Appendix 1

The Health of Children looked After in Southwark 2008/2009
Updated for Corporate Parenting Panel August 2010
Beatrice Cooper and Shola Yemi Designated health professionals for Southwark PCT

Key Points

The health of Children Looked After is

- everyone's responsibility
- important and valued by children and young people themselves
- much broader than health service needs or health assessments
- promoted by permanency, secured especially well by adoption but also Special Guardianship Orders and long term fostering
- There are excellent reviews of needs and research in the new Statutory Guidance "Promoting the Health and Wellbeing of Children Looked After". Nov 2009 (4)

Individual Health Care Plans are vital

- Need to be well done
- Distributed to right people
- Valued and Read
- Implemented
- Audited

Commissioning, health and social care

- Health needs to include CLA in contracts
- Social services need to include health in contracts
- Need specialist services such as CAMHS for CLA, including 16+
- Need for effective commissioning for Southwark CLA placed out of Borough

Current changes / challenges

- New DH Guidance Promoting the Health and Wellbeing of Looked After Children Nov 2009
- New joint NICE SCIE guidance on Health of Looked After Children, being finalised and due out soon
- New Inspection framework
- New Government –
    - Every Child matters website has the warning "A new UK Government took office on 11 May. As a result the content on this site may not reflect current Government policy."
    - "So far, this government hasn't said anything about their intentions for looked-after children – and with all the talk of cuts this silence is worrying." Ex CLA and foster carer Guardian 9.8.10
- Challenge of cuts to Southwark social care and PCT budgets
- Improving liaison with social care for children discussed at adoption panel
- Increasing use of Health Visitors and school Nurses to see children for Review health Assessments
- Discussions continue within NHS Southwark in regards to increasing the nursing and administration establishment required to meet the demands of the service

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Southwark health services for children looked after

- Health management Group – multi-agency and multi-disciplinary team across health, education and social care
- Dr Beatrice Cooper and Ms Shola Yemi, designated doctor and nurse for CLA; Dr Dilsiri Abeyakoon, Medical Adviser to Southwark Adoption Panels.
- Community paediatricians led and supervised by Dr Cooper see nearly all newly looked after children for Initial health Assessments and Initial Health Care Plan at Sunshine House Child Development Centre
- Admin team for Children in Need and PAs to Designated Dr and Medical Adviser and EOs at Social Care are part of the CLA health team
- Dedicated CAMHS Service for CLA, CareLink (not reported on in detail here)
- Preparation of Health Care Plans for CLA seen for Health Assessments by GPs
- Immunisation catch up service started at Sunshine House in last year
- Advice, training and and support to SWs, IROs, foster carers
- Liaison with other parts of health service around needs of individual CLA
- Sexual health advice to older CLA
- Review health Assessments in their own home for older children and "refusers" by CLA Nurses
- Medical Adviser to Adoption Panel – detailed assessments, reports and information gathering; vital contribution to and decision making panel

External Evaluations of Health Services to Children Looked After

- Southwark's CLA Health service was rated good in JAR inspection in 2008, and "The effectiveness of support for children and young people's physical and emotional health." was classed a major strength
- The health support for looked after children and young people, both placed within and outside the borough, is good.
- Southwark has the highest number of adopted children in SE London, with only one disruption in the last 8 years.
- Inspection of Adoption service (2008) commented "The medical adviser has been called outstanding by both professionals and adopters. Her dedicated approach ensures that the health needs of children are fully considered and communicated to prospective adopters before any match is agreed"

Appendix 1

Introduction:
An Annual Report by the Designated Doctor and Nurse for Children Looked After (CLA) is required by the new Statutory Guidance Promoting the Health and Wellbeing of Looked After Children 2009.[4]

This report aims to inform key stakeholders of an overview of the health needs and gaps in service for this very vulnerable group of children and of the relevant statutory guidance.

The health of children looked after has been recognised as poorer than other children nationally and locally; In Southwark the multi-disciplinary and multi-agency health management group (HMG) have reviewed need and services via the health part of the annual business plan for CLA, the LA performance indicators for health, and audit. We have concentrated on improving the quality of health assessments, tracking processes to improve the availability of Health Care Plans to Social Workers and other key agents in implementing plans.

The new Statutory Guidance (P38) emphasises the importance of the NHS contribution:

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

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

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

The new Statutory Guidance (P40 11.3.2) requires an annual report:

- *an annual report to inform the appropriate provider board and the commissioners;*
- *the collection and analysis of data to inform the profile of looked after children in the area for CYPP needs assessment;*

In the Practice Guidance this is described more fully (P75):

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 (The role of designated health professionals P74) and the effectiveness of health care planning for individual children and young people looked after, and describe progress towards relevant performance indicators and targets;*
- *it should also include the results of any independent local studies of the accessibility of health assessments to the children and young people themselves, to foster carers, parents, social workers and to health professionals;*
- *the report will be presented to the Chief Executive of the PCT Board who commissioned it and the Director of Children's Services.*

Of particular relevance to the annual report in the roles of the designated health professionals is the following section on P74:

Monitoring and information management

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- *ensure the quality of health care assessments carried out;*
- *ensure full registration of each looked after child – and all care leavers – with a GP and dentist;*
- *ensure that sensitive health promotion is offered to all;*
- *provide an analysis of the range of health neglect and need for health care for local looked after children – i.e. casemix analysis;*
- *ensure implementation of health plans for individual children;*
- *contribute to the production of health data on looked after children;*
- *ensure an effective system of audit is in place;*
- *review the patterns of health care referrals and their outcomes;*
- *evaluate the extent to which looked after children and young people's views are informing the design and delivery of the local health services for them.*

NICE / SCIE Guidelines on Health of Looked After Children are being developed and will be out soon. These are likely to have further recommendations for evidence based practice for health. In addition, the PDG endorsed the six entitlements of the National Children's Bureau's 'National healthy care standard2' – a child or young person will:

- have access to effective healthcare, assessment, treatment and support and have opportunities to develop personal and social skills, talents and abilities and to spend time in freely chosen play, cultural and leisure activities (6)

Background

The legislation and guidance behind health and social care for children looked after (CLA) starts with the Children Act and the United Nations Convention on the Rights of the Child. The Children Act 1989 sets out the ways in which children may become looked afte, defines parental responsibility. It also introduced two important principles for court decisions: a court may not grant an order eg Interim Care Order, if the child does not need one to be safe; and the child's needs are paramount in decisions about its care. The UN Convention speaks of rights including to health and treatment, recovery, family life, reintegration and rehabilitation for illness, recovery from abuse and neglect.

The current policy context for Southwark's shared responsibility is the umbrella of the *Every Child Matters* (2) framework for improving outcomes for children and young people and the programme set out in the *White Paper, Care Matters: Time for Change* (3), for improving outcomes for looked After Children. Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children has been published in November 2009. This imposes statutory duties on Local Authorities, Strategic Health Authorities and Primary Care Trusts to meet the health needs of all Looked After Children (4). There is special mention of the need for extra attention to the implementation of Health Care Plans, health promotion, and joint commissioning of services around sexual health and substance abuse.

The term 'Looked after Child' was introduced by the Children Act 1989 to describe children in the care of the local authority in England and Wales. These children are amongst the most socially excluded and disadvantaged of our child population. Failure to protect their health may worsen their life prospects and exacerbate previous damage and abuse. The results from research are shocking. Nearly two thirds have mental health problems, a quarter having a major depressive illness (1). 20-30% of Children Looked After have learning difficulties and 25% of children who have been in care for more than a year have a statement of educational needs, compared to 2-3% of all children. Up to 44% of substance and alcohol abusers will

have been in care as will 23% of the adult prison population. Other adverse outcomes as adults are early pregnancies, high unemployment and homelessness. Regulations (supporting Care Standards Act 2000) require that children looked after have an Initial Health Assessment by a medical practitioner and Review Health Assessments annually for the over 5s and 6 monthly for the under 5s. Most children are up to date with their annual health and dental assessments.

This report focuses on the health service contribution to the health of children looked after. Many other issues are very important to children and young people's health and wellbeing such as educational attainment, placement stability and adoption; this report has not addressed them separately.

Children and Young people Looked After, Nationally

Data for year to end March 2009
There were 60,900 children looked after as at 31.3.09 up 2% from previous year.
This is a rate of 55 per10,000 children, ie 0.55%; 57% boys

35,500 had been looked after for more than a year
3,300 children were adopted, up 3%

Reason given for becoming looked after, and legal status much the same as previous years
Abuse and neglect 61%; (Full) Care Orders 59%

Children and young people looked after in Foster care 73%, up 5 %
3,700 UASC up 5% - 87% male

Children and Young people Looked After, Southwark

Over the last 6 years there have been around 600 Looked After Children (LAC) at any one time, approximately 1% of Southwark Child Population. This compares to a national average of approximately 0.6%.

There has been a steady decrease in the number of children in care at a given point than in previous years which has continued. Nationally CLA have increased from 2008-9, probably influenced by the Baby P case, which was reflected in an increase in CLA in Southwark between March and October 09 from 535 to 573, and since decreased to 558. There continues to be a high number of children who have remained in care for a year or longer, although this figure has continued to gradually decline in Southwark.

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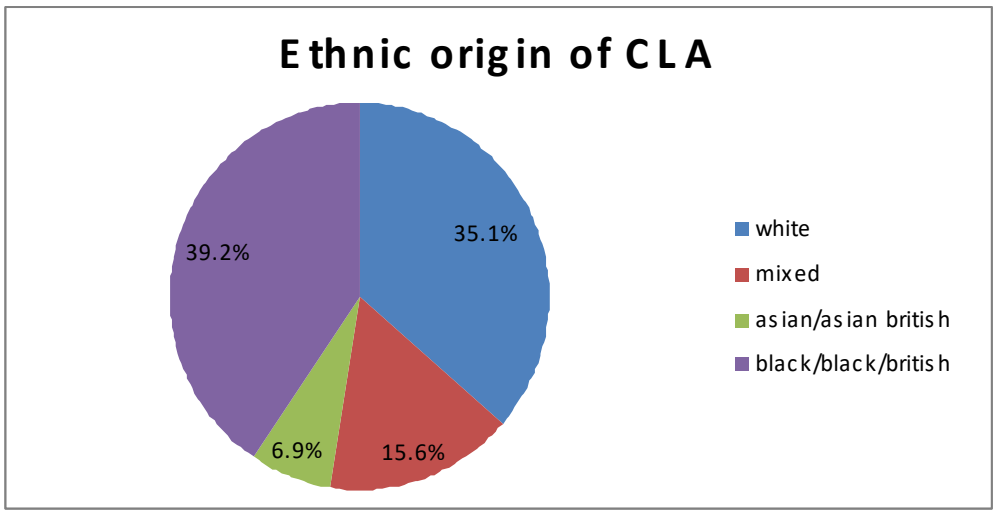
Ethnic origin at 31.10.09:



Numbers and Health Performance Indicators Southwark (England)

	2007	**2008**	**2009**
Number of Children Looked After (as at 31 March)	620 (60,000)	570 (59,400)	535 (60,900)
CLA more than 1 year	430 (44,200)	395 (43,700)	371 (43,200)
CLA starting to be looked after	255 (24,000)	225 (23,300)	220 (25,400)
Immunisations up to date	73 (80%)	89 (82%)	79 (84%)
Health Assessments up to date	84% (85.1%)	92% (86.5%)	92% (85.9%)
Substance Abuse problem	4.9 (5.4)	5% (4.9)	5% (5.1%)

Year to end Sep 2009

Children who came into care in year to 31/09/09 and who stayed in care for more than 30 days **223**
Children who have been in care for a year or more as at 30/09/09 **371**

Permanency panels, previously 2x month now all day once a month.
Children presented to Permanency Panel for decision for adoption
Jan – Dec 2009 inclusive **29**
Adults presented to Panel for approval as adopters **31**
Adoptions, year to 31.3.2009 **30**

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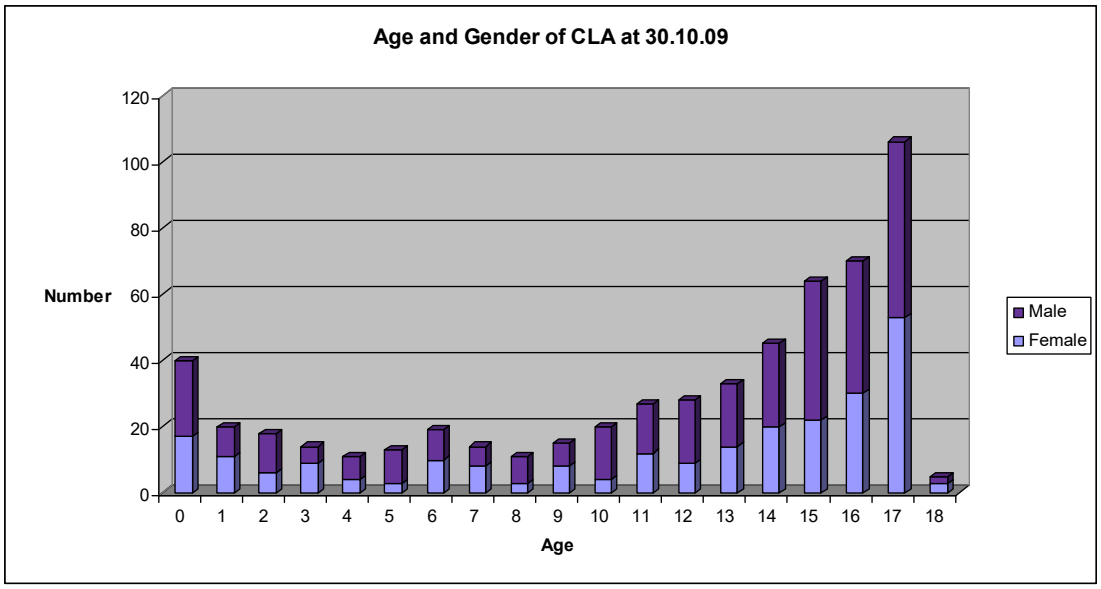

See also Business Plan – parts relevant to Health – attached

An important issue for Southwark has been the number of refugee and asylum seeking children. This has been reducing whereas the numbers elsewhere and nationally have been increasing. The children looked after in Southwark are ethnically and culturally very diverse, which includes unaccompanied asylum seekers and children from asylum seeking families. Many children and young people and their families require support in using services, and their culture and religious background must be taken into account. Providing for 15-18 year olds presents particular problems. It is important to arrange access to appropriate care for unfamiliar diseases and to recognize emotional health problems, particularly when they are related to past experiences of violence.

Gathering information on immunisations and giving missed immunisations are frequently part of the health care plans but not often done. The reasons for this are as yet unclear. We have introduced a monthly immunisation catch up clinic.

30% of children looked after for more than a year have a statement of educational needs. There are higher rates of developmental disorders, such as ASD and ADHD, which may have gone previously undiagnosed. Mental health and behavioural difficulties, along with a number of other factors in the child and carer, are linked to increased risk of placement breakdown.

We have not collected data on specific health problems identified at assessment. A survey in 2003 [5] showed that half of Children Looked After at an Initial assessment needed specialist outpatient services. Two thirds of these children had physical problems.

½ Need referral to out patients departments

- 10% no health recommendations
- 30- 50% mental health problems
- 20- 30% learning difficulties
  - 25% care > 1 year have a statement of SEN

C M Hill and J Watkins 2003 Child Care Health and Development 29 (1) 3-13

Local audit and the overview of initial and review health assessment has demonstrated that the pattern is very similar in Southwark. Anecdotally less than 10% have no health recommendations.

Appendix 1

Care matters: Time for Change expects improvements in sex and relationship education for looked After Children and increased support for pregnant women and mothers in care or who are care leavers. Southwark has appointment the named Nurse and designated nurse to help provide this education and support. From 2009/2010, the number of teenage pregnancies was to be added as a performance indicator; whether this will still happen after the change in government is not yet clear.

Southwark's PCT Strategic Plan is very relevant to Children Looked After

Four strategic aims:

- A healthier population
- More health services provided in community/ primary settings rather than hospitals
- Focus on prevention and health and well being across key public and private partners
- Patients at the heart of planning services

Context:

- Over reliance on hospital based services
- Under developed primary and community services
- The PCT's current profile of expenditure is unaffordable
- The affordability analysis requires £18m of savings in 2010/2011
- Our commissioning strategy is driven by the need to achieve a system of healthcare which is financially sustainable

Nine initiatives in place. *Especially relevant to CLA in italics*

1) *Maternity and new born*
2) *Children and young people*
3) *Staying healthy*
4) Long term conditions (includes diabetes and CVD)
5) Unscheduled care
6) Planned care (includes cancer)
7) End of life
8) *Mental health*
9) *Patient experience*

Service
Staffing

In Southwark, based at Sunshine House Children and young peoples centre, there is a designated doctor, adoption medical advisor, designated nurse and named nurse and a dedicated Children and Adolescent Mental Health service (CAMHS) service) that provides a service; clinical governance, includes the use of clinical audit to assess coverage, impact and outcomes.

BC was appointed, after a period of locum cover, in September 2004, to provide more time to fulfil the designated doctor role. There was a long period without a designated nurse for CLA until SY was appointed in 2006.

There have been on going severe problems with capacity, especially for developmental assessment and review of children with developmental difficulties, administrative tasks, and for the review of GP completed Review Health

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Assessments. Unfortunately our data systems are such that we have problems identifying children who need review and cannot collect accurate activity or outcome information.

Current Staffing

- 2 sessions Consultant Clinical time BC
- 1 session Designated Doctor time BC
- 7 Sessions Clinical and Medical Advisor to the Permanency panel
  4 Sessions medical adviser, 3 clinical sessions DA
- 4 sessions other Dr clinical time, + 1 for GP RHAs
- 1 WTE CLA Designated Nurse SY
- *1 WTE Named nurse for CLA – recently vacant due to retirement*
- 1 WTE admin post CLA
- *0.5 WTE Admin support – partially covered*
- 0.75 WTE PA post supporting Medical Advisor
- Support from EOs in LA, with close liaison with Sunshine House admin staff.

Comparison with local areas and national recommendations (WTE)

	Southwark	**Lewisham**	**Lambeth**	**Recommended**
CLA desig sessions	0.1	0.26	0.3	0.25[1]
MA sessions	0.4	0.4	0.6	#0.3 for panel + clinical per child / adult 0.15[2]
CLA nurses	2 (WTE,1 in post)	2 (WTE, 1 in post)	2 (WTE, 1 in post)	
CLA admin	1+	1 ½	2 +	"Sufficient"[2]
MA admin	½ PA includes some CLA	1/3 PA time	Appt letters	
HA done by	Send out all Some to GP In house and nurses	IHA by Drs RHA by HV, school nurses	Send out all Most in house Drs and Nurses	Led by Health Done by well trained health professional [3]
Distribution Whole Health assessment to	GP: IHA only	GP, SN/HV	GP, SW, SN/HV	GP all
Distribution Health Care Plan	HCP from RHAs and IHAs to GP, SW, Carer, HV/SN, Young person if over 13,	HCP from RHAs and IHAs to carer, SW	?	
Lead HCP role for children with disability	none			0.13 sessions[3]

½ per adopter; per child new assess 1.5 rev 1; collating 4; rpt 1/ c; overseas 3; counselling adopters 2

Recommended staffing

1- is from Child Health Promotion Report, 4th Report, Hall.
2- BAAF proposed JD and competencies
3- is from Promoting the health and Wellbeing of Children Looked After

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BAAF addressed this issue and noted that the 4th Hall report recommended 1 session (0.1 wte) designated doctor time per 100,000 people in a district. Notwithstanding the 2x greater than average looked after children rate in Southwark this would be 2.5 sessions.

Health Assessments
Overall I anticipate that there should be 220 + IHA per year and approx 400 + RHA per year for children and young people looked after by Southwark.

The clinical time recommended for health assessments by doctors at Sunshine House is adequate for the number of children seen but not to accommodate all Review Health Assessments.

Initial Health Assessments are nearly all carried out by the designated doctor and her community paediatric colleagues at Sunshine House in Southwark. 223 children became looked after last year, and remained so for more than 4 weeks. 188 were referred to us and we offered approximately 233 IHA appointments (data collection periods are not the same). Our attendance rates are very high with only 10% failing to attend.

Paediatricians at Sunshine House offered about 500 appointments in the last year to children for Initial and Review Health Assessments, including those for the Permanency panel. Slightly less than half were for initial health assessments; about 280 for reviews, mainly the most complex children.

The CLA Nurses completed about 115 RHA individually counted in the year. A few were requested from HV and school nurses although none have so far been received.

GP health assessments received at Sunshine House were about 100 per year; anecdotally some are not received at SH although they are recorded as having been done by CF. The cost varies: from nothing as the payments system seems to be poor; GPs claim from £32 – 120; and are generally paid £72. The PCT payments department have not been able to supply details, as they do not seem to collect them separately for different sorts of GP claims. The guestimate of the amount paid out is 100 x 72= £7200.
The Statutory Guidance requires (P40, 11.3.2)
Health professionals performing health assessments and contributing to health care planning have the appropriate skills and competencies by receiving appropriate training;

It is very difficult to train GPs who are all over the country, and who have very different interests and expertise which may not include the health promotion and sex education of teenagers. GPs are increasingly reluctant to assess these children. It would be much better, clinically and administratively, to have most of these children and young people seen by trained HVs or School Nurses or by specialist CLA nurses. We are struggling to get the funds transferred to pay for salaried posts such as additional CLA Nurse time.

CLA nurses and community paediatricians at Sunshine House do not currently have the capacity to see the approximately 100 children who are seen every year by GPs. Many of these children, indeed all the under 5s, should already be having an enhanced level of HV service. We aim to ask the child's HV to complete their Health Assessment and HCP. This would avoid duplication for the child, carer and the NHS

and would enhance the HV role working with the child and family. We are planning to start training soon and evaluate the change in practice, with support from the Commission for Quality in Innovation. School nurses might not already be seeing school age children and might need additional training and time. The supervision of the Health Assessments and HCPs would be by the CLA Designated Dr and Nurse: BAAF estimated that this supervision work would be about 1 hour per child – 100 hours, approx 1 session per week. With additional training and support, and time for collecting information this would require at least 1.5 sessions nurses time, which would be covered by re-allocating the GP fees.

Court Work
The designated doctor has been asked to provide many reports for CLA for court proceedings, mainly child care proceedings but also criminal cases. This is entirely appropriate and we hope helpful to SS and the courts' decisions about children's futures, but represents an increasing amount of work under tight time pressure.

Permanency Panel and Adoption Work
This is an important and time consuming, and time critical part of our work. We understand the difficulties in scheduling compounded by uncertainties about court etc. We were experiencing more problems than we used to, knowing about children likely to be going to panel 2 weeks before the Adoption Panel. We have tried to improve this with regular liaison with adoption and fostering and CLA SW Teams; we still have to do some chasing of CLA Teams. We are working on advance warning of children likely to go to panel and a simple system of notification, as soon as it is decided, of who will be going forward to the next panel. The current situation with issues of recruitment and retention of SW staff makes it difficult for us to see the children, gather all the necessary information, and write reports in time for panel.

The collection of information continues to be very time consuming. The collection of maternal and neonatal health information has improved but the receipt of parental health information is still very poor prior to presentation to panel. There could be ways of trying to improve this routinely now there are dedicated health admin in place in SS or by closer working. However all boroughs and health staff I know of or have worked with have found this difficult. Obviously improving the follow up and implementation of the recommendations of HCPs would help the panel work.

The amount of reading for panel has considerably increased over the last couple of years in response to changes in Adoption law and regulations. This has been better for decisions but has increased the amount of time for the medical advisor in preparation for the panel and at panel. The time estimates from the BAAF job descriptions pre-date these changes.

Post adoption work has also increased, for community paediatric and CAMHS services.

Data Collection
There have been considerable problems collecting activity data for all areas of work at Sunshine House, because of major problems with reporting on RiO, and it took a while for PCT staff to build up confidence in the reporting of data on CareFirst and the initial teething problems of establishing regular data input. We cannot collect the data we need from CareFirst directly.

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Clinical Oversight
All Initial health Assessments (IHAs) are referred to Sunshine House. With the exception of a few Initial health Assessments carried out by other Health care professionals eg a GP where a child is placed in a mother and baby placement in Bristol or another paediatrician where a child is already followed up closely by them, all IHAs are carried out by the community Paediatricians at Sunshine House. Review health assessments (RHA) for children who have significant health or developmental needs, or who are likely to be adopted, are also carried out at Sunshine House. These are closely supervised and their Health Care Plans (HCPs) are signed off by the designated doctor or medical advisor for adoption. The designated Nurse writes the HCPs from the assessments completed by the nurses and the designated doctor and a community paediatric colleague write the HCPs from the assessments completed by other paediatricians and GPs.

Clinical Audit
Health Care Plans are the summary and Action plan form the health assessments. They are an essential output from the Health Assessments. However as Promoting the Health and Wellbeing of Looked After Children noted the Plans are often not implemented; our audits noted this locally too. Audits have looked at process, health care plans and implementation of health care plans. Successive audits have highlighted substantial delays in the distribution of Health Care Plans (HCP), particularly the HCPs that are written by the designated doctor and colleague from the GP health assessments.

Subsequent audits looked at the availability and implementation of HCPs by SW and CLA reviews. We discovered that many were unreadable, because of poor handwriting and scanning onto SS electronic records; as a result of these audits HCPs are now always type written.

Where HCPs could have been available to Child Looked After Reviews their significance and the need for action were not always understood or brought to the attention of the review. Working closely with Social services we have enabled health professionals at Sunshine House to directly enter HCPs onto Care First (CF, SS electronic record). Initially this was fraught with problems of access, but is now being used more consistently. The advantage of direct entry to CF is the ease of availability to Social Workers and the Reviewing Officers, and the ability to pull through recommendations form the HCP to individual child or young person's reviews.

The multi-disciplinary audit in October 2008 was inspired by the need to prepare young people for transition to adult life and concentrated on one group of particularly vulnerable young people: the children in year 9 (14 years old on average) who had statements of special educational needs. We had previously identified transition to adult life as of key importance for young people looked after and had expressed concern to the multi-agency transition panel that the needs of vulnerable CLA could be missed. We had also identified a difficulty in getting prompt appropriate assessments for these children, especially psychological assessment of learning needs.

There were 10 boys and 5 girls; 1 young person was accommodated under Section 20, the rest on Full Care Orders (FCO), with no unaccompanied asylum seekers. Most of these teenagers had been in care for a long time; had learning difficulties (60%) and/or behavioural difficulties (47%). 3 teenagers` (20%) also had a diagnosis of Attention Deficit and Hyperactivity Disorder (ADHD) and 3 of Autistic Spectrum Disorder (ASD).

Appendix 1

This audit highlighted incomplete information in health and social services files about the special educational needs and relevant assessments and an unexpected difference in opinion between SS and health auditors on the need for further assessments to inform their needs as a child and especially to inform their need and eligibility for adult health services. We felt this was likely to reflect the different perspectives and expertise. This was particularly in the area of mental health and psychometric assessments. Dr Cooper, designated doctor for CLA, and Elizabeth Murphy, Head of CareLink, have reviewed the files of some of the young people where there was particular discrepancy. We felt that it would be helpful to look in more detail at these children's needs and will collect more information and 3 will be seen for more detailed assessment by a CareLink psychologist.

The most recent audit in 2009 was of children who were reported on CareFirst as having refused Health Assessments. Many young people reported as refusers had in fact been seen for health assessments, or had had analogous assessments from which a good HCP could be derived.

Peer audit will be introduced for all community paediatrician health assessments at Sunshine House this year.

Distribution of the HCP – a bottle neck in administration
It is vital that the Health Care Plan (HCP) summary and recommendations are shared with the health professionals involved with a child, the carer, social worker, and parents where appropriate. Long delay in distributing HCPs risks undermining all the good health assessments and analysis of a child / young person's needs. This was recognised as a clinical risk after a vacant post was frozen because of financial crisis in the PCT earlier in 2010. Fortunately a little more resource has been made available to the admin team. The distribution of HCPs is now almost up to date. Health and Social Services have worked closely to minimise duplication and maximise efficiency and a lot more has been achieved within the same resources.

Implementing the Actions of the HCP
This is a key issue that has come out of audit and local experience which showed that many (usually about ½) recommendations from HCPs are not being implemented. This is not just by Social care, eg foster carers and Social Workers, but also by health visitors, GPs, community paediatricians and hospital staff. Research, highlighted in the new Statutory Guidance showed similar problems had been found elsewhere and proposed a lead health professional (P42)
11.5.2 This lead health professional will:

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

There remains some uncertainty about how to deliver this and the National Children's Bureau was consulting with stakeholders on behalf of the DCSF possibly to develop more guidance on this. The introduction of this role did have cost implications identified in the economic impact assessment accompanying the draft guidance. It is

not clear how this statutory guidance will, or can be, implemented in the light of cuts and different priorities of the new coalition government.

Local audit also revealed that recommendations were not always being discussed at Care Reviews. We hope to improve the reviewing and implementation of health recommendations at Care Reviews by the direct entry onto CareFirst of HCPs and strengthening the SW and IRO responsibility for reviewing and implementing the HCP.

Children with disability

27 children are looked after with significant disability in the children with disability team. These do not include those CLA for short breaks / respite care. The disabilities of these children and young people are profound and lifelong, and most of these children are placed in specialist provision out of borough. The designated doctor and nurse have not been able to concentrate adequately on these children as mostly their special needs are met by specialist paediatricians. However they have been consulted on individual children and it is apparent that the specific needs of children as looked after and without a normal parent and with the loss of past information and family historical context can be detrimental. There is a need to refocus highly specialist paediatrician time and attention to these extremely vulnerable children away from the more routine processes of CLA administration and reviews. A lead health professional role for the specialist nurses for children looked after would be very appropriate. The financial implications assessment included with the consultation for the statutory guidance estimated the time needed for the lead role for more needy children in a range of 4-6 days per child per year.

The cost of a statutory role of a lead health professional has been calculated as somewhere between £6.2 m and 9.3m. This calculation was done based on 2008 salaries, and based this on three scenarios, to reflect the current uncertainty around the costs for lead health professionals. The scenarios are based on three different sets of assumptions about the number of days of staff time required per annum for each child and the proportion of children who have more complex needs. These assume that 85% / 80% / 75% of looked after children need 1.5 / 2 / 2.5 days of band 6 nurse time per annum and 15% / 20% / 25% need 4 / 5 / 6 days of band 7 nurse time per annum (the children with more complex needs).

Clearly the children looked after within the children with disabilities team would be included in the most needy group. Unfortunately no monies have been identified to cover this see above. To meet this need currently less of something else would have to be done.

Children in criminal justice system/ secure children's homes, under Mental Health Act Sections.

These children have been rightly identified as having particular health needs and also particular difficulties in accessing health.

The Statutory Guidance states:

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

It has often proved difficult to obtain copies of health assessments for children in secure establishments but anecdotally I have felt that, when seen, the quality of these reports has been high. As with distribution of health care Plans from GP and our assessments their utility is much reduced if they are not available to future carers and GPs and SWs.

Sexual Health of CLA: This section written by Shola yemi, August 2010

Appendix 1

This report provides a summary of the work of the CLA health nurse team with respect to Sexual health.

The team currently consists of me (Shola Yemi) the Designated Nurse for Children Looked After and the Specialist Nurse for Children Looked After – who worked 3 days a week, but has recently retired from her post - leaving a 1 wte service gap.

The Designated Nurse role is part strategic and part operational. The Specialist Nurse's role is focused on teenage pregnancy and sexual health – This leaves a gap in service deliverability. However the Designated Nurse will continue to fulfil this role with support from the Designated Doctor for CLA.

The Nursing team is responsible for the health and welfare of all the children looked after in Southwark – including those who live out of the Borough. The nurses, working closely with the Medical team, have some responsibility for their sexual health. This requires close working relationships with other professionals, in health and other agencies, including the voluntary sector; we work with them to make health care for CLA a seamless, co-ordinated, overarching contact.

The nurses are also co-located at the 13+ unit at Bradenham for 1 day a week – allowing for drop in sessions and closer working with the young people who have contact with their Social Workers based there, and their Social Workers. The CLA Nurses are a resource used by many of the young people aged 13 to leaving care and beyond for support, information, advice and advocacy.

Southwark has some young people orientated specialist sexual health services with excellent sexual health promotion which helps to maintain safer, pleasurable sexual health as a right. We support the young people looked after in accessing appropriate sexual health services. We use effective, evidence-based sexual/relationship education and support from family and community members.

London has high rates of Sexually Transmitted Infections, HIV, teenage pregnancy rates, abortions including repeat abortions:

- 1 in 5 reported incidences of Chlamydia in the UK in 2005 were in London
- 1 in 3 reported incidences of Gonorrhea/syphillis
- 1 in 4 reported incidences of Anogenital Herpes
- In 2006 53% of new HIV diagnosis in UK were in London
- 15% of England's Under 18 conceptions in 2005 were in London
- Abortion rates higher in London than England (across all age Groups)

Accessible information: [1234]

- people want accessible information - DEFINE study shows young people lack biological understanding and are embarrassed to discuss sexual health
- services that are people-friendly and open locally to meet their needs
- services promote self care and management

The Audit Commission estimated that £1 spent on contraception services would save the NHS £11.5 HIV prevention is better than cure, with considerable savings to the NHS.

There are identified key actions and levers which are required to ensure implementation of Sexual Health services in Southwark. These are demonstrated in Southwark's Teenage Pregnancy Strategy- which has previously been presented to the Board.

Appendix 1

Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies (DfES non-statutory guidance, July 2006) identifies risk factors to help local areas to identify and target vulnerable groups:
Risky behaviours:

- Early onset of sexual activity
- Poor contraceptive use
- Mental health/conduct disorder/involvement in crime
- Alcohol and substance misuse
- Teenage motherhood
- Repeat abortions

Education-related factors:

- Low educational attainment
- Disengagement from school
- Leaving school at 16 with no qualifications

Family/Background factors:

- Living in care
- Daughter of a teenage mother
- Ethnicity

These early identifiers are very common, often in combination, in children looked after. The CLA Nurse will work with the named Social Workers in assessing the risk to each young woman aged 13- 18 years old, of early sexual problems or early teenage pregnancy. The nurses work with the SW, her carers, and the young women to try to reduce the incidence of sexual health problems and teenage pregnancies.

Many young people - girls and young men with sexual health problems/issues like to know that they are able to call the CLA Nurse at any time, and that they may be accompanied to the local sexual health clinic, whilst empowering them to access this service by themselves in future. Each CLA Nurse contact with a young person includes meaningful dialogue about sexual health promotion, early pregnancy prevention and follow up support as required. Mobile contact numbers are often exchanged as the young people will use this when they feel they have no where else to turn and they have built up a good rapport with the nurses.

Sexual Health of CLA: This section written by Shola yemi, August 2010
References

[1] National Institute for Health and Clinical Excellence (NICE). One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Feb. 50 p. (Public health intervention guidance; no. 3).

[2] See work being done in Lambeth and Southwark through their Modernisation Initiative: www.modernisation-initiative.net

[3] The London Sexual Health Promotion framework, a part of the London Sexual Health Programme, within the London Specialised Commissioning Group.

[4]The Define Study (2008), on attitudes of Young People to Sex.

[5] Statistic from the paper by The Audit Commission. (2006), "Our health, our care, our say: a new direction for community services". Published by TSO (The Stationery Office).

Appendix 1

CAMHS

CareLink provides a therapeutic service to Southwark's Children Looked After up to the age of 16. CareLink provides a service to children in or near to Southwark by individual work with children, work with carers and facilitating access to local services for children and their carers. CareLink professionals work closely with SWs and the designated doctor and medical advisor in looking at children's mental health needs.

A research project into mental health screening using the Strengths and Difficulties Questionnaire (SDQ) was found to be effective at detecting mental health conditions for 5-16 year olds. From the cohort of children sent the SDQ 83% warranted going onto the next stage of screening which involved completing the Development and Wellbeing Assessment (DAWBA). Of those completing the DAWBA, 77% were found to have a diagnosable condition requiring further treatment, and all these children have now been referred to an appropriate resource. The great majority of children identified were already known to the CareLink service. Funding has now been secured for a research project to look at mental health screening for 0 to 4 year olds; the initial screening will take place alongside Initial Health Assessments.

There are difficulties securing adequate and timely mental health support for children placed a long way away from Southwark. This is made more difficult by the lack of clear procedures and agreed tariffs for cross boundary charging for children and young people looked after. This has not been resolved by the latest Statutory Guidance and work is continuing on devising a commissioning toolkit. There are difficulties in securing services for vulnerable 16+ year olds with mental health needs that do not meet the higher thresholds of adult services. Sometimes there are difficulties in providing appropriate services for children who have been looked after for less than 3 months.

Previous audits and work with the transition panel in Southwark have identified a need for more assessments, particularly psychometric and psychological assessments of young people approaching leaving care with possible learning difficulties or mental health needs. Representations have been made to Mental health commissioning for Southwark to increase the provision fro young people looked after but have not succeeded.

References

(1): Prevalence of psychiatric disorders in young people in the care system. McCann et al (1996) BMJ 313, 1529. Action Plan Health of looked After Children Islington 2007-2010

(2): Every Child Matters (2003) www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/childrenincare/childrenincare/

(3): White Paper, Care Matters: Time for Change (2007) http://publications.dcsf.gov.uk/

(4): Promoting the Health and Wellbeing of Looked After Children – DH Nov 2009 Department for Children, Schools and Families; Department of Health (2009) Statutory guidance on promoting the health and wellbeing of looked-after children. London: Department for Children, Schools and Families.

Appendix 1

2 Visit www.ncb.org.uk/healthycare

(5): C M Hill and J Watkins 2003 Child Care and Development 29 (1) 3 -13

(6): www.ncb.org.uk/healthycare

Appendix 1

Healthy Care Standard Entitlement 4

HEALTHY CARE STANDARD ENTTILEMENT 3: Having **cultural beliefs and personal identity** respected and supported

Key Areas for Action	Conditions to be met for judgement		
	RED	**AMBER**	**GREEN**
Participation	CYP say they have little opportunity to explore or express their personal identity. CYP say they have little information about how to get advice and support to develop their personal identity.	CYP say they have some opportunities to explore and express their personal identity. CYP say they have some information about how to get advice and support to develop their personal identity.	CYP say they have many opportunities to explore and express their personal identity. CYP say they have good information about how to get advice and support to develop their personal identity.
Practice	Most case recording not up to date, and case files not ready to share with looked after children.	Some case recording up to date, and some case files are ready to share with looked after children.	Evidence of most case recording up to date and many case files ready to share with looked after children.
Policy	No joint protocols in place for sharing confidential information about looked after children between professional groups. Few services in place to promote the personal identities of looked after children.	Some joint protocols in place for sharing confidential information about looked after children between professional groups. Some services in place to promote the personal identities of looked after children.	Comprehensive joint protocol in place for sharing confidential information about looked after children between professional groups. Extensive services in place to promote personal identities of looked after children.
Partnership	Few strategies, resources and priority in place to ensure diversity needs of looked after children are being met. Few cultural, racial, sexual, and disability issues are being raised at partnership boards.	Some strategies, resources and priority in place to ensure diversity needs of looked after children are being met. Some cultural, racial, sexual, and disability issues are being raised at partnership boards.	Most strategies, resources and priority in place to ensure diversity needs of looked after children are being met. Many cultural, racial, sexual, and disability issues are being raised at partnership boards.