looked after children are reflected in local plans including:
- Young people's substance misuse plans;
 - Local education and health partnership NHSS Action Plan;
 - CAMHS Development Strategies;
 - Behaviour Support Plan;
 - Education Development Plan (EDP);
 - Youth Justice Plan.
- 7.18 The 2001 Health Advisory Service (HAS) report (an update to their 1996 report) makes a series of recommendations on the commissioning, design and delivery of services and interventions. This includes making sure that 'services are child and young person centred, comprehensive and competent, respectful and protecting of children and families, sensitive and relevant to diverse populations, and work within the spirit of the law'. The Government's response to this report is currently being developed and will be published towards the end of 2002.

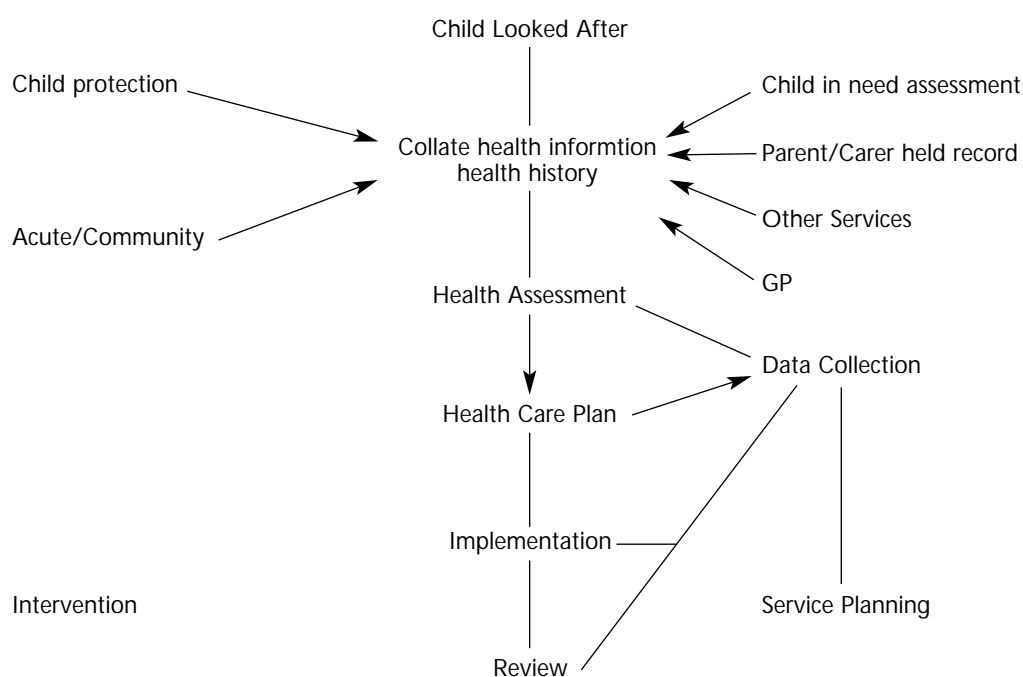
Summary

- there are 2 key areas where services need to be commissioned, planned and delivered across health and social care agencies:
Contraception and sexual health services
Young people's drugs services
- looked after children and care leavers are particularly at risk of teenage pregnancy and are more vulnerable to and engage in more drug use, and at a younger age than other children and young people;
- young people say they want to increase their knowledge and understanding about drugs, and develop the skills to access support and cope with situations;
- staff and carers have a key role in providing information and support to looked after children and young people related to these issues. All staff and carers need to be aware of local services;
- information can be obtained from the local teenage pregnancy co-ordinator and the teenage pregnancy strategy;
- a range of information, support and policies are newly developed.

PLANNING FOR GOOD HEALTH OUTCOMES INCLUDING STRATEGIC PLANNING

PLANNING PROCESS – FLOWCHART

The flowchart outlines the planning process for health assessments and health care plans. (A more detailed example is included at Appendix 5).



8. Health Assessment, Planning, Intervention and Review

Young People's Messages

Health assessments and health history

'If you are either no longer in touch with or are on bad terms with your birth family then it is impossible to ask them if you had all your vaccines when you were a baby.'

'There are also issues about family medical history ... young people ... face not only a very embarrassing situation when they are unable to fill in that section on a form but also the concern that many young people will not know if there are any hereditary diseases in their birth family.'

'I want a choice to go to my doctor's when I feel unwell. I don't want Social Services telling me when I should go.'

'No one has ever explained what a health assessment is for.'

'Just have them come to the house. Come up for a few weeks and get to know you, first and then just say 'do you want to have your health check?' Because you might not want to go to the medical centre, if you don't know someone you are stuck with it.'

'I think if you gave the young person a bit more to do with it ... Like saying you don't have to do this, or like being a bit more sensitive about subjects that may be upsetting to them.'

'When it came to my carers, they stayed and it felt like you couldn't ask personal questions ...'

Assessment

- 8.1 A health assessment should be in place in time for a written report and health plan to be available for discussion at the child's first review, four weeks after the child starts to be looked after. The progress made in implementing the plan should be considered at the second 4 month review and the plan should be modified in light of any additional information that has been collected. Thereafter consideration of the child or young person's health will form an integral part of their review.
- 8.2 If there is concern about possible abuse or neglect then the child should be seen immediately at the start of a care episode, or if the child has an acute medical problem then he/she should be seen for this without delay. Where there are concerns over the child's growth it would be expedient to arrange for baseline measurements to be taken at the time of placement. Such a consultation alone will not usually provide the information required for a full health assessment.
- 8.3 Increasingly it will be found that children being looked after have already been recently assessed under the new Assessment Framework as children in need. When this is the case the assessment should be modified to ensure that there are no gaps in information or planning. If the child has been seen for a

health assessment by a suitably qualified doctor in the previous three months a new assessment is unlikely to be necessary, but ensuring appointments are rebooked and researching family health history may need to be undertaken and any existing health plan should be reviewed and updated. Although the child's needs may not have changed the actions required to meet these needs may require amendment to take account of the child's changed circumstances.

- 8.4 At the point the child becomes looked after the social worker should review existing health plans and consult with other professionals as necessary to determine if immediate changes are needed to meet the child's health needs prior to the first review. Social workers will need to ensure that there is sufficient information relating to the child's immediate health needs available prior to placement, in accordance with the Arrangements for Placement of Children (General) Regulations 1991/2002. Where appropriate the local health care professionals should obtain information from the previous health community. It is also very important to ensure that this information is written down and shared with the carers.
- 8.5 It may be helpful to agree one health professional who will co-ordinate the gathering of information and the health plan. This may be the designated doctor or nurse, or another appropriate professional.

Collating information before health assessment

- 8.6 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 social 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 or health "fax";
 - 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.

Appendix 3 provides guidance on immunisations for children/young people with unknown immunisation status.

- 8.7 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 health authority or PCT of the previous GP).
- 8.8 Collating this information and organising the transfer of records to the appropriate place or person is a time-consuming activity. Some Councils and health agencies 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

- assessment of health risk and 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
- assessment of current health and mental health concerns
- review and advise on known existing health problems
- ascertain outstanding appointments
- 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

Approach to the assessment

- 8.9 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.
- 8.10 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 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.
- 8.11 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.

Assessment content recommendations

- 8.12 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 (see planning flowchart).
- 8.13 The aim should be to enable the child to have their 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.
- 8.14 A health assessment should be seen as an opportunity to review the child or young person's overall health, development and wellbeing. Attention should also be paid to the child or young person's behavioural and emotional development including evidence of health risk taking behaviours.
- 8.15 Information will be obtained from discussions with carers and 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 their carer may have and to advise them where further information can be obtained.
- 8.16 The doctor carrying out the assessment has a duty of clinical care to the child, and includes making any necessary referrals for investigation and treatment of conditions identified at the assessment. If the placement is to be brief this should not be used as an excuse not to follow up concerns. If the child returns home every effort should be made to continue to implement the health care plan.
- 8.17 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 lose a place on a waiting list.
- 8.18 The content of the assessment should be age sensitive and developmentally appropriate. The recommended content for the different stages of childhood are outlined in **Appendix 4**.
- 8.19 The health care plan will specify who should undertake review assessments of the child's health. In many situations it may be appropriate for an appropriately 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.
- 8.20 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.

Care plans and health plans

- 8.21 The health plan should be developed from the health assessment. A child's health plan is part of the overall plan for meeting the child's developmental needs. While the health assessment is led by the team of health professionals, the social worker will bring together all the information gathered in the assessment, with all professionals involved, including the child, carers and parents, except where there are specific reasons for not including them, in which case these should be clearly recorded on the child's file, to construct the health plan for the child.

- 8.22 It is a requirement that other than in emergencies, the responsible authority should have a written care plan for the child prior to placement. Clearly the level of detail within the plan at the time of placement will be dependent on the amount of information gathered in advance. One of the critical factors in determining suitability of a placement and in achieving stability is ensuring that a child's health and educational needs can be met within the placement. Issues concerning placements outside the Council or PCT area have been discussed in section 6.
- 8.23 Each child or young person's health plan should follow a broadly similar structure, but the content will vary. It should set out both short-term and longer-term objectives together with the actions needed to achieve them. It should address how to provide health advice and health promotion, including age-appropriate information on lifestyle, diet, exercise, sexual behaviour, risky behaviours (e.g. substance misuse), in addition to guidance and support on the management of specific health problems.

A brief description of identified health issues should be followed by clearly headed action points, with a time-scale by when they should be actioned, and who is expected to act.

Providing services: implementing the health plan

- 8.24 There is ample evidence cited earlier that health care decisions for children and young people who are looked after are often not implemented. For example, glasses are not prescribed, immunisations and dental check ups are missed, hearing tests are omitted, investigations not carried out. These failures occur more commonly than is the case for their peers in the general population, partly because of increased mobility, but mainly because the information gets lost before it can be acted on or there was lack of clarity about where responsibility lay for ensuing action.
- 8.25 The implementation of each child or young person's health plan requires a systematic check through the action list to ensure things happen when they should. The co-ordinating role, as mentioned in paragraph 8.5 would undertake this.
- 8.26 It is the responsibility of the designated doctor and nurse to ensure that there is a local system in place to deliver this responsibility. Where there is a dedicated service providing health assessments, this responsibility should be identified within the service level agreement. The service level agreement will also outline the role of the designated doctor and nurse in monitoring individual health care plans.

Reviews

- 8.27 Reviews are a key element of the continuous process of assessment, planning, intervention and review – reviewing plans and decisions, monitoring the child's progress and implementation of agreed actions, as well as taking account of changes in the child's circumstances. Reviews act as an important safeguard for the child or young person.
- 8.28 CSSRs have a duty to consult with all relevant agencies and individuals as part of the review process. The social worker should discuss the progress in achieving the objectives in the child's health plan with relevant health professionals prior to a review meeting. Discussing personal health matters with a child requires sensitivity at all times; the social worker must take account of the child's needs and wishes in accordance with his/her age and understanding, as to how to manage the review of the health plan and what information the child or young person wishes to be shared in a meeting. Preparation for a review requires consideration of the most appropriate professionals to attend the meeting and whether their contribution may best be made outside the meeting. As with the development of the health plan, its review should form part of the review of the care plan and should not be carried out in isolation.

For children and young people with complex needs the health plan may need to be reviewed in between reviews of the overall care plan. A format for recording the health plan is contained within the Integrated Children's System.

- 8.29 The Review of Children's Cases Regulations 1991/2002 set out maximum time-scales for conducting further assessments of a child's health. These are at least once in every six months for children under five and at least once a year after a child's fifth birthday. However, when needed more frequently, the child's health plan should clearly set out the arrangements for achieving this. The social worker is responsible for co-ordinating this process, but should be supported by a designated professional or a professional undertaking a co-ordinating role.
- 8.30 From the start of the care episode the health plan will usually be reviewed concurrently with the care plan – within 28 days, 4 months, 10 months and thereafter every 6 months. However, reviews can take place at any time in response to arising needs, relevant changes or at the request of the young person. Significant decisions about a child or young person's health should not be made without reviewing the health plan and this must involve the child or young person.
- 8.31 The lead health record for every looked after child should be the GP-held record which should include information about dental and oral health status. Arrangements should be made to fast-track existing GP records to ensure they are available as soon as possible after a child moves. Every effort must be made to ensure the child does not end up with a series of "temporary" records. Additional records used will depend on local circumstances, but should also include a completed health assessment and a regularly updated health plan to be shared with the social worker, carers, child and usually the birth parents and integrated with statutory reviews.

Summary

- each child or young person should have a holistic health assessment on entering care;
- this assessment should be undertaken by a suitably qualified medical practitioner, but 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, four weeks after becoming looked after;
- where children have already been assessed under the Assessment Framework, this assessment should be updated in the light of the child's changed circumstances;
- attention should be given to the continuity of previous plans and interventions where appropriate;
- all health 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;
- health assessment is not an isolated event, but part of a continuous process;
- successful health assessments will require a flexible approach, appropriate to the child or young person's age and stage of development;
- the health plan should clearly set out the objectives, actions, time-scales and responsibilities, arising from the health assessment;

- the health plan will be reviewed in line with the statutory review 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 and young person's health information whilst ensuring it is appropriately integrated into the overall care plan;
- 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 continued as appropriate when the child returns home.

9. The Parenting Role

- 9.1 Competent parents are aware that bringing up healthy children involves a range of tasks. A key role undertaken by parents on behalf of their children is to act as a champion or advocate in accessing and using services. It is even more important for CSSRs and other service providers to undertake this advocacy role on behalf of looked after children because of their greater needs and the greater barriers to accessing services.
- 9.2 The Children Act 1989 and Regulations and Standards issued under the Care Standards Act 2000 (Department of Health, 2002b,c,d,e) impose clear duties on foster carers and residential workers as well as social workers and managers in improving the health of looked after children.
- 9.3 Responsibilities of foster carers, carers and residential staff in ensuring that the child's health needs are met include:
- an understanding that achieving optimum health starts early and includes the provision of good quality care which starts in infancy and which provides a child with a positive sense of identity and self-esteem;
 - encouraging and supporting each child in achieving optimum health and in particular exercising the corporate parent's responsibility as health educator;
 - providing a home environment which actively encourages and supports a healthy lifestyle;
 - ensuring the child attends health appointments and clinics as necessary;
 - contributing to the child's health plan and care plan;
 - ensuring and facilitating contact and communication with the child's parents and family in accordance with agreed plans;
 - ensuring that the child or young person makes maximum benefit from education and broader experiences offered by leisure activities, hobbies and sport.

Education

- 9.4 It is important to link the promotion of good health for looked after children to their educational experiences. Access to good education has a direct impact on a child's wellbeing, including a sense of self-worth and self-confidence. It can enable integration within a social network and encourage a sense of being a valued member of the local community, as well as helping to establish positive peer relationships.

- 9.5 School provides children with both formal and informal opportunities for developing cognitive and social skills. Specific education about health issues is provided through the Personal, Social and Health Education (PSHE) curriculum and physical fitness is promoted through both sport within the curriculum and a range of extra curricular activities. Local education authorities will be involved in an accredited education and health partnership through the National Healthy School Standard.
- 9.6 Many looked after children experience disruption to their schooling through placement moves. They make up a disproportionate number of children either temporarily or permanently excluded from school. This not only affects their academic achievement, but contributes towards them becoming socially excluded and places them at greater risk of engaging in activities which may be detrimental to their health and future wellbeing.
- 9.7 Lack of detailed and quantitative educational assessment may lead to the extent of learning difficulties not being recognised. The same lack of consistent assessment may also lead to a failure to recognise a child's gifts and strengths. Social services should act as an advocate with Education services e.g. ensuring that a young person who moves retains his or her GCSE options, ensuring access to an appropriate school and providing practical and financial support for participation in extra curricular activities.
- 9.8 The Department for Education and Skills (DfES) has recently launched guidance to schools to improve the mental health of children in primary schools (DfES, 2001). The Department for Education and Skills and the Department of Health are working jointly to implement guidance on the education of looked after children. (Department for Education and Skills, 2000)

Leisure, hobbies and sport

- 9.9 Gilligan (2001) cites many examples where success and involvement in a range of activities and sports have provided a turning point in the lives of children and young people.
- 9.10 Opportunities for physical activity and for expressing creativity are recognised as important factors for enhancing emotional wellbeing and combating a low sense of identity and self-esteem.
- 9.11 Sporting activities in particular can provide opportunities both for safe risk taking and for developing teamwork skills. Arts and drama can have therapeutic applications through providing a means for expressing feelings in a safe environment. Use of drama workshops as a means of consulting with young people, including those in a secure setting, about their health, have proved very successful.
- 9.12 Children and young people may enter the looked after system with leisure interests and hobbies which should be supported and developed during their stay in care. Equally there is great potential for carers to engage children and young people in their own hobbies and interests or to engage them in opportunities available in the local community.

Summary

Education

- access to good education has a direct impact on child's health and wellbeing;
- the high incidence of disrupted schooling and temporary or permanent school exclusions, not only affects looked after children's academic achievement, but contributes towards them becoming socially excluded and places them at greater risk of engaging in activities which may be detrimental to their health;
- to improve both the education and health of looked after children, reference should be made to the Department for Education and Skills guidance to schools to improve the mental health of children in primary schools, the Guidance on the Education of Looked After Children, and the Assessment Framework and Working Together to Safeguard Children issued by the Department of Health;
- the regulations and standards set out under the Care Standards Act 2000, identify a clear role for carers in promoting the health of looked after children.

Leisure, hobbies and sport

- social, recreational and sport activities need to be considered as part of a holistic approach to health.

10. Children in Special Circumstances

Disabled children

- 10.1 A looked after child with a disability should have any associated special educational needs identified in line with the Department for Education and Skills *Code of Practice for the Assessment of Special Educational Needs (SEN)* (Department for Education and Skills, 2001). Those with substantial SEN requiring provision beyond that which a mainstream school can provide from its own resources will be subject to multi-disciplinary statutory assessment and any additional provision will be set out in a statement of SEN. In some cases Local Education Authorities and Social Services may decide that a child's needs will be best met through a jointly funded residential school placement. Tripartite funding arrangements which include health may be required for children with very complex needs arising from disability.
- 10.2 For children using short-term breaks the parents will retain the prime responsibility for ensuring the health of their child. These children do not need a full health assessment, but the key issues will be to ensure that carers have appropriate understanding of the child's disabilities and any medical, behavioural and social consequences. It is also essential that carers know what to do in an emergency and who to contact.
- 10.3 Disabled children in longer-term care should have a very detailed health history and health plan. Many disabled children are well known to consultant paediatricians and other specialists including dentists. Their advice is essential to the health care planning of many disabled children and in most circumstances they will be the most appropriate person to undertake the health assessment and contribute to the health plan. The provision for the health assessment should take account of any communication barriers and ensure that the child's wishes and feelings are represented and respected.
- 10.4 A health assessment of a disabled child should recognise the importance of identifying any disabling barriers in the child's environment which exacerbate the effects of the child's impairments. Steps should be taken to ensure that the child's environment promotes the development of the child's potential. Disabled children have the same developmental needs for appropriate social, leisure and recreational activities as other children.
- 10.5 Where disabled children are 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.

Black and minority ethnic children

- 10.6 Research has clearly identified that 'there are considerable disparities in health experience between white and black populations as a whole and around childbirth' (Butt et al. 1988). Combined with the evidence already quoted in this document, highlighting the strong correlation between the physical health of children at all ages and adverse social and economic conditions, it is clear that black and minority ethnic children suffer considerable health disadvantage. This has implications for the health assessment and monitoring of children who enter the looked after system.

- 10.7 In addition, black and minority ethnic populations are vulnerable to certain hereditary illnesses such as sickle cell anaemia, thalassemia and pre-disposed to certain forms of diabetes. Taking an accurate family health history as part of the health assessment process for a child or young person who is looked after is therefore extremely important.
- 10.8 There is also evidence of high levels of depression among certain groups in the Asian community; African-Caribbean people have been significantly more likely to be diagnosed as schizophrenic than white adults and are more likely to be users of acute mental health services than preventive services. Less is known about access to CAMHS by children and young people from black and minority ethnic groups but clearly there may be implications for the assessment of their emotional and behavioural development.
- 10.9 Religion will also be an important factor informing the provision of services since there may be requirements concerning, for example, the gender of the doctor. Prior discussion about any health appointments in order to enable choice is therefore very important.
- 10.10 Children and young people for whom English is not their first language may have difficulty in communicating their needs and experiences. Arrangements should be made to enable them to use the language they feel most confident in. Any translation arrangements will need to be sensitive to cultural difficulties in use of language and ensure that issues of confidentiality and consent are managed appropriately.

Asylum seeking children and refugees

- 10.11 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)
- 10.12 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.
- 10.13 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.
- 10.14 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.

Care leavers and transition to independence

- 10.15 Preparing to leave care is critically important for all 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.
- 10.16 High levels of early parenthood, mental ill-health and stress, loneliness and risk-taking behaviours amongst the population of young people leaving care are indicators of the failure of local authorities and health authorities to address the health needs of looked after children. Whilst these factors cannot solely be attributed to experiences and failures within the care system young people themselves think that their education on health matters has been inadequate, particularly in preparing them to take responsibility for their own health. (Broad, 1999)
- 10.17 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 or 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.

Children cared for in secure settings

- 10.18 The route by which children and young people enter secure settings will determine with whom responsibility for their welfare and care rests. In secure units children and young people in the same establishment will be cared for by the same staff but under different legal frameworks, e.g. welfare and criminal justice. This presents particular challenges for councils in respect of the children for whom they act as corporate parent and for secure establishments and staff within them which receive children and young people through different routes.
- 10.19 These children and young people are another very vulnerable group whose placement in a secure establishment poses particular problems in meeting their health needs. Councils should pay particular attention to ensuring that the arrangements for providing health assessments and access to a comprehensive range of health services for children for whom they are responsible are in place and are closely monitored. For individual children, as for other children placed outside the area, monitoring and reporting arrangements will be required. For establishments run by the Council which care for children and young people placed through welfare and criminal justice routes, the Council will need to pay particular attention to achieving coherence and consistency in securing the delivery of effective and high quality health services for all of them.
- 10.20 It is all too easy for the health needs of children and young people cared for in local authority secure care, secure training centres, and young offender institutions and prisons to become secondary to the need to keep them secure or to address offending behaviour. Health expectations can be lower for such children and young people, yet their health needs are often greater.

- 10.21 A joint strategy agreed with all relevant local agencies such as social services PCTs and the Youth Offending Team (YOT) should be developed to address issues of access to health services for children and young people in secure settings, particularly for specialist services where several visits may be necessary, or for paediatricians needing to make a thorough assessment. Providing continuing care may be difficult when children are placed far from home and records and medical history do not transfer quickly. The health service should co-operate in transferring these as speedily as possible.
- 10.22 Legislative changes mean that children are now being placed in secure settings at a younger age. It is particularly important therefore, that attention remains focused on their developmental needs including their primary care needs. Children and young people who are looked after in a secure setting will have had a core assessment and will have a health plan available. Actions identified within the health plan must be undertaken.
- 10.23 The very small numbers of looked after children who may be in a secure hospital placement should have a health assessment and health plan as part of their overall care plan.
- 10.24 Particular issues arise in relation to the commissioning and payment for physical and mental health services for children and young people in secure settings. Arrangements about the finance, commissioning and delivery of these services are outlined in Establishing Responsible Commissioning Guidance. (Department of Health, 2002a)

Summary

Disabled children

- parents will retain the prime responsibility for the health of children in short-term breaks;
- carers must understand the child's needs, the implications of these, and what to do in an emergency;
- disabled children in longer-term care should have a detailed assessment and health plan, which will usually be undertaken by the consultant paediatrician who knows the child;
- the health plan should ensure that the child's environment promotes the development of his/her potential, including ensuring the safe installation of any equipment or adaptations required;
- looked after children with a disability should have any associated special educational needs identified in line with the Department for Education and Skills and Welsh Office Code of Practice.

Black and minority ethnic children

- black and minority ethnic children are likely to suffer both the health disadvantage of looked after children plus the health inequalities related to their ethnicity;
- staff should include an accurate family history as part of the health assessment to ensure any hereditary illnesses are identified;
- particular attention should be paid to the assessment of emotional and behavioural development;
- specific requirements related to the child's religion should be considered when planning for their health;
- for children and young people for whom English is not their first language, arrangements for translation may need to be made. These will need to be sensitive to cultural difficulties in the use of language, and ensure issues of confidentiality and consent are managed appropriately.

Refugees

- unaccompanied refugee and asylum seeking children may have been orphaned, be at risk of developing or suffering from a range of illnesses depending on their country of origin, have little or no health history or records available, and have unknown immunisation status;
- these children may have often suffered events outside the experience of workers dealing with them;
- when undertaking health assessments and providing services, access to translation services, and link workers familiar with the child's culture should be used. While some children may be psychologically distressed, their resilience and resourcefulness should be acknowledged and respected.

Care leavers and transition to independence

- young people think that their education on health matters has been inadequate, particularly in preparing them to take responsibility for their own health;
- following the Leaving Care Act (2000), all eligible and relevant young people are required to have a Pathway Plan. This plan should take account of the assessed health needs of the young person;
- within the Pathway Plan particular attention should 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.

Children cared for in secure settings

- the route by which children and young people enter secure settings determines with whom responsibility for their welfare rests. This means children and young people in the same establishment will be cared for by the same staff, but under different legal frameworks, i.e. welfare and criminal justice;
- health expectations for these children and young people can be lower, yet their health needs are often greater and may be related to their offending behaviour;
- a joint strategy should be devised and agreed with all relevant local agencies, to address the issues of arrangements for health assessment, and access to a range of comprehensive health services;
- local authority children's homes should ensure that consistent and coherent health services are available for all children and young people in their care;
- the health service should co-operate in transferring health records as speedily as possible, to help provide continuity of care when children and young people are placed far from home;
- the wider developmental needs of younger children in secure settings should be recognised;
- a health assessment and health plan as part of their overall care plan should be provided for the small number of children in a secure hospital setting.

11. Health Promotion

Context

- 11.1 In response to a Health Action Zone survey in 2001 in Lewisham, Southwark and Lambeth, 45% of looked after young people were not aware of agencies that could provide advice and help for smoking, drinking and drug related problems.

Promoting health and achieving wellbeing

- 11.2 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.
- 11.3 *Saving Lives – Our Healthier Nation* (Department of Health, 1999a) stressed the importance of health promotion and healthy settings. The knowledge, skills, values and attitudes, which children learn and practise while young, can stay with them for life. Looked after children and young people often experience poor health and low esteem as a result of their life experiences of disruption, poverty, and emotional and physical deprivation. This may be demonstrated in poor physical and mental health, challenging behaviour and delayed development.
- 11.4 Young people who are looked after are recognised as being vulnerable to risk taking behaviour, including unsafe sex, self-harming, misusing illegal and/or volatile substances and alcohol. These early risk-taking behaviours are indicators of poor mental and emotional health and may be the forerunner of wider social exclusion such as homelessness and unemployment.

A healthy care setting

- 11.5 Early findings from the evaluation of the National Healthy School Standard record that schools describe pupils as more confident and motivated, staff as less stressed and enjoying school life and improvement in academic standards. Much can be learnt from this programme and transferred to care settings.
- 11.6 The National Healthy Care Standard is being developed as a parallel programme to the National Healthy School Standard and will provide social services, health agencies and wider partner agencies with an opportunity to evidence the development of their work in promoting health. Such evidence will include programmes to enable children and young people to access personal, social and health services.
- 11.7 The context in which health promotion takes place should be healthy. Talking about healthy food where the food provided is unhealthy will negate positive work. Equally talking about relationships and the importance of respect for self and others will be unhelpful if carers lack confidence to talk with young people or challenge bullying. A healthy care setting creates a healthy ethos, which can demonstrate a measurable improvement in children's self-esteem, health and wellbeing.

- 11.8 A recent health audit in one Council identified a significant proportion of care leavers as being malnourished. Materials to support foster carers and residential staff in the provision of a healthy diet have been developed with an accompanying training pack. (Caroline Walker Trust, 2001) A research study has recently reported on the influence of nutrition on the anti-social behaviour of young adult prisoners. (Gesch et al, 2002)
- 11.9 The promotion of physical and mental health is identified as the responsibility of all those involved with children and young people. *Making it Happen – A guide to delivering mental health promotion* (Department of Health, 2001e) identified ten elements of mental health promotion and demotion. At an individual level it aims to increase each person's ability to manage their own health, build self-esteem, gain trusting and supportive friendships and advance their ability to influence decision making.

Definition of promoting health in care

- 11.10 Children and young people in care need planned and co-ordinated personal, social and health development opportunities, as well as access to health services, which will enable them to:
- understand how to maintain health and its relationship to wellbeing;
 - develop personal and social skills, value themselves, making choices, carrying out decisions and accessing support;
 - explore and consider how to manage moral dilemmas, assess risk and be able to keep themselves and others safe.
- 11.11 Three elements of health promotion are health education, health protection and prevention. Local planning will need to integrate the opportunity to develop knowledge and skills to maintain health and wellbeing with adequate access to health care and prevention of poor health through the development of policies and structures that promote wellbeing. A likely vehicle for this will be the local strategic partnerships. At an individual child level health plans will ensure children and young people who may be excluded from school will still receive access to these services.

Planning

- 11.12 Effective corporate parenting will provide personal, social and health education to complement that which is provided by school. It will be planned and integral to local policy and practice, a part of each child's health plan and overall care plan. Health care and health promotion policies should describe clearly what should be provided, how it should be done and the roles and responsibilities of social workers, carers and other agencies in improving health outcomes. Clear measurable objectives and measures of success will be integral to the policies.

The following topics should be covered:

- mental health and wellbeing;
- healthy eating;
- physical activity;
- safety and keeping safe;
- oral and dental health;

- sexual health;
- drugs, alcohol, tobacco and volatile substances.

Participation

- 11.13 The Quality Protects programme has supported good practice in consultation with children and young people. Staff and carers will actively support their participation in decisions which affect their lives. Their needs should be central to the planning process. Effective promotion of health and wellbeing is about empowerment and the development of self-esteem. If children and young people are part of the planning, the assessing of needs, and the development of programmes and/or planned activities they are more able to participate and benefit.
- 11.14 Responsibility for health promotion and health care for looked after children and young people usually lies with social services in partnership with colleagues in other agencies. Front line staff such as foster carers, key workers, personal advisors, mentors and youth workers who deliver the programmes should participate in the development of good policy and practice in health promotion.

Partnership

- 11.15 Partnership working between social services staff, birth parents, health professionals, teachers and other community workers is essential. Partners have different perspectives and bring a body of knowledge about the child, professional knowledge as well as information about local resources, local health priorities and health inequalities. Shared ideas and approaches can be developed in partnership with carers and social workers. A range of local planning mechanisms will address national priorities by setting local targets to meet the needs of vulnerable children. Meeting joint targets and achieving objectives will be a shared activity. The co-ordinators of these local plans and strategies will want to encourage and develop partnership work to ensure that those who are vulnerable to poor health are effectively targeted and that all settings are actively promoting health and wellbeing:
- the Local Government Act 2000 places a clear responsibility on Councils to promote the wellbeing of their communities;
 - the local Healthy School Standard Programme is working towards all schools being accredited as healthy schools;
 - the local Teenage Pregnancy Strategy aims to reduce teenage pregnancy by 50% by 2010 and to improve the support of teenage parents;
 - local plans to improve the general health of the local population by actively addressing cancer, accidents, coronary heart disease and mental health as well as addressing social health inequalities;
 - Drugs Action Teams will be implementing a Young People's Substance Misuse Plan, which aims to reduce the number of under 25s reporting class A drug use by 25% by 2005 and by 50% by 2008;
 - Youth Offending Teams have targets to reduce offending behaviour;
 - Councils have targets to increase educational attainment and reduce offending behaviour by looked after children.

This will ensure a co-ordinated four-tier service for young people, including increased provision, and targeted interventions for vulnerable groups, including young people in care, school excludees and young offenders.

Training and support

- 11.16 Staff and carers will need support and training in order to feel confident in the skills and knowledge needed to promote health and wellbeing. It is important that all those with responsibility for young people – social workers, foster carers and residential staff – are aware of the legislative framework and the help they may offer particularly in relation to sexual health and contraception services. Guidance is available which makes it clear that if a social worker or carer thinks that a young person is in need of help they should direct them to an appropriate source of advice. (Department of Health Teenage Pregnancy Unit 2001e) Multi-disciplinary approaches to training and support have proved useful and can often be arranged in partnership with colleagues from health and voluntary organisations. Young people themselves may contribute to training programmes, through planned health advocacy projects.
- 11.17 Carers have many opportunities to have informal discussions but training can also be delivered through planned programmes or workshops. Working with an agreed policy, and with some training and support will enable staff and carers undertake this work with confidence. Leaflets, booklets, games and videos are also useful. Keeping clear boundaries and agreeing ground rules makes it safer for the worker to teach and for the child or young person to learn. Resources and advice on methodology can be accessed from the Health Promotion Service in the local PCT.

Examples of Good Practice

Health Promotion in Avon Health Authority

Health Promotion Service Avon works in partnership with social services departments and fostering agencies to provide health promotion training to carers and social workers.

All prospective carers in North Somerset receive health and health promotion training, based on NCB material as part of the Choosing to Foster course.

Southampton Social Services – The Quays Project

Southampton Social Services have developed a social service/health partnership to provide a centralised health service for vulnerable children including looked after children. The service has concentrated on the needs of teenage groups who are less likely to attend health assessments but are more vulnerable to risk-taking behaviour such as drug abuse or unsafe sex. The service provides health promotion and health services in a setting and format, which is attractive and relevant to young people at a local leisure centre.

Health Promotion Partnerships

Hammersmith and Fulham Social Services Department

Hammersmith and Fulham Social Services Department have worked in partnership with other statutory bodies, the voluntary sector and young people in care to produce a Health Policy Guide.

Summary

- improved health outcomes for looked after children require the focus of health care planning to be on health promotion and a healthy environment as well as physical, emotional and mental health needs;
- children and young people should understand their right to good health, to access services, and to have the knowledge and skills to communicate and relate to others, and take responsibility for themselves;
- effective promotion of health is through empowerment and the development of self-esteem;
- the National Healthy Care Standard will provide social services, health agencies and partner agencies with an opportunity to evidence their work in promoting health;
- the environment in which health promotion takes place should be healthy;
- local strategic partnerships should be the vehicle for ensuring that local plans integrate the opportunity to develop knowledge and skills to maintain health, with adequate access to health care and prevention of poor health;
- effective corporate parenting should be supported by health care and health promotion policies which set out responsibilities at all levels of the organisation, and are developed in partnership with children, young people and their carers, and other agencies;
- staff and carers will need support and training to feel confident, and have the necessary knowledge and skills to promote health, particularly related to the legislative framework in relation to sexual health and contraception services.

12. Mental Health

Mental health and emotional wellbeing

'I keep it to myself until the feelings go away.'

"The happiest day I can remember was when I felt I belonged in the family I'm in now because I had never belonged before."

12.1 Mental health problems in children and young people are broadly defined as disorder of emotions, behaviour or social relationships sufficiently marked or prolonged to cause suffering or risk to optimal development in the child, or distress or disturbance in the family or community (Rutter et al, 1970). Conduct and attentional disorders, anxiety disorders and depression are particularly common in this group of children and young people.

12.2 There are a number of factors which impact on a child's mental health, some of these are related to the child and some to family and community factors:

- family disadvantage;
- family discord or separation;
- a parent with a mental illness;
- chronic physical illness in the child;
- chromosomal or other genetic abnormalities in the child;
- brain damage in the child;
- physical, sexual or emotional abuse;
- experiences of sudden or extreme trauma;
- learning difficulties or language and communication problems;
- bereavement.

Additional factors for children looked after are:

- stability and quality of current care;
- child's links to family, friends and peers.

12.3 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 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.

- 12.4 Looked after children and their carers need access to the full range of child and adolescent mental health services (CAMHS) across the tiers, from promotion, advice and services in primary care/community settings to highly specialist, sometimes residential or inpatient provision. These services will assist in the prevention of mental health problems in children and young people, as well as helping to reduce the impact of established mental health disorders on their lives. Effective care will reduce the likelihood of looked after children and young people experiencing some of the secondary consequences associated with poor mental health, such as non-school attendance, educational failure, juvenile crime and placement disruption.
- 12.5 There should be no assumption that because children and young people are looked after that they have mental health problems, as such an assumption is not only stigmatising but may lead to the failure to investigate possible organic causes for difficulties. However, evidence suggests that many mental health difficulties are missed in this group of children and young people, in particular the effects of grief and loss and resulting depression in younger children.
- 12.6 Child and Adolescent Mental Health Services (CAMHS) for looked after children and young people should be planned through a partnership of health, social services, education and voluntary sector providers and in partnership with young people and their carers. In planning services, needs and resources across all age groups, levels of need and the needs of black and ethnic minority children should be considered and an appropriate range of services developed. The specific needs of children with disabilities, particularly those with learning difficulties and **asylum seekers and refugee children also need to be addressed** and specialist services consulted with as necessary.
- 12.7 Young people aged 16+ may be particularly vulnerable at the point of leaving care and managing their lives with fewer supports than other young people and thought should be given to appropriate services for this age group. Leaving care services will need support from CAMHS and adult mental health professionals, both in terms of prevention and access to referral on for some young people.

A primary level of service-tier 1

- 12.8 All professionals and carers who work with children looked after have a responsibility to promote their mental health and emotional wellbeing. They may do this by building secure relationships with children and ensuring that their basic needs are met. However, at times they may need to seek additional advice or training from child mental health professionals, in order that they can meet the needs of children they are working with or caring for.
- 12.9 Health assessments should include reference to the child or young person's mental health and emotional wellbeing. Some local authorities are now using screening tools, such as Goodman's 'Strengths and Difficulties Questionnaire', to identify children with mental health problems at an early stage. Paediatricians, GP's and other health care professionals who carry out health assessments should have training in the early identification of mental health difficulties. They also need a link into CAMHS for advice and consultation and a clear access route to refer children and young people who need more specialist help.
- 12.10 Education professionals working with looked after children should also have training in promotion of emotional wellbeing and in initial identification of mental health problems. Within education departments and schools there are many professionals who can contribute to children's wellbeing and ensure the early identification of difficulties. These include teachers, educational psychologists, school nurses, behavioural support services and link teachers for looked after children. The Department for Education and Skills (DfES) has recently produced guidance for schools on promoting children's mental health. (Department for Education and Skills, June 2001)

- 12.11 Social workers with responsibility for looked after children and fostering link workers also require training in the early identification of mental health problems and promoting children's emotional health. They can also benefit from consultation from CAMHS professionals on care planning for children with mental health difficulties.
- 12.12 Carers, including foster carers and residential workers should have training on promoting emotional wellbeing and resilience in children and young people, strategies to deal with behavioural difficulties and identifying when to seek specialist help. Residential homes and foster carers will benefit from having a link worker within the CAMHS team who can offer on-going advice as well as input on particular children. In some authorities CAMHS professionals are making a useful contribution to the training and development of foster carers through the NVQ programme (e.g. Northamptonshire).
- 12.13 The National Healthy Care Standard will support the development of health care settings which will promote emotional health.

Community based child and adolescent mental health services

- 12.14 Many areas are now developing a network of CAMHS professionals who work within a range of agencies, for example health centres and schools, offering support to front line staff and input with children and carers where appropriate. Looked after children and young people may benefit from this type of community provision but CAMHS may also offer input specifically for looked after children and their carers in residential units, foster homes and leaving care teams, for example.
- 12.15 Some children and young people will require referral to more specialist services from a multi-disciplinary CAMHS team, including clinical psychologists and psychiatrists. All Councils and PCTs should ensure that looked after children and young people have access to appropriate services without a long wait. Some authorities have established designated services for looked after children to ensure the above, whilst others have funded specific posts within existing teams. In all cases strong links between looked after children's services and mainstream CAMHS are essential.

Services may use a variety of 'therapeutic' approaches to engage young people.

In Southwark the Care Link project has worked with young people in producing a film about their experiences in care. This proved an important learning and therapeutic process for the young people concerned as well as producing a valuable product for other young people and professionals.

In Dorset, the 'Connections project' offers individual therapeutic packages for children and young people. This can include funding therapeutic leisure activities for young people, such as horse riding, as well as offering access to talking and creative therapies.

- 12.16 CAMHS teams may sometimes work more effectively through input to the carer than in working directly with the child or young person, either with very young children or where a young person may be reluctant to use services themselves.

In Staffordshire for example, the Sustain project offers training and support to foster carers with the aim of increasing their skills and reducing placement breakdown.

- 12.17 When referrals are made from social services to a child mental health service an initial discussion about the purpose of the referral and the nature of the child's difficulties is useful for both sides. Child mental health professionals, carers and social workers need to work in partnership with each other and the child or young person in order to maximise the impact of any intervention. Experience of good practice in this area indicates that work with the child's network as well as the child themselves is important in promoting change and that this should include education colleagues wherever possible.

In Sheffield the Support Service for Looked After Children offers a multi-disciplinary CAMHS to children and young people who are looked after. Services are offered within residential homes and youth settings, as well as in a more traditional clinic setting and the team includes social workers, clinical and educational psychologists, psychiatric nurses, art and drama therapists and specialist teachers.

- 12.18 CAMHS may also provide services for some children and young people in adoptive and long-term foster placements who require input from mental health services. This may be provided by mainstream CAMHS, however in some areas specialist teams or posts have been developed to work with children and long-term carers where there are attachment difficulties.
- 12.19 For some young people with high levels of mental health need, there will be a need for highly specialist provision, which may be provided on a regional basis. This will include psychiatric in-patient units for children and adolescents and in some areas specialist outreach teams which are able to support young people with mental illness in the community. Both social care and education may have input into these health led units through the provision of staff and input into planning for young people on discharge.
- 12.20 In some areas health, social care and education are now taking a joint approach to commissioning and planning of services for young people with complex mental health needs. In other areas joint panels of all three agencies meet to agree plans and joint funding for such young people. Below are some examples of jointly planned services aimed at young people with high levels of mental health need but also complex social and educational needs.

In Southampton all three agencies jointly commission and provide a specialist residential unit and an outreach team for young people with high levels of need and challenging behaviour (the Behaviour Resource Service). This service has now been designated a Beacon CAMHS service and further details are available from the NHS Beacons web site.

- 12.21 In other areas specialist therapeutic fostering schemes are being established to try and maintain young people with high levels of need within family based provision.

ROSTA Project – The ROSTA Project in Liverpool has recruited a group of therapeutic foster carers who receive specialist training in working with young people with complex needs. These carers are then part of a therapeutic team working with that young person and continue to be given a high level of support.

- 12.22 These joint approaches recognise that many young people with high levels of mental health need may also have complex social and educational difficulties.
- 12.23 Children and young people in secure provision are particularly vulnerable and often have the most complex difficulties. Each unit requires reliable access to specialist CAMHS and to training and consultation for their staff on mental health. This is best provided on a regular and consistent basis rather than purely on request or through spot purchasing.

Summary

- looked after children and their carers need access to the full range of CAMHS;
- these services will assist in the prevention of mental health problems, as well as helping to reduce the impact of established mental health disorders on their lives;
- effective care will reduce the likelihood of looked after children and young people experiencing many of the problems associated with poor mental health, such as non-school attendance, educational failure, juvenile crime and placement disruption;
- whilst evidence suggests that many mental health difficulties are missed in looked after children, there should not be an assumption that they have a problem;
- the specific needs of children with disabilities, particularly those with learning difficulties should be addressed;
- leaving care services require support from CAMHS and adult mental health services, both in terms of prevention and access to referral on;
- health, social services and education professionals require training in the early identification of mental health problems;
- carers should have training on promoting emotional wellbeing and resilience, strategies to deal with behavioural difficulties, and when to seek specialist help;
- CAMHS should be offered in a variety of locations in order to increase access, and reduce stigma. CAMHS teams may sometimes work more effectively through input to the carer;
- all Councils and PCTs should ensure that looked after children and young people have access to appropriate services without a long wait;
- experience of good practice in community based services indicates that services need to work with the child's network as well as the child themselves. This often includes educational colleagues, and a multi-agency approach can ensure this;
- the needs of black and ethnic minority children and their carers, and asylum seekers and refugee children should be considered in local service provision;
- those young people with high levels of mental health needs may need specialist provision which should be planned on a multi-agency basis;
- in some areas innovative specialist therapeutic fostering schemes can maintain young people with high levels of need within family based provision. This enables them to remain in a family, but also within the local community and local education services.

13. Confidentiality, Information Sharing and Consent

Confidentiality

'All health issues are discussed in reviews in front of everyone attending, and therefore I have met many young people who will try to hide their health problems rather than let a carer know that something is wrong and risk it being talked about in front of other people attending their reviews.'

'I certainly couldn't think of anything worse than having my carer and social worker discuss whether or not I was still wetting the bed at fourteen whilst in the presence of virtual strangers and my form tutor.'

- 13.1 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 www.doh.gov.uk/ipu/confiden
- 13.2 The general principle of confidentiality is that *'in general – and in all walks of life – any personal information given or received in confidence for one purpose may not be used for a different purpose or passed to anyone else without the consent of the provider of the information. The duty of confidence is long established in common law, but with proper safeguards, need not be construed so rigidly that, when applied to the NHS or related services, there is a risk of it operating to a patient's disadvantage or to that of the public generally.'* Caldicott Ch.2. para 2.1
- 13.3 Common Law 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.

- 13.4 The NHS and Councils with Social Services Responsibilities (CSSRs) should have in place protocols which establish the framework for information sharing at an intra and inter-agency level. Councils were required to have Caldicott Guardians in place by 1 April 2002. [<http://tap.ukwebhost.eds.com/doh/coin4.nsf/Circulars> [ReadForm refers]. Guidance on information sharing between the NHS and Local Authorities can also be found at www.doh.gov.uk/jointunit/info.htm.
- 13.5 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.

- 13.6 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.
- 13.7 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.

Consent

- 13.8 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.
- 13.9 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.'

More detailed guidance is available from the Department of Health publication Seeking Consent: Working with Children – www.doh.gov.uk/consent.

Children aged 16 and 17

- 13.10 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.
- 13.11 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 (see also paragraph 13.15 below). 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

- 13.12 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.
- 13.13 ‘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.
- 13.14 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. (See below.)

Significant harm

- 13.15 *The Framework for the Assessment of Children in Need and their Families* discusses consent and confidentiality issues at paragraphs 3.46–3.57 (Department of Health, 2000) www.doh.gov.uk/scg/cin.htm. *Working Together to Safeguard Children* (Department of Health, 1999) provides guidelines in cases where there are concerns that the child is or may be at risk of significant harm at paragraphs 7.27–7.36. Appendix 4 includes the Data Protection Registrars checklist for setting up information-sharing arrangements.

Parental responsibility

- 13.16 The Children Act 1989 sets out clearly who has parental responsibility including:
- the child’s parents if married to each other at the time of conception or birth;
 - the child’s mother, but not father if they were not so married *unless* the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;
 - 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

- 13.17 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 CSSR – 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 and the Placement Information Record. Sample formats are provided within the Integrated Children's System.

Requirements for consent

- 13.18 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.

Appendix 1

Children Act (Miscellaneous Amendments) (England) Regulations 2002

STATUTORY INSTRUMENTS

2002 No. 546

CHILDREN AND YOUNG PERSONS, ENGLAND**Children Act (Miscellaneous Amendments) (England)
Regulations 2002***Made - - - - 6th March 2002**Laid before Parliament 11th March 2002**Coming into force 1st April 2002*

The Secretary of State, in exercise of the powers conferred upon him by sections 23(2)(a) and (f), (5) and (9), 23A(3), 25(2) and (7), 26(1), (2), (5) and (6), 51(4), 59(2) to (5) and 104(4) of, and paragraphs 12 to 14 of Schedule 2, paragraph 4(1)(a) of Schedule 4, paragraph 7(1)(a) of Schedule 5, and paragraphs 10(1)(a) and (2)(1) of Schedule 6 to, the Children Act 1989^(a), and section 119(1) of the Care Standards Act 2000^(b) and of all other powers enabling him in that behalf, hereby makes the following Regulations—

Citation, commencement and extent

1.—(1) These Regulations may be cited as the Children Act (Miscellaneous Amendments) (England) Regulations 2002, and shall come into force on 1st April 2002.

(2) These Regulations extend to England only.

Amendment of the Arrangements for Placement of Children (General) Regulations 1991

2.—(1) The Arrangements for Placement of Children (General) Regulations 1991^(c) shall be amended in accordance with the following provisions of this regulation.

(2) In regulations 1(2), 2(1), 5(1), 6, 10(2) and (3) and 11, and in paragraph 5 of Schedule 4, in each place in which they occur, for the words “registered children’s home”, substitute “private children’s home”.

(3) In regulation 1(2) (interpretation), in the definition of “placement”, in each of paragraphs (a) and (b), for “(b),(c),(d)” substitute “(aa)”^(d).

(4) In regulation 2(2) (application of regulations), for the words after “voluntary organisation”, substitute “, in a school which is a children’s home within the meaning of section 1(6) of the Care Standards Act 2000.”.

(5) In regulation 5(1) (notification of arrangements)—

(a) for sub-paragraph (b) substitute—

“(b) the Primary Care Trust, or if there is no Primary Care Trust, the Health Authority, for the area in which the child is living and, if it is different, for the area in which the child is to be placed;”;

^(a) 1989 c.41. These powers are exercisable by the Secretary of State in relation to England. Their exercise in relation to Wales has been transferred to the National Assembly for Wales. See article 2 of, and the entry for the Children Act 1989 in Schedule 1 to, the National Assembly for Wales (Transfer of Functions) Order 1999 (S.I. 1999/672).

^(b) 2000 c.14. The power is exercisable by the appropriate Minister, who is defined in section 121(1) of the Care Standards Act in relation to England, Scotland and Northern Ireland, as the Secretary of State, and in relation to Wales, as the National Assembly for Wales.

^(c) S.I.1991/890, as amended by S.I. 1991/2033, S.I.1993/3069, S.I.1995/2015 and S.I. 1997/649.

^(d) As substituted by section 116 of, and paragraph 14 (1), (3) and (8) of Schedule 4 to, the Care Standards Act 2000.

- (b) in sub-paragraph (c), at the end, add “and, if it is different, for the area in which the child is to be placed;”; and
- (c) in sub-paragraph (d), at the end, add “and, where applicable, any registered medical practitioner with whom the child is to be registered following the placement;”.
- (6) For regulation 7 (health requirements) substitute—

“Health assessments

- 7.—(1) Subject to paragraphs (3) and (4), a responsible authority shall—
 - (a) before making a placement, or if that is not reasonably practicable, as soon as reasonably practicable after a placement is made, make arrangements for a registered medical practitioner to conduct an assessment, which may include a physical examination, of the child’s state of health;
 - (b) require the registered medical practitioner who conducts the assessment to prepare a written report of the assessment which addresses the matters listed in Schedule 2; and
 - (c) having regard to the matters listed in Schedule 2 and, unless paragraph (4) applies, to the assessment report, prepare a plan for the future health care of the child if one is not already in existence.
- (2) A responsible authority shall ensure that each child is provided during the placement with—
 - (a) health care services, including medical and dental care and treatment; and
 - (b) advice and guidance on health, personal care and health promotion issues appropriate to his needs.
- (3) Paragraph (1) does not apply if within a period of three months immediately preceding the placement the child’s health has been assessed, and a report of the assessment prepared in accordance with that paragraph.
- (4) Sub-paragraphs (a) and (b) of paragraph (1) do not apply if the child, being of sufficient understanding to do so, refuses to consent to the assessment.”.
- (7) In regulation 11 (access by guardians ad litem to records and register), and in the heading to that regulation, for “guardian ad litem” substitute “officer of the service”(a).
- (8) In Schedule 2 (health considerations to which responsible authorities are to have regard)—
 - (a) in paragraph 1, at the end, add “including his physical, emotional and mental health.”;
 - (b) in paragraph 2, at the end, add “including, as far as practicable, his family health history.”; and
 - (c) in paragraph 6, at the end, add “and for advice and guidance on health, personal care and health promotion issues appropriate to the child’s needs.”.
- (9) In Schedule 3 (educational considerations to which responsible authorities are to have regard), in paragraph 4—
 - (a) for “Education Act 1981” substitute “Education Act 1996(b)”; and
 - (b) for “section 7” substitute “section 324”.

Amendment of the Placement of Children with Parents etc. Regulations 1991

- 3.—(1) The Placement of Children with Parents etc. Regulations 1991(c) shall be amended in accordance with the following provisions of this regulation.
- (2) In regulation 1(2) (interpretation), the definition of “guardian ad litem” is omitted.

(a) Section 105(1) of the Children Act provides that “officer of the service” has the same meaning as in the Criminal Justice and Court Services Act 2000 (c.43). See section 11(3) of that Act.

(b) 1996 c.56.

(c) S.I. 1991/893 as amended by S.I. 1995/2015.

- (3) In regulation 8(4) (notification of placements)—
 - (a) for sub-paragraph (a) substitute—
 - “(a) the Primary Care Trust, or if there is no Primary Care Trust, the Health Authority, for the area in which the child is living and, if it is different, for the area in which the child is to be placed;”;
 - (b) in sub-paragraph (b), at the end, add “and, if it is different, for the area in which the child is to be placed;”; and
 - (c) in sub-paragraph (c), at the end, add “and, where applicable, any registered medical practitioner with whom the child is to be registered following the placement.”.
- (4) In paragraph 1 of Schedule 1 (particulars to be taken into account)—
 - (a) in sub-paragraph (f), for the words from “under” to “Act” substitute “for child minding or day care”; and
 - (b) for sub-paragraph (k) substitute—
 - “(k) details of any criminal offences of which he has been convicted, or in respect of which he has been cautioned by a constable and which, at the time the caution was given, he admitted.”.

Amendment of the Review of Children’s Cases Regulations 1991

4.—(1) The Review of Children’s Cases Regulations 1991(a) shall be amended in accordance with the following provisions of this regulation.

- (2) In regulation 1(2) (interpretation), the definition of “guardian ad litem” is omitted.
- (3) In regulations 1(2) and 12, in each place in which they occur, for the words “registered children’s home” substitute “private children’s home”.
- (4) For regulation 6 (health reviews), substitute—

“Health reviews

6.—(1) Subject to paragraph (2), the responsible authority shall, in respect of each child who continues to be looked after or provided with accommodation by them—

- (a) arrange for an assessment, which may include a physical examination, of the child’s state of health, to be conducted by a registered medical practitioner, or a registered nurse or registered midwife acting under the supervision of a registered medical practitioner—
 - (i) at least once in every period of six months before the child’s fifth birthday; and
 - (ii) at least once in every period of twelve months after the child’s fifth birthday;
- (b) require the person who carried out the assessment to prepare a written report which addresses the matters listed in Schedule 2; and
- (c) review the plan for the future health of the child prepared under regulation 7(1)(c) of the Arrangements for Placement of Children (General) Regulations 1991(b) at the intervals set out in sub-paragraphs (i) and (ii) of paragraph (a).

(2) Sub-paragraphs (a) and (b) of paragraph (1) do not apply if the child, being of sufficient understanding to do so, refuses to consent to the assessment.”.

(5) In regulation 13 (exceptions to application of Regulations), for the words from “on behalf of” to the end of the regulation, substitute “by a local authority or a voluntary organisation, in a school which is a children’s home within the meaning of section 1(6) of the Care Standards Act 2000.”.

(6) In Schedule 2 (considerations to which responsible authorities are to have regard), in paragraph 4, for “Education Act 1981” substitute “Education Act 1996”.

(a) S.I. 1991/895, as amended by S.I. 1991/2033, S.I. 1993/3069, S.I. 1995/2015, and S.I. 1997/649.

(b) S.I. 1991/890, as amended by S.I. 1991/2033, S.I. 1993/3069, S.I. 1995/2015, S.I. 1997/649 and these Regulations.

(7) In Schedule 3 (health considerations to which responsible authorities are to have regard)—

- (a) in paragraph 1, at the end, add “including his physical, emotional and mental health.”;
- (b) in paragraph 2, at the end, add “including, as far as practicable, his family health history.”; and
- (c) in paragraph 6, at the end, add “, and for advice and guidance on health, personal care and health promotion issues appropriate to the child’s needs.”.

Amendment of the Representations Procedure (Children) Regulations 1991

5. The Representations Procedure (Children) Regulations 1991(a) shall be amended as follows—

- (a) in regulation 11(2) (application to voluntary organisations and registered children’s homes), in each place in which they occur, for the words “registered children’s home” substitute “private children’s home”; and
- (b) in regulation 11A (exceptions to application of regulations) for the words after “voluntary organisation” to the end of the regulation, substitute “, in a school which is a children’s home within the meaning of section 1(6) of the Care Standards Act 2000.”.

Amendment of the Refuges (Children’s Homes and Foster Placements) Regulations 1991

6. The Refuges (Children’s Homes and Foster Placements) Regulations 1991(b) shall be amended as follows—

- (a) in regulation 2(1), in the definition of “home” and in regulation 4(2), for the words “registered children’s home” substitute “private children’s home”; and
- (b) in regulation 4(1) (withdrawal of a certificate)—
 - (i) in sub-paragraph (b), for “Part II of the Children’s Homes Regulations 1991” substitute “Parts III to V of the Children’s Homes Regulations 2001(c)”; and
 - (ii) for sub-paragraph (c), substitute—

“(c) where a foster parent providing a refuge fails to comply with any provision of—

 - (i) the agreements with him concerning the matters to which paragraphs 7 to 15 of Schedule 5, or paragraphs 4 to 8 of Schedule 6, to the Fostering Services Regulations 2002(d) apply; or
 - (ii) an agreement with him concerning the duties set out in regulation 38(3) of those Regulations in respect of an emergency placement under those Regulations; or”.

Amendment of the Children (Secure Accommodation) Regulations 1991

7. The Children (Secure Accommodation) Regulations 1991(e) shall be amended as follows—

- (a) in regulation 2(1) (interpretation), in the definition of “children’s home”, for “registered” substitute “private”;
- (b) in regulation 5 (children to whom section 25 of the Act shall not apply), in paragraph (1), for “section 53” to the end of that paragraph, substitute “section 90 or 91 of the Powers of the Criminal Courts (Sentencing) Act 2000 (detention at Her Majesty’s pleasure or for specified period)(f).”; and

(a) S.I.1991/894, as amended by S.I. 1991/2033, S.I. 1993/3069 and S.I. 2001/2874.

(b) S.I.1991/1507.

(c) S.I.2001/3967.

(d) S.I.2002/57.

(e) S.I.1991/1505, as amended by S.I.1992/2117, S.I. 1995/1398, S.I. 1996/692, S.I. 2000/694 and S.I.2001/2237.

(f) 2000 c.6.

(c) in regulation 7 (children to whom section 25 of the Act shall apply and have effect subject to modifications)—

- (i) in each of paragraphs (1)(b) and (3)(b), for “residential care homes, nursing homes or mental nursing homes” substitute “care homes or independent hospitals”; and
- (ii) in paragraph (3)(a) for “residential care home, a nursing home or a mental nursing home” substitute “care home or an independent hospital”.

Amendment of the Children (Secure Accommodation) (No 2) Regulations 1991

8. Regulation 2 of the Children (Secure Accommodation) (No 2) Regulations 1991(a) shall be amended as follows—

- (a) in paragraph (1), after the second mention of “health authority”, insert the words “Primary Care Trust”; and
- (b) in paragraph (2), for “residential care home, nursing home or mental nursing home” substitute “care home or independent hospital”.

Amendment of the Children (Leaving Care) (England) Regulations 2001

9. In regulation 4 of the Children (Leaving Care) (England) Regulations 2001(b), for paragraph (4)(b)(ii) substitute—

- “(ii) a registered establishment within the meaning of section 34(1) of the Mental Health Act 1983(c).”.

Signed by authority of the Secretary of State for Health

6th March 2002

Jacqui Smith
Minister of State,
Department of Health

(a) S.I. 1991/2034, as amended by S.I. 2000/694.

(b) S.I. 2001/2874.

(c) 1983 c.20. Section 34(1) is amended by section 116 to, and paragraph 9(4) of Schedule 4 to, the Care Standards Act 2000. A registered establishment is an establishment which is not a hospital for the purposes of Part II of the 1983 Act, in respect of which a person is registered under Part II of the Care Standards Act 2000 as an independent hospital in which treatment or nursing (or both) are provided for persons liable to be detained under the 1983 Act.

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make miscellaneous amendments to a number of sets of Regulations which govern the placement, care and accommodation of children looked after by local authorities in the exercise of their functions under the Children Act 1989, and related matters.

Firstly, they make consequential amendments to reflect the implementation of Parts I and II of the Care Standards Act 2000 in respect of children's homes and care homes. Various other minor and updating amendments are also made.

Secondly, amendments are made to the Arrangements for Placement of Children (General) Regulations 1991 and the Review of Children's Cases Regulations 1991 relating to the health and health care of children looked after by local authorities or accommodated by voluntary organisations and others. The Schedule of matters to be considered in relation to a child's health on placement and review is expanded. A health care plan is to be prepared for each child. The frequency of health reviews for children aged between two and five is increased. Health assessments on placement or review may, but need not, include a physical examination of the child, and reviews may be conducted by a registered nurse or midwife, under the supervision of a registered medical practitioner.

STATUTORY INSTRUMENTS

2002 No. 546

CHILDREN AND YOUNG PERSONS, ENGLAND

Children Act (Miscellaneous Amendments) (England)
Regulations 2002

Appendix 2

Suggested information collection

No and % of LAC registered with GP/dentist near to address of placement

No and % of LAC with outstanding immunisations identified

No and % of LAC failing routine screening for vision/hearing

No and % of LAC referred to specialist services following assessment

Broad diagnostic breakdown of referrals made

% of LAC referrals actioned and completed within 3 months – by diagnostic category

% of LAC who had health care plans agreed by the first review.

Appendix 3

Vaccination of children with unknown immunisation status

It is very rare that children born in the United Kingdom will not have received any immunisations whatsoever. Where a child 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:

- Patient Held Child Record (PHCR);
- GP records;
- Health visitor records;
- Child protection leads;
- Child health departments.

In the unusual 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.

Children coming to the UK, particularly from areas of conflict, may not have been fully immunised as per the recommended schedule of their country of origin. Details of these schedules can be found on www.nt.who.int/vaccines. These children should complete their immunisations in line with the UK schedule. The following table will help to determine which immunisations should have been given at which age.

Vaccine	Age	Notes
BCG	At birth	If high risk, e.g. babies born to immigrant families
Hepatitis B	At birth 1 month 2 months	If high risk, e.g. born to mothers who are carriers of hepatitis B or who have had hepatitis B during pregnancy
Diphtheria Tetanus Pertussis Hib Meningitis C Polio	2 months 3 months 4 months	1st dose 2nd dose 3rd dose Primary course
Meningitis C	5 months of age 1 month later	1st dose 2nd dose 2 dose schedule for previously unimmunised babies over 5 months and under 12 months
Hepatitis B booster	12 months	Blood test to check immunity
Hib	12–48 months	Single dose for previously unimmunised children
Measles/Mumps/Rubella (MMR) 1st dose	12–15 months	
Meningitis C	1–24 years	Single dose for previously unimmunised individuals
Pre-school booster of Diphtheria/ Tetanus/acellular Pertussis (DTaP) Polio MMR, 2nd dose	3–5 years	3 years after completion of primary course
BCG	10–14 years	Preceded by Heaf Test
Booster for young people of Tetanus/low-dose Diphtheria (Td) Polio	13–18 years	
MMR	Over 12 months of age and no upper age limit	2 doses with a 3-month gap if there is no previous history of MMR.

Appendix 4

The Content of a health assessment

THE NEEDS OF THE VERY YOUNG – UNDER 5

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

THE MIDDLE YEARS – 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.

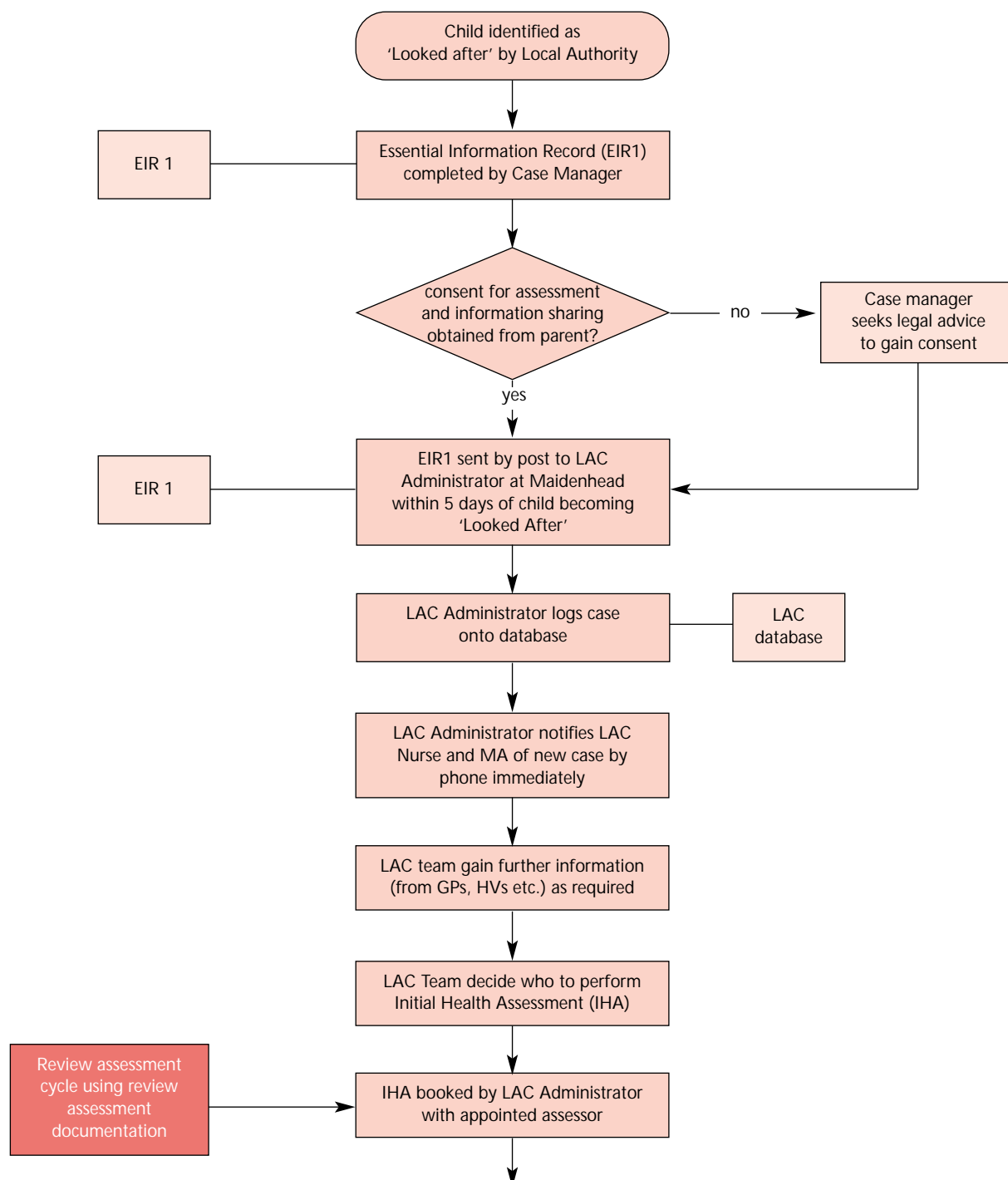
ADOLESCENCE AND LEAVING CARE – 11–18

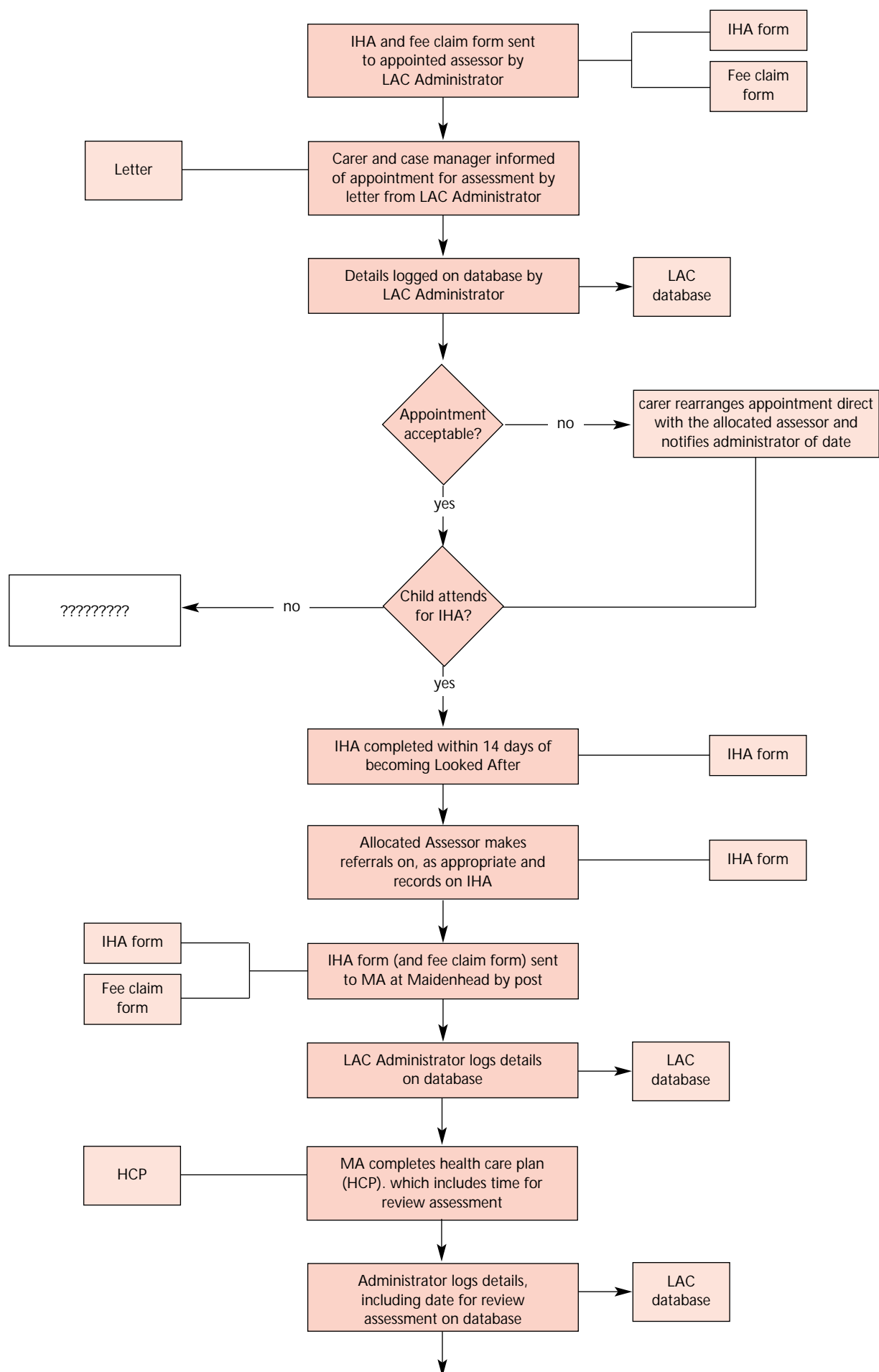
For secondary school age children and young people the focus will be on:

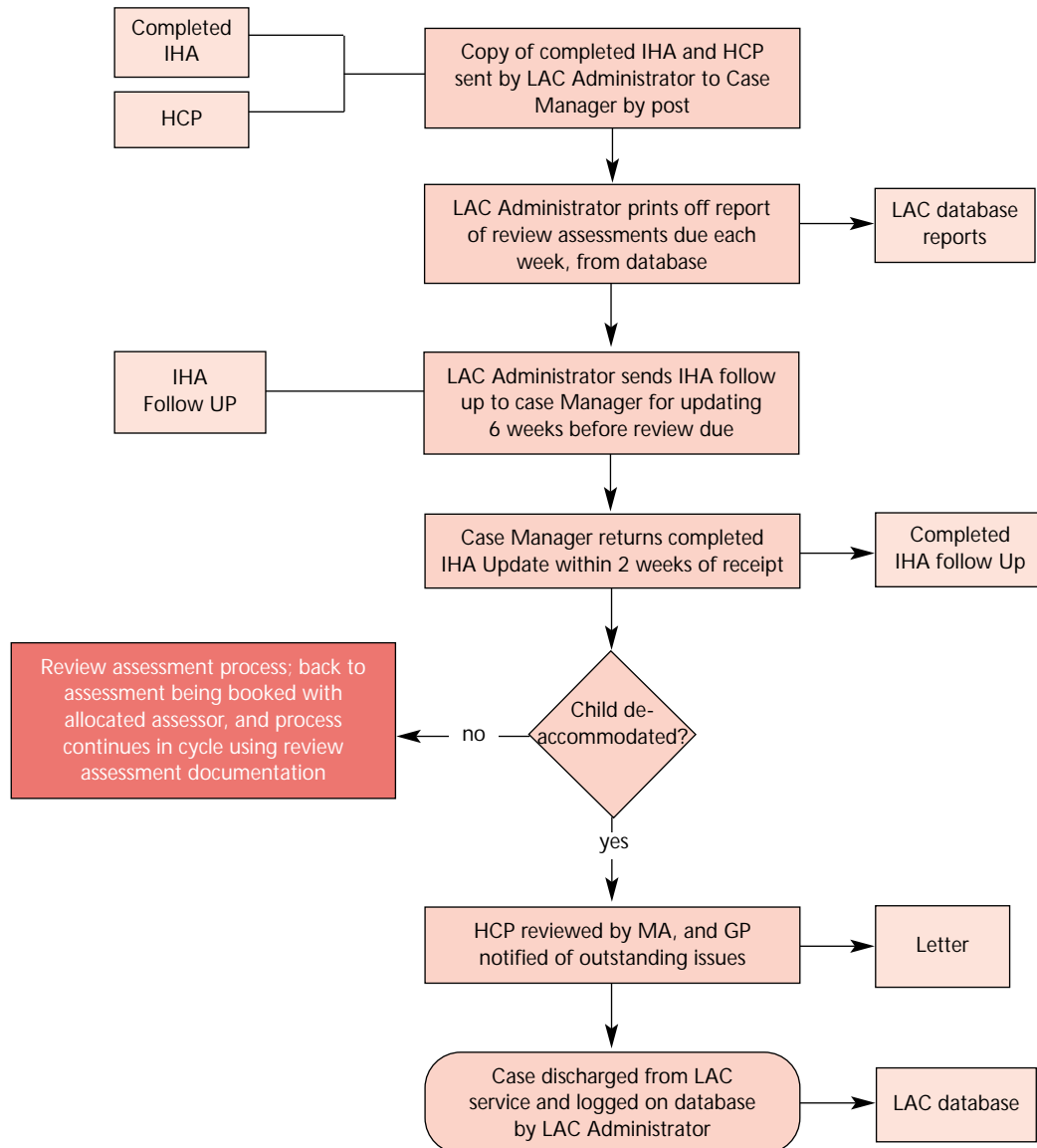
- ability to take appropriate responsibility for own health, including management of specific health conditions e.g. asthma, diabetes;
- communication and interpersonal skills;
- educational and social progress;
- lifestyle including diet and physical activity;
- mental and emotional health including 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;
- 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.

Appendix 5

Flow chart for health care of an individual child
(East Berkshire March 2002 v 2.0)







Appendix 6

Project Development Group membership

Helen Jones	Social Services Inspector, Department of Health
Jonathan Corbett	Social Services Inspectorate for Wales
John Hayward	Director of Public Health, Newham Primary Care Trust
Megan Hopkins	Primary Community Health Division, Welsh Assembly Government
Margaret Lynch	Professor of Community Paediatrics at Guy's, Kings and St Thomas' School of Medicine (On secondment to the Department of Health for the period of the project)

Appendix 7

References

- Acheson D. *Inequalities in health: report of the independent working party*. London: The Stationery Office, 1999.
- Arcelus J, Bellerby T, Vostanis P. A mental health service for young people in the care of the local authority. *Clinical Child Psychology & Psychiatry*, 1999; **4:2** 233–45.
- Bamford F, Wolkind S. *The physical and mental health of children in care: research needs*. London ESRC, 1998.
- Barn R, ed. *Working with black children and adolescents in need*. London: BAAF, 1999.
- Bebbington A, Miles J. *The background of children who enter local authority care*. *British Journal of Social Work* 1989; **19**: 349–368.
- Biehal N, Clayden J, Stein M, Wade J. *Moving on: young people and leaving care schemes*. London: HMSO, 1995.
- Bilaver LA, Keinberger Jaudes P, Koepke D et al. Notes on research. The health of children in foster care. *Social Care Review*, 1999; The University of Chicago.
- Broad B. Improving the health of children and young people leaving care. *Adoption and Fostering* 1999; **23 (1)**: 40–48.
- Brodie I, Berridge D, Beckett W. The health of children looked after by local authorities. *British Journal of Nursing* 1997; **6 (7)**: 386–390.
- Buchanan A. *Cycles of child maltreatment: facts, fallacies and interventions*. Chichester; John Wiley & Sons, 1996.
- Butler I, Payne H. The health of looked after children by the local authority. *Journal of Adoption and Fostering*, 1997; **21:2** 28–35.
- Butt J, Box L. *Family centres: a study of the use of family centres by black families*. London: Race Equality Unit, 1988.
- Caroline Walker Trust. *Eating well for looked after children and young people*. The Caroline Walker Trust, 2001.
- Chambers H, Howell S, Madge N, Olle Hannah S. *Healthy care: building on evidence base for promoting the health and wellbeing of looked after children and young people*. London: National Children's Bureau, 2002.
- Children and Young People's Unit. *Building a strategy for children and young people: consultation document*. Children and Young People's Unit, 2001.
- Clare M. *Understanding and improving the provision of general practice services to children in state care*. University of Western Australia, June 2000.
- Corlyon J, McGuire C. *Young parents in public care: pregnancy and parenthood among young people looked after by local authorities*. National Children's Bureau, 1997.
- Dartington Social Research Unit. *Looking after children: assessment and action records (revised version)*. London: HMSO, 1995.
- Department for Education and Skills. *Special educational needs code of practice*. Department for Education and Skills, November 2001. (DfES/581/2001).
- Department for Education and Skills. *Promoting children's mental health within early years and schools settings*. Department for Education and Skills, 2001.

- Department of Health. *Arrangements for placement of children (general) regulations 1991*. London: HMSO, 1991a. (SI 1506).
- Department of Health. *Review of children's cases regulations 1991*. London: HMSO, 1991b.
- Department of Health. *Substance misuse and young people: the social services response*. A Social Services Inspectorate study of young people looked after by local authorities. Department of Health, 1997.
- Department of Health (Social Services Inspectorate). *When leaving home is also leaving care: an inspection of services for young people leaving care*. Department of Health, 1997a. (CI(97)4).
- Department of Health. *The government's response to the children's safeguards review*. London: The Stationery Office, 1998. (Cm. 4105).
- Department of Health. *Quality protects circular: transforming children's services*. London: Department of Health, 1998. (Local Authority Circular LAC (98)28).
- Department of Health. *The government's objectives for children's social services*. London: Department of Health, 1999.
- Department of Health. *Me survive out there? New arrangements for young people living in and leaving care*. London: HMSO, 1999.
- Department of Health. *Promoting health for looked after children: a guide to healthcare planning, assessment and monitoring: consultation document*. Department of Health, 1999.
- Department of Health. *Saving lives – our healthier nation*. Department of Health, 1999a.
- Department of Health. *A dedicated centralised service for looked after children*. Department of Health: Quality Protects Newsletter (December 2000 edition).
- Department of Health. *Care Standards Act 2000*. London: The Stationery Office, 2000a.
- Department of Health (Teenage Pregnancy Unit). *Best practice guidance on the provision of effective contraception and advice services for young people*. Department of Health (Teenage Pregnancy Unit), November 2000b.
- Department of Health. *Children looked after in England at 31 March 2001 with three or more placements during the year*. London: Department of Health, 2001a.
- Department of Health. *Children (leaving care) act: draft regulations and guidance*. London: Department of Health, 2001.
- Department of Health. *Outcome indicators for looked after children, year ending 30 September 2000*. London: Department of Health 2001.
- Department of Health (Teenage Pregnancy Unit). *Guidance for developing contraception and advice services to reach boys and young men*. Department of Health (Teenage Pregnancy Unit), April 2001c.
- Department of Health (Teenage Pregnancy Unit). *Guidance for developing contraception and advice services to reach young people from black and minority ethnic groups*. Department of Health (Teenage Pregnancy Unit), April 2001d.
- Department of Health (Social Services Inspectorate). *Co-ordinated service planning for vulnerable children and young people in England*. Department of Health, 8 May 2001.
- Department of Health. *Shifting the balance of power within the NHS: securing delivery*. Department of Health, July 2001.
- Department of Health. *Making it happen: a guide to delivering mental health promotion*. Department of Health, 2001f.
- Department of Health (Teenage Pregnancy Unit). *Guidance for field social workers, residential social workers and foster carers on providing information and referring young people to contraceptive and sexual health services*. Department of Health (Teenage Pregnancy Unit), 2001e.
- Department of Health. *The integrated children's system briefing papers 1–5*. London: Department of Health 2001–2002.

- Department of Health. *The NHS Plan: a plan for investment a plan for reform*. London: The Stationery Office. July 2000.
- Department of Health. *Child protection responsibilities of primary care trusts*. Letter to Chief Executives of PCTs. Department of Health, 28 January 2002.
- Department of Health. *Establishing the responsible commissioner (draft consultation document)*. London: Department of Health, 2002a.
- Department of Health. *Fostering services national minimum standards and fostering services regulations*. London: The Stationery Office, March 2002b.
- Department of Health. *Children's homes national minimum standards and children's homes regulations*. London: The Stationery Office, March 2002c.
- Department of Health. *Residential special schools national minimum standards and inspection regulations*. London: The Stationery Office, March 2002d.
- Department of Health. *Boarding schools national minimum standards and inspection regulations*. London: The Stationery Office, March 2002e.
- Department of Health. *Children looked after by local authorities, year ending 31 March 2001, England*. London: Department of Health 2002.
- Department of Health. *Working with children in need and their families*. Consultation document. London: Department of Health, forthcoming.
- Department of Health, Department for Education and Employment. *Children's services planning guidance*. Department of Health and Department for Education and Employment, 1996.
- Department of Health, Department for Education and Employment, Home Office. *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: The Stationery Office, 1999.
- Department of Health, Department for Education and Employment, Home Office. *Framework for the assessment of children in need and their families*. London: The Stationery Office, 2000.
- Dimigen G, Del Priore C, Butler S, Evans S et al. Psychiatric disorder among children at time of entering local authority care: questionnaire survey. *British Medical Journal* 1999; **319**: 675.
- Drug Education Forum. Drug education in schools: making it more effective. DPAS Briefing Paper 2002.
- DrugScope. *Taking care with drugs: responding to substance use among looked after children*. DrugScope, October 2002.
- Gallagher B. The abuse of children in public care. *Child Abuse Review*. **8**: 357–365.
- Gesch CB, Hammond SM, Hampson SE, Eves A, Crowder MJ. Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners. *British Journal of Psychiatry* 2002, **181**: 22–28.
- Gilligan R. *Promoting resilience: a resource guide on working with children in the care system*. British Agencies for Adoption and Fostering, 2001.
- Hall DMB, Elliman D, eds. *Health for all children*. Oxford: Oxford University Press, 2002.
- Hill CM, Watkins J. *Does the statutory medical review offered to children looked after by Southampton city council provide an effective means of health assessment?* Report SE Regional NHSE, 2000.
- House of Commons. Health Select Committee. *Children looked after by local authorities*. London: The Stationery Office, 1998.
- Howell S. *Promoting health in care: a literature review. National healthy care standard*. National Children's Bureau, 2001.

- Jackson S, Williams J, Maddocks A, Love A, Chung W, Hutchings H. *The health needs and health care of school aged children looked after by local authorities*. Final report to the Wales office of research and development. University of Wales. Swansea: July 2000.
- Latham C. *Statutory health checks and personally held health records*. London: The Children' Society, 2000.
- Mather M, Batty D. *Doctors for children in public care. A resource guide advocating, protecting and promoting health*. London: British Agencies for Adoption and Fostering, 2000.
- Mather M, Humphrey J, Robson J. The statutory medical and health needs of looked after children. Time for a radical review? *Adoption and Fostering*, 1997; **21 (2)**: 36–40.
- Meltzer H, Gatward R, Goodman R, Ford T. *Mental health of children and adolescents in Great Britain*. London: The Stationery Office, 2000.
- McCann J, James A, Wilson S, Dunn G. Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal* 1996; **313: 15**: 29–30.
- McGuire C, Corlyon J. *Health promotion and looked after children in Brent and Harrow*. London: National Children's Bureau, 1997.
- NHS Centre for Reviews and Dissemination (CRD) University of York. Prevention and reducing the adverse effects of unintended pregnancies. *Effective Health Care Bulletin*, 1997; **3 (1)**: 1–12.
- National Children's Bureau. *Report of looked after young people's feedback on the national healthy care standard*. London: National Children's Bureau, forthcoming.
- Patel PB, Brook AM. Inequalities in health and education amongst looked after children in Leicestershire and Rutland. *British Association of Community Child Health Newsletter*, 2000; Winter Edition.
- Polnay L. Promoting the health of looked after children. Government proposals demand leadership and a culture change. *British Medical Journal*, 2000; **320**: 661–662.
- Richardson J, Joughin C. *The mental health needs of looked after children*. London: The Royal College of Psychiatrists, 2000.
- Roberts H. *What works in reducing inequalities in child health?* Ilford: Barnardo's 2000. NB 2001 in text.
- Rutter M, Tizard J, Whitmore K, eds. *Education, health and behaviour*. London: Longman 1970.
- Simms MD, Dubowitz H, Szilgyi MA. Health care needs of children in the foster care system. *Paediatrics* 2000; **106 (4)**: 909–918.
- Skuse T, MacDonald I, Ward H. *Looking after children: transforming data into management information, report of longitudinal study at 30.9.99, third interim report to the Department of Health*. Loughborough: Loughborough University, 2001.
- Skuse T, Ward H. *Looking after children: children and young people's views of care and leaving care, final report to the Department of Health*. Loughborough: Loughborough University (forthcoming).
- Skuse T, Ward H. (2001)? – [is this a separate reference to the one above see above.
- Stewart-Brown S. *Parenting, well-being, health and disease in Buchanan A, Hudson (eds) – Promoting children's emotional well-being*. Oxford: Oxford University Press, 2000; 28–47.
- Swadi H. Substance misuse in adolescents. *Advances in Psychiatric Treatment*, 6: 2000.
- The Children's Society. *Statutory health checks and personally held health records – the views of 14 looked after young people: health consultation with looked after young people*. The Children's Society, November 2000.
- The Health Advisory Service (HAS). *The substance of young needs*. Review 2001.
- Utting W. *People like us: the report of the review of safeguards for children living away from home*. London: The Stationery Office, 1997.
- Ward H, (ed). *Looking after children: research into practice*. London: The Stationery Office, 1995.

Ward J. Substance use among young people looked after by social services. *Drugs: education prevention and policy*, 5(3).

Ward H, MacDonald I, Skuse T. *Looking after children: longitudinal cohort study, final report to the Department of Health*. Loughborough: Loughborough University (forthcoming).

Ward H, Skuse T. *Looking after children: transforming data into management information, report of first year of data collection, second interim report to the Department of Health*. Dartington: Dartington Social Research Unit, 1999.

Webb E. Children and the inverse care law. *British Medical Journal* 1998; **316**: 1588–1590.

Who Cares? Trust. Remember my messages, Who Cares? Trust, 1998.

PHOTO REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



© Crown Copyright
Produced by Department of Health
30027 1p 6k Nov 2002 (ESP)
CHLORINE FREE PAPER

The text of this document may be reproduced without formal permission or charge for personal or in-house use.

First published: November 2002

If you require further copies of this publication
quote 30027/*Promoting the Health of Looked After Children* contact:

Department of Health Publications
PO Box 777
London SE1 6XH
Tel: 08701 555 455
Fax: 01623 724 524
E-mail: doh@prolog.uk.com

30027 can also be made available on request in braille, on audio cassette tape, on disk, in large print, and in other languages on request.

This publication is also available on the following website addresses:
www.doh.gov.uk/lookedafterchildren/promotinghealth.htm and
www.doh.gov.uk/qualityprotects/index.htm