Appendix 2

PCT Report: Update on the Health of Children looked After in Southwark 2008/2009

Introduction:
This is the first Annual Report as described in Promoting the Health of Looked after Children 2002 and the Statutory Guidance Promoting the health and well being of looked after children 2009.

This report has been prompted by the need to inform key stakeholders of an overview the health needs and gaps in service for this very vulnerable group of children and to comply with the statutory guidance.

In previous years the multi-disciplinary and multi-agency health management group (HMG) have reviewed need and services by 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,. There have also been major difficulties in collecting accurate activity data in the PCT for children seen at Sunshine House, Children and Young Peoples Centre, and for the health care Plans written based on Health assessments done elsewhere.

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 and 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

- 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 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.

Background

The legislation and guidance behind health social care for children looked after (CLA) start 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 after, defines parental responsibility, the principle of no order and in guidance the needs of the child are paramount. The UN Convention speaks of rights including to health and treatment, recovery, 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 just 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 of our child population. Failure to protect their health may worsen their life prospects and exacerbate damage and abuse. The results from research are shocking. Nearly two thirds will 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. 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%; (F)CO 59%

Children and young people looked after in Foster care 73%, up 5 %
3,700 UASC up 5% - 87% male
Pregnant girls >12 was 1.2%, over ½ of whom were aged 17

Health and education data for period ending 30.9.08, continuously looked after for >12 months
(not yet available nationally for 2009)

82% immunisations up to date	(previous year) 80%
87% dental assessments up to date	(previous year) 86%
87% health assessments up to date	(previous year) 84%
87.5 developmental assessments up to date	(previous year) 88.3%

Substance abuse 5% (63% had an intervention)

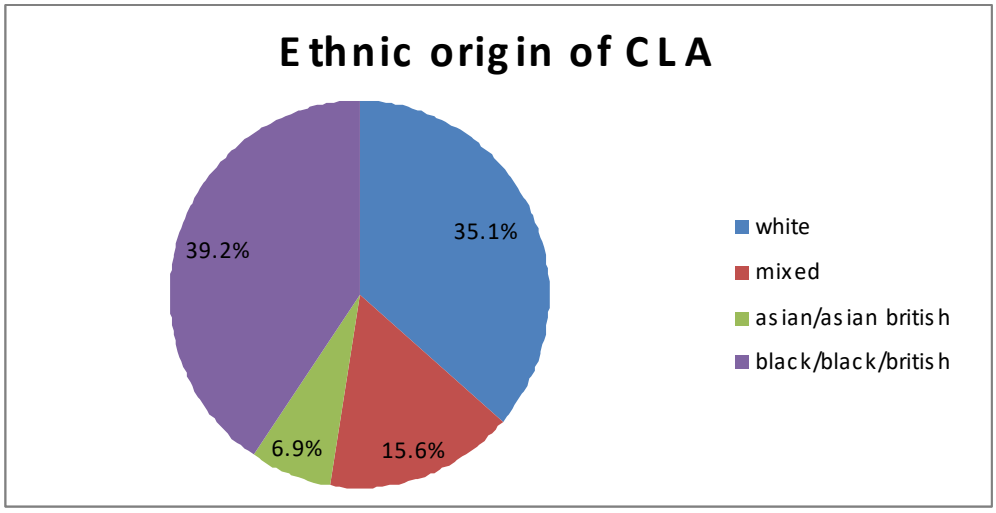
Children and Young people Looked After, Southwark

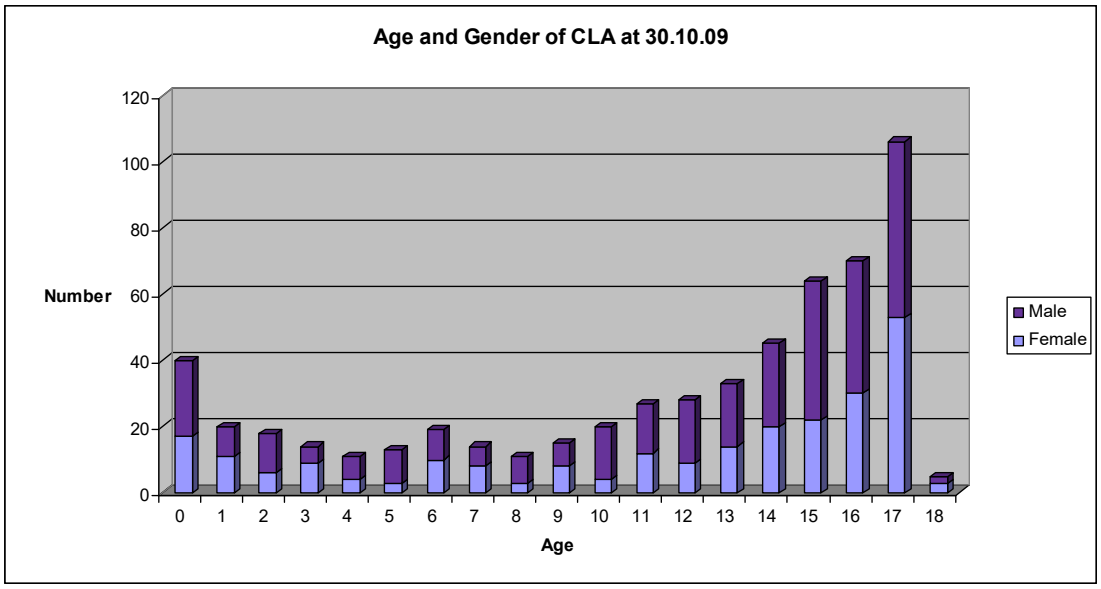
Over the last 6 years there have been around 600 Looked After Children (LAC) at any one time, approximately 1.2% of Southwark Child Population. This compares to a national average of approximately 0.6%.

Appendix 2

Data:

31.10.09





Starting to be looked after in year to 31.3

	2005	2006	2007	2008	2009
Nationally	25,000	24,600	24,000	23,300	25,400
Southwark	265	265	255	225	220

Year to oct 09

Nov 2009 573

children who came into care in year to 31/08/09 and 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
373

Children presented to Permanency Panel Jan – Dec 2009 inclusive
29

Adults presented to Panel for approval as adopters
31

Performance Indicators

Currently there are two LA Children in Care performance indicators that relate specifically to health both for children and young people who have been looked after for more than a year:

91.3% of the 373 are recorded as up to date with their health and dental checks
79.1% of the 373 are recorded as up to date with their immunisations

See also Business Plan – parts relevant to Health – attached
There has been a steady decrease in the number of children in care at a given point than in previous years to end of March 2009. There started to be an increase nationally in CLA from 2008-9 which was reflected in an increase in CLA in Southwark between March and October 09 from 535 to 573. There continues to be a high number of children who have remained in care for a year or longer.

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 ethnic and cultural diversity of children looked after in Southwark is very diverse and 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 for these groups are frequently part of the health care plans but not often done, due to a number of factors.
Many children have a statement of educational needs. There are higher rates of developmental disorders, such as ASD and ADHD, which may have gone previously undiagnosed before entering the care system. 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. Audit and the overview of initial and review health assessment has demonstrated that the pattern is very similar in Southwark to that reported in the literature and research reported in the Statutory Guidance. Anecdotally less than 10% have no health recommendations.
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

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 will be added as a performance indicator.

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, 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.

(Consultant Paedtrician of named CLA Doctor) 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 2005

There have been on going severe problems with capacity, especially for administrative tasks and for the review of GP completed Review Health Assessments. Unfortunately PCT data systems are such that we have problems identifying children who need review and cannot collect accurate activity or outcome information. We are grateful for the effective partnerships developed with Southwark Children's Services who have enabled full access to their data system which provide helpful data tracking function and direct inputting capacity.

Current Staffing

- 2 sessions Consultant Clinical time BC
- 1 session designated doctor time BC
- 7 Sessions Clinical and Medical Advisor to the Permanency panel DA
- 4 sessions other Dr clinical time, + 1 for GP RHAs
- 1 WTE CLA Designated Nurse SY
- 1 WTE Named nurse for CLA – 0.6 filled
- 1 WTE admin post CLA
- 0.75 WTE PA post supporting Medical Advisor
- 0.5 WTE Admin support – unfilled and likely to be lost
- Support from EOs in LA

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 (1.4 in post)	2 (WTE)	2 (WTE)	
Cla admin	1 (was + ¼ lost)	1 ½ 1/3 PA time	2 + Appt letters	"Sufficient"[2]
MA admin	¾ PA			
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 form to	GP for IHA only	GP, SN/HV	Everyone	GP all
Distribution Part C	IHA Rest Part C RHA all	rest Part C		
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 hall 4
2- BAAF proposed JD and competencies
3- is from Promoting

BAAF addressed this issue and noted that the Child health promotion report (hall 4) 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 estimate 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 interest and expertise which may not include the health promotion and sex education of teenagers. 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 CLA nurses. Nonetheless we have been told that the funds cannot be

transferred from the PCT GOP Assessment Budget to salaried posts: this seems unfortunate at best, we understand that other PCT's have achieved this. This will be compounded when the Specialist Nurse leaves on a sabbatical for 6 months commencing February 2010.

CLA nurses and community paediatricians at Sunshine House do not have the capacity to see the approximately 100 children who are currently seen by GPs. Many of these children, indeed all the under 5s, should already be having an enhanced level of HV service. For a child's HV to complete their Health Assessment and HCP would avoid duplication for the child, carer and the NHS and would enhance the HV role working with the child and family. 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 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. However we are still experiencing more problems than we used to, knowing about children likely to be going to panel before 2 weeks before panel. We have tried to improve this with regular liaison with adoption and fostering but still have to do all the chasing. We need to find better ways of 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 is making it extremely difficult for us to see the children, gather all the necessary information and write reports for panel. It is also unnecessarily time consuming and stressful for us, and sometimes for children and carers who have to alter plans to come at short notice at inconvenient times.

The collection of information continues to be very time consuming, and despite many pleas, and recommendations in health care plans, the collection of Parental, maternal and neonatal health information is 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 arrangements. However all boroughs and health staff I know of or have worked with have found this difficult and it is very labour intensive. Obviously improving the follow up and implementation of HCP s 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 Care First and the initial teething problems of establishing regular data input. We cannot currently collect the data we need frum CareFirst directly but this will be part of the 2010/11 agenda.

Clinical Governance
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 c paediatrician where a child is followed up closely already, 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 seen 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 from the health assessments. They are an essential output from the Health Assessments. However national researches has noted that plans are often not implemented in full, our audits noted this locally also. 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. This had improved but, recently the delay in distribution of health care plans has again reached unacceptable levels again secondary to long term sick leave and cutting of posts. See also attached Audit summaries.

Subsequent audits (undertaken jointly with CLA Services) also looked at the availability and implementation of the health care plan from health assessments by SW and CLA reviews. We discovered that many were unreadable, because of poor handwriting and scanning on SS electronic records; as a result of audits these are now being typed. Where they could have been available to reviews their significance and the need for action were not always understood or brought to the review.

Working closely with Social services we have enabled health professionals at Sunshine House to directly enter HCP onto Care First (CF, SS electronic record). Unfortunately this has been fraught with problems of access, but is beginning to be used more consistently. The advantage of direct entry to CF is the availability to SW and the Reviewing Officers and to pull through to 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).

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. The designated doctor for CLA, and 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.

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 currently the National Children's Bureau is 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.

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.

Distribution of the HCP – a bottle neck in administration

It is vital that the Health Care Plan summary and recommendations are shared with the health professionals involved with a child, the carer, and parents where appropriate, and social worker. Health and Social Services have worked closely to minimise duplication and maximise efficiency and a lot more has been achieved within the same resources, for example entering health care plans (HCPs) directly on to SS records.. We are continuing to meet to look for improvements but currently there is simply insufficient PCT admin time to make appointments, upload reports and distribute HCPs in anything like a timely manner. This is becoming a serious clinical risk. A post was frozen because of financial crisis in the PCT and an already stretched service has become untenable. We risk undermining all the good health assessments and analysis of a child / young person's needs by not distributing health care plans promptly and not being able to complete review health assessments when needed.

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 has 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 to these children. 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 social workers.

CAMHS
CareLink provides a therapeutic service to Southwark's Looked After Children up to the age of 16. CareLink provide 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 SW and the designated doctor and medical advisor in looking at children's health needs. This service is co located with social work staff and has developed high quality practice related to integral working with special health, special education and fostering services.

A research project into mental health screening programme 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 source. The great majority of children identified were already known to the CareLink service. Fortunately funding has been secured for a research project to look at mental health screening for 4 year olds and under.

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 looked after children aged 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. This has been escalated to SLAM and Young Southwark and it is hoped this significant service gap will be addressed.

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 for young people looked after but have not succeeded.

<u>References</u>

(1): Prevalence of psychiatric disorders in young people in the care system.

Appendix 2

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 – revised statutory guidance

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