West Essex CCG
North East Essex CCG
Mid Essex CCG
Southend on Sea CCG
Castle Point & Rochford CCG
Basildon & Brentwood CCG
Thurrock CCG

Essex-wide Health Strategy for Looked After Children September 2013

Designated Professionals for Looked After Children
Safeguarding Children Clinical Network

Preface

The health of Looked After Children and young people who originate from or are placed in the geographical county of Essex is a priority for the 7 Clinical Commissioning Groups (CCG's) and the Essex Local Area Team (LAT) who are responsible for commissioning health services for the population. Responsibility for commissioning services such as CAMHS tier 4 in-patient services, and Health & Justice, lie with the Anglia Area team of NHS England. In partnership with our community, acute and primary care providers and the 3 local authorities of Southend, Essex and Thurrock we will, as a corporate parent, strive for the best possible health outcomes for our children and young people and those whose care we host on behalf of other local authorities and CCG's. Accordingly, this strategy has been developed with the aim of improving health outcomes for this vulnerable group.

A child is defined as anyone who has not yet achieved their 18th birthday and the statutory responsibilities for health bodies relating to children in care end when the young person reaches that age. However, there is a growing focus on the needs of young people who are over 18 and have left care. This strategy will set out what may be done in partnership with the local authorities and adult healthcare providers to ensure that the impact of having been in care is recognised by those who provide care in the future.

This document sets out the national and local context for Looked After Children. The desired outcomes, and the actions needed to achieve them, have been identified by the Designated Doctor and Nurses for Looked After Children. Progress against the outcomes will be reviewed at least annually.

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September 2013

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1. Introduction

The term 'Looked After' was introduced by the Children Act in 1989, and applies to children for whom the Local Authority provides accommodation, through either a Court Order or with the child's parental consent, or if aged 16 or 17 years old, their own consent. A child may become Looked After (or be 'in care') for a variety of reasons. In most cases children are in care as a result of temporary or permanent problems facing their parents or as a result of abuse or neglect of the child.

This strategy has been developed in order to improve the health outcomes for Looked After Children (or Children in Care) in Essex. It sets out the main issues, key objectives and the actions necessary to achieve the objectives.

The strategy will ensure that healthcare commissioners and providers, in partnership with the 3 local authorities within Essex, comply with the Department of Health (DH) Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (2009) which outlines the responsibilities of key agencies working with Looked After Children and young people.

For improved health outcomes amongst the population of Looked After Children and care leavers a truly "joined up" approach is needed. The local authority is in effect the parent of the child in care and the NHS has a duty and responsibility to support them in fulfilling their role as Corporate Parent. Any good parent desires the best health outcomes for their children.

This involves a professional network working in partnership delivering services. The key players in Essex are:

- Elected Members of the 3 local authorities who comprise the Corporate Parenting Panels or Committees which have full council committee status
- Children and Family Social Care staff
- The 7 Clinical Commissioning Groups of Essex
- The Essex Local Area Team of NHS England
- The community health care provider organisations
- The acute and secondary health care providers
- The mental health care providers
- All primary care services including GP, dentists and opticians
- Schools
- Foster and residential carers who look after the children day to day
- Education.

2. Background

Looked After Children are amongst the most vulnerable children in our society and the factors that increase a child's vulnerability are being better understood and recognised. The responsibility of health organisations and professionals to comply with requests for support from local authorities in improving life outcomes for children in care, and after care, was strengthened in 2009 under section 10 of the Children Act, 2004 (Department of Health & Department for Children, Schools and Families, 2009). However, whilst the health needs of Looked After Children are receiving greater attention and focus than ever before this is set against significant challenges in the context of a changing NHS.

The Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (DH/DCSF, 2009) recognises the complex reasons behind children and young people who

enter the care system and highlights that whilst Looked After Children share many of the same health risks and problems as their peers it is often to a greater degree. They frequently enter care with a higher level of health and social needs than their peers as their poor early life experiences, such as parental mental ill-health, deprivation, substance misuse, abuse (physical, sexual and emotional), neglect and domestic abuse, are factors that contribute to inequalities in health outcomes.

Once in care, children and young people may have experiences that negatively impact on their mental and emotional wellbeing which can be lifelong, affecting quality of life in adulthood. Therefore, alongside the understanding of the needs of children in care is the recognition that after care support is also necessary.

3. Profile of Looked After Children

3.1 National Data

On 31 March 2012 67,050 children were in care in England; of which 46,590 had been Looked After continuously for at least 12 months (Dept Education, 2012). Over 28,000 had started care within the 12 months up to 31st March 2012 and over 27,000 left care. There has been a year on year increase since 2007 in England of the number of children becoming looked after, the majority being subject to a care order due to abuse or neglect. During the year 93,020 children had experienced an episode of care, representing almost 1% of the total child population of England. In contrast, Southend and Essex local authorities have reduced the number of children in care in the last 2 years through more effective early intervention work with families or increased use of permanency options such as adoption or Special Guardianship Orders. Thurrock has continued to see an increase despite this work which may be attributable to local changes in population demographics. By reducing the number of children who need to become Looked After it is reasonable to predict that these children will have more long standing and complex problems.

Local authorities are responsible for ensuring that the health needs of Looked After Children are met and their performance is measured by the Department for Education through 5 indicators: uptake of health assessments, up to date immunisations, dental checks, emotional health and wellbeing (measured by Strengths and Difficulties Questionnaire score), and substance misuse. Nationally and locally, the uptake of health assessments has improved significantly since 2006 and this may be attributed to increased specialist nursing resources and involvement with children in care, and better co-ordination of services between originating and host health care providers. Children who are placed outside their originating area are a major challenge for commissioners of health care and for providers in the co-ordination of health assessments. Uptake of dental checks and immunisations have also increased but to a lesser degree.

Emotional health and wellbeing is assessed annually using the Robert Goodman Strengths and Difficulties Questionnaire (Goodman, 1997) and substance misuse by the annual completion of a Drug Use Screening Tool (DUST). Both are completed by the local authority. Within the Looked After population there are sub groups of children who have additional needs. These include children with disabilities, unaccompanied asylum seeking children and those placed in secure accommodation. New legislation, enacted in 2013, requires that children and young people who are remanded in custody will have Looked After status and must receive all the support afforded to other children in care.

3.2 The Health Needs of Looked After Children

Looked After Children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of

health than their peers in part due to the impact of poverty, abuse and neglect (Department for Children, Schools and Families/Department of Health, 2009).

The understanding of the health needs of Looked After Children is increasing as the focus on this vulnerable group gains higher recognition. In the late 1980's, and before, physical health needs were gaining greater attention and led to the requirements for regular health assessments as set out in the Children Act 1989. Throughout the 1990's and early 2000's, services to monitor and address physical health deficits improved vastly as a result of such initiatives as Quality Protects (Department of Health, 1998), Every Child Matters (Department of Health, 2004), and subsequently, the Care Matters agenda (Department for Education and Skills, 2007 & 2008). However, throughout the last decade, the evidence of the impact of abuse on the mental health of children and their families, and how poor mental health affects every aspect of a persons' life, is being better understood. Nationally, various reports have provided evidence that illustrates the poorer outcomes for Looked After Children. For example, Looked After Children are 7 times more likely to suffer mental health problems than their peers who are not looked after, more likely to misuse drugs and alcohol, more likely to have a statement of special educational needs and 5 times more likely to be mothers whilst in care themselves (Department for Children, Schools & Families, 2009). Prison data indicates that approximately 25% of all prisoners experienced being in care at some point during their childhood (Ministry of Justice, 2010).

The aim of early intervention is to support troubled families before their problems reach a level of significant harm with the objective of diverting families from the path of child protection and care interventions. However, the impact of reducing the numbers of children entering the care system nationally is yet to be measured. This needs to be balanced against those children who are subject to a care order which have continually increased since 2008.

Nevertheless, the impact of early support may mean that those children and families who reach the threshold for the statutory intervention of services (social care, police and health) are fewer but those who do reach the threshold will be much more complex in nature and more likely to require longer term support with greater health need.

3.3 Local profile

Essex is a large county lying north east of London and within the East of England region. It has borders with the counties of Suffolk and Cambridgeshire to the north and Hertfordshire to the west; the east and south of the county comprises the longest coastline of any English county. The geographical county comprises of 3 administrative authorities of which Essex County Council is the largest, covering most of the county. The two smaller authorities are Southend-on-Sea Borough council and Thurrock Council. The population of Essex local authority is approximately 1,720,400 (Mid 2009 estimate, ONS 2010) of which approximately 25% are aged under 18 years. A major proportion of the county is rural with large urban areas and pockets of affluence and deprivation.

A number of children are placed outside the county boundaries requiring that health services are sourced (commissioned) from a host provider. In contrast, there are a number of children who are placed by other local authorities within the county. In contradiction to national guidance (DH/DCSF, 2009, DH, 2013 and NHS England, 2012) many areas differentiate in the service provided to children by only providing for those children who originate from their area (including those who are placed elsewhere) and not for those who are placed in their area by other local authorities, resulting in a two tier system. In Essex the approach is to provide equal care for children who orginate or are hosted in Essex and maintain oversight for the children placed outside the county alerting commissioners when difficulties arise.

The comparative data illustrated below is taken from the Department of Education First Statistical Releases Children Looked After by Local Authorities in England, 2012.

3.31 Southend Borough Council

Southend-on-Sea is a small unitary authority in the far south east corner of the geographical county of Essex; its population is 164,200 (Mid 2009 estimates, ONS 2010). The river Thames is to the south of the borough and the North Sea to the east; it borders with Essex County council to the north and west. On 31st March 2012, 185 children had been Looked After by the local authority for at least 12 months (Department of Education, 2012). The statistical neighbours for Southend include Telford & Wrekin and Bournemouth local authorities.

Local Authority	Number Looked After continuously 12 months on 31/03/12(31/03/10)	Up to date Immunisations no/% 2012 (no/% 2010)	Up to date dental check no/% 2012 (no/% 2010)	Up to date Health Assessment no/% 2012 (no/% 2010)
Southend-on-Sea	185 (210) ↓11% 112:100,00	120/65% (155/73%)	180/97% (170/81%)	160/86% (175/83%)
Telford & Wrekin (Pop = 162,300 Mid 2009 estimates, ONS 2010)	200 (180) ↑10%	195/97.5% (175/97.2%)	190/95% (175/97.2%)	185/92.5% (170/94.4%)
Bournemouth (Pop = 164,900 Mid 2009 estimate, ONS 2010)	140 (135) ↑3.6%	135/96.4% (120/88.8%)	125/89% (115/85%)	140/100% (125/92.6%)

Source: Department of Education SFR 20/2012

3.32 Essex County Council

On 31st March 2012, Essex County Council were responsible for 1,075 children who had been in care continuously for at least 12 months (Department of Education, 2012). The counties who are the statistical neighbours with Essex are Hampshire and Kent, with 760 and 1,175 children in care continuously for 12 months respectively on 31/03/12.

Local Authority	Number Looked After continuously 12 months on 31/03/12(31/03/10)	Up to date Immunisations no/% 2012 (no/% 2010)	Up to date dental check no/% 2012 (no/% 2010)	Up to date Health Assessment no/% 2012 (no/% 2010)
Essex	1,075 (1,015) ↑9% 62:100,00	525/50% (830/81%)	960/89% (895/88%)	920/85% (835/82%)
Hampshire (Pop = 1,289,400 Mid 2009 estimate, ONS 2010)	760 (775) ↓1%	640/84% (535/69%)	220/84% (620/80%)	660/87% (635/82%)
Kent (Pop = 1,411,100 Mid 2009 estimate, ONS 2010)	1,175 (910) ↑23%	1,095/93% (785/86%)	935/80% (600/66%)	895/76% (540/59%)

Source: Department of Education SFR 20/2012

3.33 Thurrock Council

Thurrock Council is the second unitary authority in the geographical area of Essex. Its population is 157,200 (Mid 2009 estimate, ONS 2010). Its borders are with the river Thames to the south and Essex County council to the north and east. To the west is the M25 motorway and outer London boroughs. Thurrock shares some services with Barking and Havering Council. On 31st March 2012 Thurrock Council were responsible for 135 Looked After Children. Thurrock's statistical neighbours include Bolton and Dudley.

Local Authority	Number Looked After continuously 12 months on 31/03/12(31/03/10)	Up to date Immunisations no/% 2012 (no/% 2010)	Up to date dental check no/% 2012 (no/% 2010)	Up to date Health Assessment no/% 2012 (no/% 2010)
Thurrock	135 (150) ↓11% 86:100,000	65/48% (75/50%)	120/89% (100/66%)	120/89% (120/80%)
Bolton (Pop = 265,100 Mid 2009 estimate, ONS 2010)	380 (325) ↑14.5%	370/97.3% (305/93.8%)	320/84.2% (285/87.6%)	320/84.2% (285/87.6%)
Dudley (Pop = 306,600 Mid 2009 estimate, ONS 2010)	520 (455) ↑12.5%	405/77.8% (360/79%)	335/64.4% (310/68%)	445/85.5% (340/74.7%)

Source: Department of Education SFR 20/2012

Within the East of England 4,480 children were Looked After on 31st March 2012. Of these, 3,120 (69%) were up to date with their immunisations, 3,580 (80%) had had their teeth checked by a dentist and 3,520 (78%) had an up to date health assessment. Overall, children who are Looked After by the 3 Essex local authorities are above the East of England average for dental checks and health assessments. Data for immunisations indicates that rates are low; however, this does not appear to correlate with data collected by health. A status of 'up to date' cannot be recorded within social care systems and the need to have individual immunisations recorded is not always possible as when children are placed outside the county the host health providers do not always share the full information. Work is continuously on-going to improve recording within both health and social care.

4. Joint Strategic Needs Assessments - Key Health Data For Looked After Children

4.1 Southend BC JSNA

Information relating to children who are Looked After by Southend Borough Council is contained within the pan-Essex JSNA of 2009. No specific health data relating to Southend is available.

4.2 Essex CC JSNA - draft December 2012

Fifty four per cent of the children Looked After by Essex County Council are male and 46% are female. Forty per cent of the children are aged 12 to 16 years with the peak years of age for being in care being 14 to 17.

Nationally, it is recognised that children from Black and Minority Ethnic (BME) groups are over represented in the care system in comparison to the general population; Essex has a slightly higher proportion of BME children in care than is represented in the general 0-15 year population.

Twenty-two per cent of the care population are identified as having a disability, with the most common being learning disability and Autism/Asperger's.

The JSNA identified key groups of children who are in placements outside the county due to there being insufficient provision locally. These included:

- Placements for children with disabilities
- Placements for children described as having challenging behaviour
- Children with severe attachment disorders
- Young men against whom allegations of sexually harmful behaviour have been made.

Co-ordinating the statutory and routine healthcare for these children can be a complex and a costly health commissioning pressure.

Nationally, health outcomes for care leavers are known to be worse than for their peers who have not been in care. The JSNA did not present any health data in relation to this group.

4.3 Thurrock JSNA - March 2012

Thurrock is noted to have a higher turn-over of Looked After Children than the national average and after a fall in the numbers of children in care in 2010/11 numbers have increased since. The JSNA did not provide any health data for this group of children. However, Thurrock is known to have a higher proportion of children who are unaccompanied asylum seekers amongst its care population than Essex or Southend.

5. Ofsted/CQC inspection findings

In June 2012, the Safeguarding and Looked After Children services of Southend Borough Council and Thurrock Council were inspected by the Office for Standards in Education (Ofsted) and the health safeguarding services were inspected by the Care Quality Commission (CQC). In November 2012, Essex County Council participated in a pilot Ofsted inspection of its Looked After Children services as part of the testing of a revised inspection framework of which the CQC were part of the inspection team. The 3 inspections identified common themes for health: quality of health assessments, health information for care leavers and inclusion of Strengths and Difficulties Questionnaire (SDQ) results in health assessments. The three areas have been subject to action across the entire health economy to draw to resolution. The action plan for the health information for care leavers included work with young people in care which has resulted in the development of a health passport. However, there is a need for further development of this model to ensure it meets the needs of care leavers in terms of being an effective, practical and cost effective tool for the future. Improvement of quality standards is an on-going process that is part and parcel of staff training, monitoring, audit and supervision processes. Embedding of SDQ results in health assessments also fall within these on-going processes.

6. Legislative and Policy Framework

The principal legislation that sets out the framework in which a child is classed as Looked After and the support that must be provided to the child is the Children Act, 1989. This legislation is underpinned by further Acts of Parliament, most significantly The Adoption and Children Act 2002, The Children Act 2004, The Children and Young Person's Act, 2008 and most recently, The Legal Aid, Sentencing and Punishment of Offenders Act, 2012.

All of the above legislation has the underlying principles of the United Nations Convention on the Rights of the Child (United Nations, 1989) ratified by the UK Government in 1991at its heart. 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 the 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 legislative framework places specific duties on Councils with Social Services Responsibilities, and their partner agencies to promote the health of Looked After Children and these duties are supported by statutory guidance:

- Statutory guidance on Promoting the Health and Wellbeing of Looked After Children, DH, 2009 (The guidance is due for update later in 2013)
- The Children Act, 1989 Guidance and Regulations volume 2: Care Planning, Placement and Case review. Dept Education, 2010
- Sufficiency: Statutory Guidance on Securing Sufficient Accommodation for Looked After Children. Dept Education, 2010.
- The Children Act 1989 Guidance and Regulations: Volume 3 Planning Transition to Adulthood for Care Leavers. Dept Education, 2010.

7. NICE Guidance and Quality Standards

In addition to statutory guidance, the National Institute for Health and Care Excellence (NICE) have developed guidance to support service delivery and practice to improve outcomes for Looked After Children (NICE, 2010). NICE will be updating this guidance shortly. In addition, NICE have also produced quality standards which will set out the focus for service delivery to achieve the best outcomes for children who are in care (NICE, 2013).

8. Skills and Competency

A skilled and competent health workforce working with children and young people in care, at both practice and strategic levels, is central to the delivery of high quality care. The Royal College of Paediatrics and Child Health (RCPCH) have developed a framework that sets out the training requirements of health care staff dependent on their role and level of responsibility to support high standards of practice (RCPCH, May 2012).

9. Key Responsibilities of Health Services for Looked After Children

Promoting the Health and Wellbeing of Looked After Children sets out the key roles and responsibilities of health bodies in relation to Looked After Children. Since the guidance was published in 2009 the NHS has embarked on a radical programme of change in how services are commissioned and provided, and how health services are scrutinised and organisations are held to account.

Whilst the changes are significant, it remains that the NHS has the major role in ensuring the timely and effective delivery of health services to Looked After Children and young people. Under the Children Act 1989, CCG's and NHS England have a duty to comply with requests

from the local authority to help them to provide support and services to children in need. The support and the 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 optimal outcomes any good parent would wish for their child.

The key responsibilities are:

- The CCG must secure the expertise of a Designated doctor and nurse to provide strategic and clinical leadership and advice to commissioners and the local authority.

- Upon entering care a Looked After Child must have a thorough assessment (Initial Health Assessment) of his or her health carried out by a Registered Medical Practitioner, preferably a paediatrician, within 20 working days.

- Subsequent health assessments (Review Health Assessments) may be carried out by a suitably qualified and trained Registered Nurse or Midwife at intervals not greater than 6 months for children aged 0 – 4 years and at intervals not greater than 12 months for children and young people aged 5 – 17 years. Young people preparing to leave care should have an enhanced health assessment. All health assessments must result in a health care plan that contributes to the interagency care plan for the child or young person.

- Young people preparing to leave care must be supported to develop responsibility for their own health, be provided with their health history on leaving care and given advice and information on how to access health services.

- Health professionals performing health assessments and contributing to health care planning must have the appropriate skills and competences by receiving training in accordance with the RCPCH competency framework, 2012. All health care staff who may come into contact with Looked After Children during the course of their work should also receive appropriate training to enable them to understand the unique needs of this vulnerable group.

- Commissioning of secondary health care provision, including all statutory health assessments, remains the responsibility of the CCG from where the child originates, regardless of where they are placed. This includes monitoring of the quality of health care provision. (NHS England, 2012).

- All Looked After Children must have full registration with a GP close to their placement address.

- All Looked After Children must have an assessment of their dental health carried out by a dentist at intervals not greater than 12 months.

- Ensure that clinical governance and audit arrangements are in place to assure quality of services for Looked After Children.

- Ensure that the voice of the child or young person in care is heard throughout service design, development and delivery.

- The local authority is responsible for notifying the originating CCG and GP when a child is taken into care. If a child is placed outside his or her originating area the local authority is also responsible for notifying the local authority of the area in which the child is placed and the new host CCG.

- All clinical records should clearly identify that the child is Looked After so that their particular needs can be acknowledged. Clinical records should be kept up to date and transferred without delay when a child moves placement.

In addition to the statutory requirements, best practice indicates that all health services must have an understanding of how being in care, and the experiences before entering care, may have a lasting effect throughout the person's life course and is not limited to childhood.

10. Continuous Improvement in Outcomes

Nurse led Review Health Assessments were introduced in Essex in 2006 in response to poor completion rates and no co-ordinated oversight of the health status of the children by health services. In order to promote consistency in how health assessments are carried out and health needs identified, the use of the Review Health Assessment forms produced by the British Association for Adoption and Fostering (BAAF) was introduced. These replaced a locally designed assessment form which did not encourage practitioners to consider wider implications for health or for the assessment to be an opportunity to promote health and wellbeing. In subsequent years, the commissioning of paediatricians to carry out Initial Health Assessments has enabled a holistic and higher quality assessment to be undertaken. Additionally, this has enabled the Initial Health Assessment to also be used for adoption procedures thereby reducing the number of times the child is examined and ensuring that medical intervention is based on health need rather than following a process. The development of GP's to undertake Initial Health Assessments for older children who enter care by providing additional training and support is progressing across Essex. A pilot in South East Essex in 2012 proved very successful and lead to 4 GP's being recruited.

All initial health assessments in Greater Essex are carried out by medical practitioners and the statutory timescale for the assessment is always met which is a considerable achievement, so long as Social Care submits the documentation in time together with appropriate consent.

The Designated professionals are aware of the slightly different approach taken in each Provider unit for the assessments, but that the issues are generally the same, namely access to Child and Adolescent Mental Health Services (CAMHS), refusal to engage by older Looked After Children, and administrative problems at times in accessing information needed to carry out the assessments.

All these issues have been referred to in the outcomes to be achieved, including the development of improved IT systems.

For some children who enter care it is not necessary or appropriate that they are seen by a paediatrician. This is particularly true for adolescents who have different health needs compared to younger children and for whom the care plan is unlikely to be adoption. Adolescents generally enter care for different reasons to younger children. They are more likely to have experienced physical or sexual abuse, family dysfunction or they may display socially unacceptable behaviour. Following implementation of the Legal Aid, Sentencing and Punishment of Offenders Act, 2012 children aged 12 years and over who are remanded to custody are now classed as Looked After under section 20 of the Children Act, 1989 until they are sentenced. Consequently, young people in care require different approaches to their health care dependent on their circumstances. Whilst the legislation requires that the Initial Health Assessment is undertaken by a Registered Medical Practitioner the variety of needs of the young people demands a creative and flexible approach.

Overall, healthcare provision in Essex fulfils the statutory requirements and is underpinned by a standard service specification that sets out the level of service required of community teams providing care to Looked After Children and achievement is measured through Key Performance Indicators. Payment by Results Guidance (Department of Health, 2013) has been implemented throughout Essex from April 1st which aims to support improvements in quality and timeliness of assessments for children placed outside their originating area. Whilst progress has been made, it is imperative to continuously drive the proactive and holistic health agenda. This should be evidence based and quality assured. Our work in partnership to improve sharing of information and ensure pathways of care promote high quality provision will continue and will be subject to partnership audit programmes.

The following sets outs a two year plan to improve the health care design, delivery and pathways for Looked After Children. The actions to achieve the outcomes are primarily for the Designated Looked After Children professionals who will work in partnership with others involved in the care of Looked After Children. The actions are intended to encompass all children and young people in care regardless of their reason for being in care, for example disability, Unaccompanied Asylum Seeker, Remanded to Custody, abuse or neglect, or their placement type or location. Influencing the healthcare provided by host providers will be through promoting robust commissioning arrangements.

This is an ambitious programme that will require the support from the seven Essex Clinical Commissioning Groups, Essex Local Area team, Specialist commissioning teams within NHS England, the 3 Local Authorities of Essex, and other key stakeholders, for the outcomes to be achievable. Action plans will be developed for each outcome to outline the specific activities and evidence required to achieve.

Outcome 1
Babies discharged to care from birth receive timely and appropriate health care and are not disadvantaged by their status.

Objectives

- We will work with social care and maternity services to develop pathways that ensure pre-birth planning where the plan is for discharge to care includes obtaining parental health information, completion of BAAF form MB (maternal and Birth information) consent for the Initial Health Assessment and to share information, and Delegation of Authority to Consent for an identified carer. We will also ensure that Delegated Authority to Consent addresses parental consent for immunisations.
- We will work with maternity services and child health departments to ensure that notification of discharge to care is appropriately directed and that all birth screening results including neo-natal hearing screening are recorded in the child's health record (electronic and PCHR).
- We will work with the neo-natal units and fostering services to ensure that carers for babies with additional needs are provided with the training and post-discharge support needed to care for the baby's individual needs.
- We will work with commissioners, community children's services and children's social care to ensure that birth mothers remain involved in decisions about their child's health care.

Outcome 2
Children in care with emotional and behavioural health needs, and their carers, are supported and positive mental health is promoted.

Objectives

- We will work with Commissioning teams to ensure that children's mental health service design (CAMHS tiers 1 – 4) meets the needs of Looked After Children and young people whilst in care and through transition to adult service provision. This will include identifying provision through Improving Access to Psychological Therapies (IAPT) programmes.
- We will support mental health service providers by designing and delivering training programmes to develop their knowledge and understanding of the impact of being in care and how their experiences may affect mental health and wellbeing.
- We will work with commissioning teams to ensure that Learning Disability service design encompasses Looked After Children and young people.
- We will work with Children's Social Care so that carers receive the training and support necessary to enable them to promote positive mental health, calling on specialists and experts as necessary to support development programmes.
- We will actively promote the needs of Looked After children and young people in the redesign of CAMHS provision in Essex.

Outcome 3
Carers are enabled to support specific health needs and promote positive health for the children in their care.

Objectives

- We will work with Children's Social Care to support the design and development of health care training for carers, calling upon specialist and expert knowledge and skills as necessary.
- We will promote Delegated Authority to Consent for carers and ensure that all practitioners are aware of the particular issues and their roles and responsibilities in seeking consent for health care for Looked After Children.

Outcome 4
Health records for children who are adopted are complete, accessible, identify key health issues for the child and are sensitive to birth family confidentiality.

Objectives

- In the absence of a proposed national directive on the transfer and storage of pre-adoption health records we will work with Information Governance leads and other key stakeholders to develop robust guidance on the management of pre-adoption records, including the Personal Child Health Record (PCHR/Red Book).

Outcome 5
Young people leaving care know and understand their health history and know how to access services.

Objectives

- We will work with young people in care, Children in Care Councils, community Looked After Children health teams and Children's social care to develop a means of access to personal health information that is confidential, user friendly and meaningful, that is cost effective and has longevity.
- We will promote the continued use of the PCHR throughout the child's care career so that their health history is always available to health care staff, carers and to the young person on leaving care.

- We will provide advice, support and guidance to ensure that the child's health record is complete and contains all relevant and key data such as immunisations, screening results and statutory health assessments, and will support the development and implementation of a SystmOne LAC health template. We will also work with GP practices who are not SystmOne users, to ensure their records for a Looked After Child are kept up to date with all relevant information.

Outcome 6
All health care providers, including adult services, recognise and understand the impact on current and future health of being in care and know their role and responsibilities in promoting health.

Objectives

- We will work to increase awareness of the issues relating to being or having been in care throughout all health care providers so that they understand the impact of having been in care on the whole life-course.
- We will work to ensure that Looked After Children who are in transition from children's services to adult services are not disadvantaged and receive support and treatment that is appropriate and timely.
- We will continue to seek the views of children and young people in care to inform health care design and delivery.

Outcome 7
Children with additional needs or vulnerabilities are recognised and supported.

Objective

- We will promote the physical, mental, sexual and social health of Looked After Children and ensure that that health care staff are skilled in the recognition of known or potential problems so that vulnerabilities are reduced.
- We will review input to panels where decisions about health care commissioning to meet a child's care are made so that Designated Nurse knowledge and expertise is used in the most appropriate and effective way to support planning for the child's health care.

To achieve the above objectives we will seek out the views and experiences of children in care, their carers, key stakeholders in health and children's social care and we will ensure all practices are underpinned by commissioning arrangements, audit, policies, procedures, guidance and training as appropriate.

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Appendix 1

Communication strategy

The draft of the strategy was shared widely within health and with social care partners. They were asked to share within their agency or group and provide feedback from June 2013. All comments received have been considered and incorporated into the final version as necessary.

Agency/group	**Feedback received**
Designated Professionals for Safeguarding and Looked After Children	Yes
Safeguarding Children Clinical Network Board	Yes
Essex County Council via the Children in Care Partnership Board	Yes
Thurrock Council via the Children in Care Health Group	Yes
Southend Borough Council	No
Via Essex safeguarding Children Health Executive Forum	No
Via Locality Safeguarding Locality Operational Groups	No

Appendix 2

The undersigned have approved this strategy and support its implementation.

Name & Role	**CCG**	**Signature**	**Date**
Lisa Llewelyn Director of Nursing	North East Essex		
Carol Anderson Director of Nursing	Mid Essex		13/02/14
Denise Hagel Director of Nursing	West Essex		
Linda Dowse Executive Nurse	Southend		
Patricia Dorsi Executive Nurse	Castle Point & Rochford		
Lisa Allen Executive Nurse	Basildon & Brentwood		
Jane Foster-Taylor Executive Nurse	Thurrock		