NHS
Blackburn with Darwen
Clinical Commissioning Group

Blackburn with Darwen

Looked after Children

Annual CCG Report

August 2016

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1. Introduction

1.1 This is the 2015-2016 Blackburn with Darwen Clinical Commissioning Group (BWDCCG) report in relation to Looked after Children (LAC) produced in partnership with Lancashire Care Foundation Trust (LCFT), East Lancashire Hospital Trust (ELHT), and Public Health (PH); the report covers the period from 1 April 2015 to 31 March 2016. The purpose of the report is to inform the reader and give assurances that the CCG are meeting their statutory requirements in commissioning services for looked after children that are safe, effective, caring, responsive and well-lead within Blackburn with Darwen (BwD).

1.2 Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults

2. 2015-16 Summary of Achievements.

- 98% of statutory review health assessments for LAC in care for >12mths completed[1].
- 96% of those LAC had dental checks recorded
- 90% of those under 5yrs had development checks
- 86% of those were up to date with their immunisations
- 95% in-house review health assessments (RHA) completed on time.
- Quality Assurance checks for all review health assessments(RHA)
- Designated LAC Nurse maintaining interagency working to ensure a high level of continued communication to promote the health of children in care by being co-located within LA Children's Services.
- Appointment of Doctor for Looked after Children (ELHT)
- Re-recruitment of full-time Specialist Nurse for Care Leavers (Nov 2015)
- Health questionnaire targeting care leavers.
- Health passports available to all care leavers.
- Weekly health drop in for care leavers held at Barbara Castle Way
- Specialist Nurse achieved the '*Investors in Children Award'* for her work with care leavers in BwD
- Quarterly Joint Strategic LAC meetings with the LA & BwD CCG commissioners/senior managers
- Designated Nurse for LAC attends and contribute to multi agency Case Tracking and management panel
- Designated Nurse for LAC attends and contributes to the Corporate parenting Board (CPB)

[1] First statistical Response. Looked after children https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464756/SFR34_2015_Text.pdf

- Designated Nurse for LAC attend and contributes to multi agency Fostering Panel
- Designated Nurse for LAC attends and contributes to the statutory Virtual School Governing Body meetings hosted by the Local Authority (LA)
- Designated Nurse for LAC delivers safeguarding supervision for LCFT staff working with LAC & Care leavers
- LAC Promoting the Health & Wellbeing Training/workshops delivered across LCFT
- Joint Strengths & Difficulties Questionnaire (SDQ) workshops delivered in BwD by ELCAS & Designated LAC Nurse
- Multi-agency SDQ panel meetings held fortnightly to address the emotional health & wellbeing of LAC & Care leavers.
- Blackburn with Darwen Public Health department commissioned Liverpool John Moore's University to undertake research in BwD on the health and wellbeing of Looked after Children.

3. Statutory Framework, Legislation and Guidance

3.1 'Promoting the health and wellbeing of looked after children – March 2015'[2]

This statutory guidance issued jointly by the Department of Education and health. It is issued to local authorities, clinical commissioning groups, providers and NHS England. It replaces the guidance issued in 2009 which has been updated to reflect reforms to the National Health Service following the Health and Social Care Act in 2012. It also takes account of other reforms such as the changes to the special educational needs legislative framework and the cross government mental health strategy, which emphasises that mental health, is as important as physical health.

It is issued under sections 10 and 11 of the Children Act 2004[3] and under section 7 of the Local Authority Social Services Act 1970.

Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework, 2015[4]

This has been jointly reissued by The Royal College of Nursing, Royal College of Paediatrics and Child Health and the Royal College of General Practitioners.

This document sets out the specific knowledge, skills and competencies which professionals working in dedicated roles for looked after children at specialist, designated and named level should possess as distinct from individuals whose focus may be centred on child protection and safeguarding.

3.2 Legal Status/Children Act (1989)

[2] Promoting the health and well-being of looked after Children DfE, DH 2015

[3] Children Act 2004 section 10 - Legislation.gov.uk http://www.legislation.gov.uk/ukpga/2004/31/section/10 Statistics at DfE - Department for Education - GOV.UK

[4] Looked After Children: Knowledge, skills and competences of health care staff. Intercollegiate Role Framework March 2015

3.2.1 Under the Children Act 1989, a child is defined as being 'looked after' by the local authority if he or she is in their care or is provided with accommodation for a continuous period of more than 24 hours by the authority (section 22). These fall into four main groups:

- Children who are accommodated under a voluntary agreement with their parents (section 20)
- Children who are subject to a care order (section 31) or interim care order (section 38)
- Children who are the subject of emergency orders (section 44 and 46); and
- Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21)

3.2.2 Others

- Children and Families Act 2014
- The Children and Young Person's Act 2008
- Adoption and Children Act (2002)
- The Children and Adoption Act 2006 and associated regulations
- Care Matters: Time for change (2007)

4. National Institute of Clinical Excellence (NICE) research[5] identified the following issues with LAC;

- 60% (England) reported to have emotional and mental health problems
- More likely than their peers to have experienced the death of a parent or sibling
- Nearly a quarter aged 11-17 report having experienced some kind of sexual abuse
- Around 5% are unaccompanied asylum seekers
- Around 10 times more likely than their peers to have significant learning difficulties;
- Around 3 times more likely to drink & smoke than their peers.
- Around 4 times more likely to simultaneously be a smoker, regular drinker and drug user and present with risky behaviour, such as unprotected sex. Children and young people who are placed outside of their local authority area can face particular difficulties accessing health services.

4.1 Parents want their children to have the best start in life, to be healthy and happy and to reach their full potential. As corporate parents the local authority and those

[5] https://www.nice.org.uk/guidance/ph28/chapter/1-recommendations

involved in providing local health services for the children they look after should have the same high aspirations and ensure the children receive the care and support they need in order to thrive. The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989[6] to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

5. Governance and Quality Assurance

5.1 BwD CCG as with all NHS commissioners must ensure that the services it commissions meet the particular needs of looked after children. In meeting the health needs of this vulnerable group, it needs to focus on ensuring that looked after children are able to access universal services as well as targeted and specialist services where necessary. The CCG with its partner CCG's and public health services contributes to meeting the health needs of looked after children by:

- Commissioning effective services i.e. Community Adolescent Mental Health Services (CAMHS), Speech and Language Therapy (SALT).
- Individual health practitioners providing co-ordinated care for each child, young person and carer.
- Delivery through provider organisations i.e. Lancashire Care Foundation Trust (LCFT) Child and family Health services (CFHS).

5.2 LCFT has a major role in ensuring the timely and effective delivery of health services to looked-after children. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies[7] and The NHS Constitution for England[8] make clear the responsibilities of CCGs and NHS England to looked-after children (and, by extension, to care leavers). In fulfilling those responsibilities the NHS contributes to meeting the health needs of looked-after children in three ways: commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child.

5.3 This includes employing, or securing, the expertise of designated doctors and nurses for looked after children. CCGs need to demonstrate that their designated clinical experts (children and adults), are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice. This document outlines that the designated professional's role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. It clearly identifies that designated professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in

[6] https://www.gov.uk/government/uploads/.../Children_Act_Guidance_2015

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223843/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-DH-Response-to-Consultation.pdf

[8] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

CCGs, the local authority and NHS England, other health professionals in provider organisations, QSGs, regulators, the LSCB/SAB and the health and wellbeing board.

5.4 The arrangements for BwD CCG are that the Designated Doctor (LAC) is commissioned by the CCG from ELHT and the Designated Nurse for LAC is commissioned by the CCG from LCFT. The intercollegiate document (2015), advises on the designated capacity required by a CCG which is proportionate to the child population and numbers of looked after children in the geographic footprint that is covered by the CCG

5.5 Service specifications with clearly defined service outcomes and reporting arrangements have recently been updated to reflect the core responsibilities of these roles as outlined in the intercollegiate framework 2015. The Designated Doctor LAC specification is in the final negotiation stages with the provider.

5.6 There have been difficulties experienced with the agreement and provision of the revised designated nurse LAC specification. The new functionality has clearly been re-defined in the intercollegiate document 2015 to take a more strategic assurance and commissioning functionality rather than a provision focus. The detail can be seen in appendix 3 of the document, please follow link below[9]:

5.7 As outlined earlier this role is currently commissioned from a Provider organisation and conflict of interest issues are impacting considerably on the delivery of the expected outcomes. Following the NHS England recent benchmarking exercise of the CCG's arrangements in respect of the Designated LAC Nurse function, early indications suggest that the role should sit within the CCG. At the time of writing this report discussions are on-going within the CCG and with the Provider in respect of this.

5.8 In addition the intercollegiate document identifies that all provider organisations must have a named nurse for LAC and outlines the capacity per population required, this is not a CCG commissioning responsibility, however, the CCG as part of its assurance function will need to be assured that this is in place.

6. NHS England (NHSE) 2016 Benchmarking CCG Commissioning Compliance Tool

6.1 The role of the designated & named nurses for looked after children.

6.2 NHS England commissioned the roll out of a CCG commissioning compliance tool "Right People, Right Place, Right Time, Right Outcomes for Children" which has been developed to benchmark and monitor commissioning compliance with statutory guidance and intercollegiate framework. The initial phase of the benchmarking exercise covered the North of England. Designated Nurses for Looked after Children were invited to attend a peer benchmarking workshop that was held in January 2016. The workshop was facilitated by Hannah Smith and Nikki Shepherd (NHSE) who developed the benchmarking tool to empower and support Looked after Children designated health professionals working in complex commissioning/provider

[9] http://www.rcpch.ac.uk

arrangements. Designated LAC professionals completed the benchmarking tool prior to the workshop, considering the evidence they had to support compliance with the standards and highlight any challenges or barriers they face locally. NHSE presented the final thematic report to CCG Children's Commissioners, Chief Nurse/Executive Leads/ Provider Executive Leads on Wednesday 27th April 2016.

7. Joint Working with Local Authorities within BWD

7.1 The CCG has a Looked after Children Group meeting which meets on a quarterly basis. The group consists of the designated health professionals, Local Authority LAC managers; public health; children's commissioners (CCG); Senior managers for the LCFT health visiting and school nursing services and the provider safeguarding team. The aim of this group is to ensure that the CCG is receiving appropriate advice and support in respect of the planning, strategy and the audit of quality standards in relation to health services for looked after children. It is also a forum for integrating the working and learning of the lead health professionals for looked after children in the CCG area. The key messages from this group feed into the CCG safeguarding assurance meeting. An annual Looked after Children health report is received by the CCG Quality performance and Effectiveness Committee (QPEC), and the BwD Corporate Parenting Specialist Advisory Group.

7.2 Under the Children Act 1989, CCGs and NHS England have a duty to comply with requests from a local authority to help them provide support and services to LAC. Local authorities, CCGs and NHS England can only carry out their statutory responsibilities to promote the health and welfare of looked-after children if they cooperate. They are required to do so under section 10 of the Children Act 2004[10].

7.3 The Designated Nurse has forged successful professional relationships with all strategic leads for LAC within BWD, and sits on the Corporate Parenting Board. This has resulted in partnership working on service planning, strategy, commissioning of Looked after Children and Care Leavers provision in BwD.

7.4 When a child becomes looked after, changes placement or ceases to be looked after, the local authority must also notify in writing; the CCG for the area in which the child is living and the CCG and the local authority for the area in which the child is to be or has been placed. This written notification must be provided within five working days of the start of the placement unless not reasonably practicable to do so. There is now a notification system and process in place for this to happen. This enables the Designated Nurse of behalf of the CCG to carry out and meet its statutory requirements to ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care for the child.

8. Children Act 1989

8.1 Under the Children Act 1989, a care order is defined as an order made by the court on the application of any local authority or authorised person to: (a) place a child with respect to whom the application is made in the care of a designated local authority; or (b) put him under the supervision of a designated local authority. A voluntary

[10] www.legislation.gov.uk/ukpga/2004/31/section/10

agreement under section 20 of the Children Act 1989 enables a local authority to provide accommodation for any child in need if they consider that to do so would safeguard or promote the child's welfare. Such an arrangement requires the consent of (i) those with parental responsibility where a child is under 16; or (ii) the child themselves where the child is over 16. A local authority is required to provide accommodation for a child within their area under section 20 as a result of— (a) there being no person who has parental responsibility for him; (b) his being lost or having been abandoned; or (c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care. Placement order is a court order which gives a local authority the legal authority to place a child for adoption with any prospective adopters who may be chosen by the authority. Only local authorities may apply for placement orders. The order continues in force until it is revoked, an adoption order is made in respect of the child, the child marries, forms a civil partnership or the child reaches 18.

9. National Profile of Looked After Children

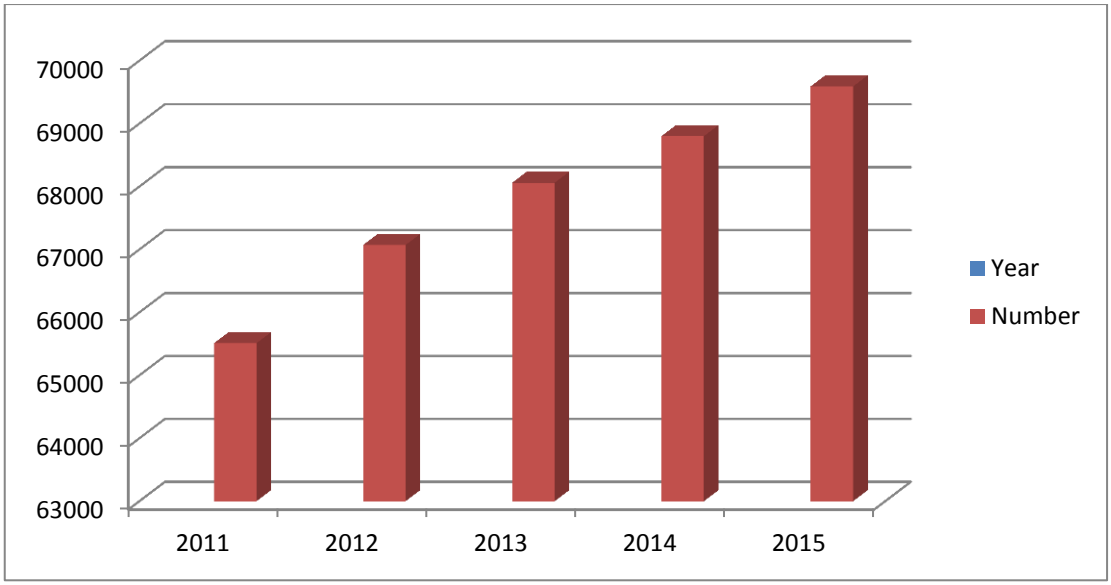
9.1 The demographics for looked after children nationally are taken from the Statistical First Release (SFR[11]) which provides information about looked after children in England for the year ending 31 March 2015, including where they are placed, their legal status, numbers starting and ceasing to be looked after. It also provides figures on looked after children who were placed for adoption, the number of looked after children adopted and the average time between different stages of the adoption process. The accommodation and activity of former care leavers (now aged 19 to 21) is also included. For the first time, newly collected information is included about children looked after who were missing or away from placement without authorisation.

9.2 **Key Findings:**

9.2.1 The number of looked after children has increased steadily over the past seven years. There were 69,540 LAC as of 31 March 2015, an increase of 1% compared to 31 March 2014 and an increase of 6% compared to 31 March 2011. This rise is not just a reflection of a rise in the child population: in 2015, 60 children per 10,000 of the population were looked after, an increase from 2011 when 58 children per 10,000 of the population were looked after.

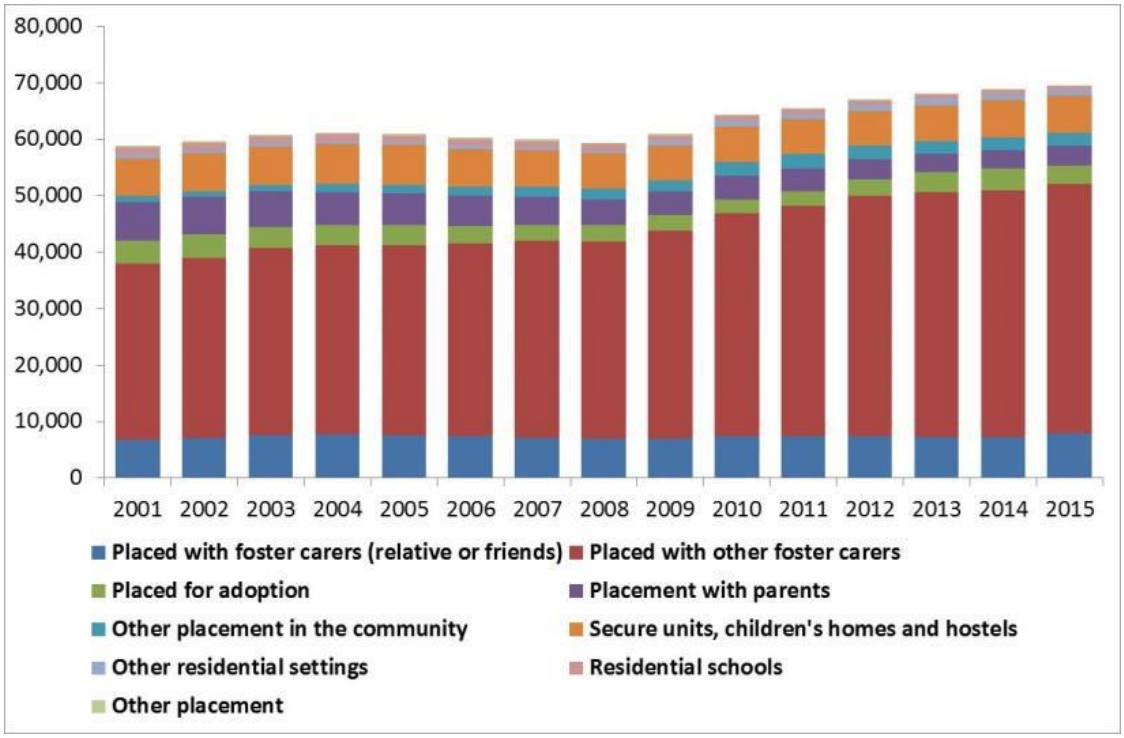
9.2.3 Chart 1: National number of children looked after at 31 March 2011 to year ending 2015

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464756/SFR34_2015_Text.pdf



9.2.4 The majority of children looked after are placed with foster carers. In 2015 the number of children in foster care continued to rise; of the 69,540 children looked after at 31 March, 52,050 (75%) were cared for in a foster placement.

9.2.5 Chart 2: More children with foster carers



9.2.6 The number of LAC has increased steadily over the past seven years and it is now higher than at any point since 1985.

9.2.7 Whilst the reasons why children become looked after have remained relatively stable since 2011, the percentage becoming looked after due to family dysfunction has

increased slightly (16% of children in 2015 compared with 14% in 2011).The majority of looked after children – 61% in 2015 - are looked after by the state due to abuse or neglect.

9.2.8 The ethnic breakdown for children looked after has varied little since 2011. The majority of children looked after at 31 March 2015 (73%) are from a White British background: similar to the general population of all children. Children of mixed ethnicity continue to be slightly over-represented, and children of Asian ethnicity slightly underrepresented in the looked after children population[12].

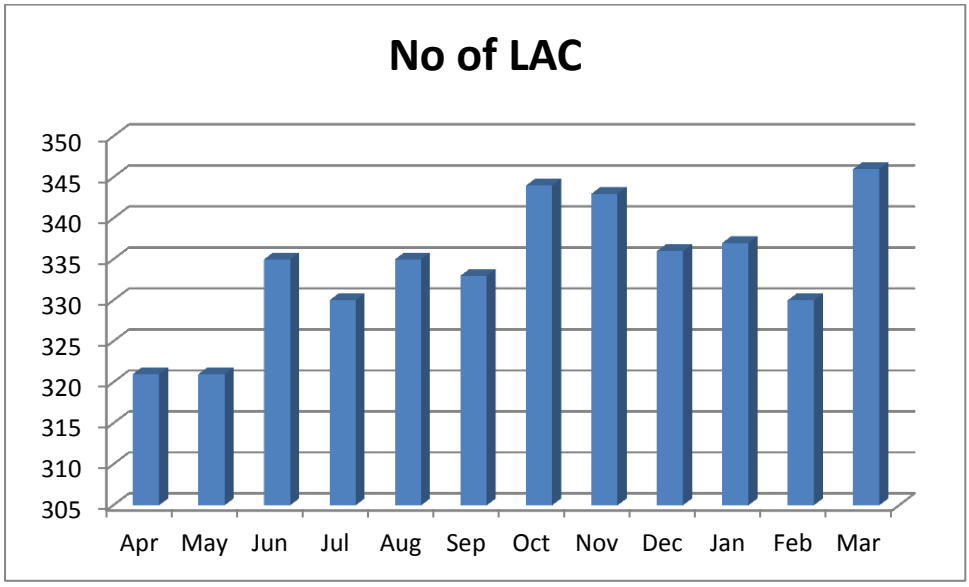
9.2.9 At 31 March 2015, 42,030 (60%) children were looked after under a care order (either an interim or full care order), a 5% increase compared to 2014 and an 8% increase since 2011. A further 19,850 (29%) children were looked after under a voluntary agreement under Section 20 of the Children Act 1989 - this number and percentage has increased steadily since 2013. However, there has been a drop in the number of children looked after with a placement order at 31 March 2015, from 9,580 (14% of looked after children) in 2014 to 7,320 (11%) in 2015. This is in line with quarterly adoptions data collected by the Adoption Leadership Board[13], which has indicated that since Quarter 2 2013-14, numbers of Adoption Decision Maker decisions for adoption and numbers of adoption placement orders granted have decreased.

9.3 Numbers of BwD Children Placed in Care

9.3.1 On the 31st March 2016 there were 346 BwD LAC; of those children and young people 134 were placed out of the borough. It should be noted that a further 120 LAC are placed in BwD from other authorities raising the number of LAC to approximately 470 at any one time. These figures do not reflect the actual workload as many children enter and leave care throughout the year. On average there were 9 new LAC per month, however, this varied between 3 and 22 per month.

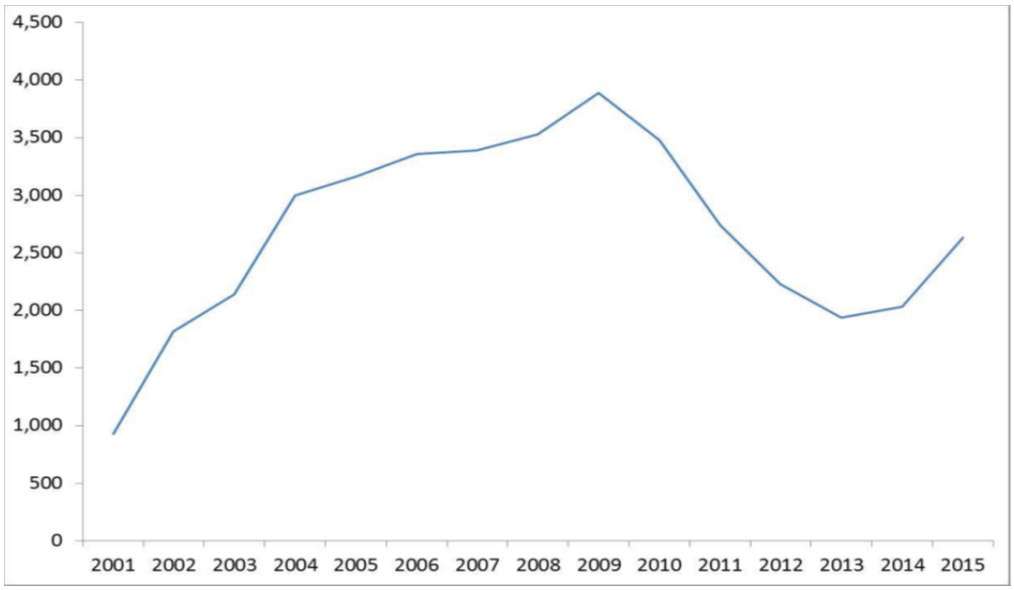
[12] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption--2
[13] https://www.gov.uk/government/.../adoption-leadership-board-quarterly-data-reports

9.3.2 Chart 3: Number of BwD LAC April 2015- March 2016



9.3.3 Of the 69,540 children looked after at 31 March 2015, 2,630 (4%) were unaccompanied asylum seeking children (UAASC). The number of looked after UAASC has been falling since 2009, but increased by 5% between 2013 and 2014. However, Home Office figures show that the number of UAASC arriving in Britain rose by 56% in the year to 2015. It should be noted that the number of UAASC in BwD is relatively low at this time.

9.3.4 Chart 4: Unaccompanied asylum seeking children looked after at 31 March 2001 to 2015



9.3.5 Most LAC are placed with foster carers and the number of children in foster care has continued to rise in 2015. The number of children placed with their parents, and the number placed in the community has also risen in 2015; this is a reversal of previous

downward trends. However, the year-on-year changes are relatively small and the percentage of looked after children in these placement types has stayed relatively stable over the last 5 years. The number of children placed for adoption at 31 March has fallen for the first time since 2011, and number placed in children homes has also fallen slightly in 2015. The number of BwD LAC on a care order placed at home with parents is 38.

9.3.6 In 2015, 52,050 of the 69,540 children looked after at 31 March, were cared for in a foster placement. This represents an increase of 8% since 2011 - a larger increase than the rise in overall numbers of LAC (6%). The percentage of LAC cared for in foster placements was 74% in 2011; in 2015 it increased to 75%.

9.3.7 There were 6,570 LAC cared for in secure units, children's homes and hostels. Numbers have been increasing in recent years in line with the overall increase in looked after children, but there has been a slight decrease this year. The proportion of LAC in secure units, children's homes and hostels has remained stable over the same time period.

9.3.8 A Fostering for Adoption (FfA) placement relates to when a LAC is placed in a foster placement with carers who are foster carers who are also approved prospective adopters and adoption is likely to be the outcome. The local authority are considering adoption for the child or are satisfied that the child ought to be placed for adoption but do not have a placement order or parental consent to place the child for adoption, but are seeking to obtain the order or consent. Concurrent planning is where the local authority is trying to rehabilitate the child with the birth parents, but at the same time, the local authority is planning for adoption, in the event that rehabilitation fails

9.3.9 A special guardianship order is defined under the Children Act 1989 as an order appointing one or more individuals to be a child's "special guardian" (or special guardians). 10.7 Under the Children Act 1989, a residence order is defined as an order settling the arrangements to be made as to the person with whom a child is to live. The Children and Families Act 2014 replaces residence orders (and contact orders) with 'child arrangements orders' from 22 April 2014. References to residence orders have therefore been expanded to reflect this change

10. Children looked after who were missing from placement without authorisation.

10.1 For the first time this year, local authorities provided the Department of Health with more detailed information about children looked after who were missing or away from placement without authorisation. The collection was changed to gather information on all episodes of missing or away from placement without authorisation, rather than just those that lasted for over 24 hours, as was the case previously. As this is the first year of this new collection – and as noted in the accompanying data below - the figures should be treated with caution.

10.2 Of the 99,230 children looked after during the year ending 31 March 2015, 6,110 (6%) were recorded as missing at least once from their placement. The number of children who were away from their placement without authorisation was 3,230 (3%).

The number of times children were missing or away from placement was 28,570 and 13,080 respectively. The majority of the 6,110 children who were missing (just over half), or away from placement (half) were accommodated in secure units, children's homes or hostels. This is largely due to the high proportion of children aged 16 years and over who are mostly placed in these accommodation settings. Nearly half of the missing incidents were for children aged 16 and over; the equivalent figure for children away from placement without authorisation was 58%.

11. LAC placed out of Borough

11.1 There are many reasons why some looked after children live away from their home authority. Some may need to live out of area to help keep them safe from harm or from dangerous influences closer to home. Others may need specialist care that is not available in all local authority areas, or long-term foster placements that are in very short supply in many areas. Some looked after children move out of area so that they can live with brothers and sisters, or to be cared for by relatives who are approved as foster carers. Local authorities will be held more accountable for their decisions to send children to live far from home (Ofsted, From a Distance, looked after children living away from their home area April 2014[14]). Since January 2014, a decision to place a looked after child in a 'distant' placement, out of their home area, can only be approved by the Director of Children's Services in a local authority. They will need to be satisfied that the placement is in the child's best interests and will meet the child's identified needs. (Consultation on safeguarding for looked after children: changes to the Care Planning, Placement and Case Review (England) Regulations 2010: government response, Department for Education[15]). The Designated Nurse receives many requests to undertake health assessments for LAC placed in BwD from other authorities. However, the exact number of LAC placed in our area is often unknown due to authorities failing to notify the Designated Nurse that they have placed a child in BwD. Private residential/fostering agencies also fail to notify the Designated Nurse that they are operating in BwD. Michael Gove (Secretary of State for Education, 2013[16]) announced new arrangements that would enable information about children's homes to be shared more effectively between those who are responsible for keeping children safe, however this did not include health authorities.

11.2 Informing other Authorities about children placed with them is undertaken by the Local Authority rather than by health, although there is direct communication between nurses and health visitors. A transfer letter will be completed if a looked after child is to be placed outside of borough. This will provide essential information about registrations with GP's and Dentists, as well as identifying specific requirements, for example, specialist equipment, so that services are in place in advance and the transition is as seamless as possible.

[14] Ofsted. From a distance looked after children 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419070/From_a_distance_Looked_after_children_living_away_from_their_home_area.pdf

[15] 1. Consultation on safeguarding for looked after children: changes to the Care Planning, Placement and Case Review (England) Regulations 2010: government response, Department for Education)

[16] https://www.gov.uk/government/.../From_a_distance_Looked_after_children_living_

12. Out of area placements & placement moves

12.1 Appropriate and effective planning of placement moves and related information sharing between agencies has been a challenge in some areas. The PHWB guidance includes a number of points that will be particularly relevant for dealing with these challenges. These include:

- Stressing that in making a judgement about the suitability of an out authority placement for a child, the responsible authority should assess, with input from health services, the arrangements which it will need to put in place to enable the child to access services such as primary and secondary health care. Regulations require that the receiving CCG is consulted.
- Reiterating the legal requirement for local authorities to notify the child's GP, the CCG where child is currently living and the CCG for where the child will be placed (as well as those caring for the child, and where appropriate parents) when a new placement is to be made in out or out of area. It is suggested that the person to notify in the CCG could be the designated nurse.
- Making clear that fear about sharing information should not get in the way of promoting the health of looked after children, and that protocols for information sharing should reflect the HM Government guidance on information sharing for practitioners and managers.
- There are over 200 CCGs covering England, so many local authorities will be working with multiple CCGs, even for children placed within their area. The guidance states that, when a child is moved out of a CCG area, arrangements should be made through discussion with the originating CCG, those currently providing healthcare and new providers to ensure continuity of healthcare. It stresses that CCGs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care and that the needs of the child should be the first consideration.

13. LAC TRAINING

13.1 It is essential that staff working with LAC possess the knowledge, skills and competences to effectively safeguard, protect and promote the welfare of children and young people in care.

13.2 The need for professionals working with LAC to have the appropriate knowledge to enable them to deliver safe, effective and appropriate care is highlighted in statutory guidance pertaining to the promotion of the health and wellbeing of LAC (DoH, 2015[17]).

13.3 The requirement for staff to undertake LAC training is further strengthened by the Intercollegiate Document 'Looked after Children: Knowledge, Skills and Competences of Health Care Staff[18]' (March, 2015). The interface between the training requirements for safeguarding and LAC are clearly demonstrated in both

[17] https://www.gov.uk/.../promoting-the-health-and-wellbeing-of-looked-after-children-

[18] Intercollegiate Document 'Looked after Children: Knowledge, Skills and Competences of Health Care Staff' (March, 2015). www.rcpch.ac.uk/system/files/.../page/Looked%20After%20Children%202015_0.pdf

intercollegiate documents. Although not statutory guidance, health service planners, commissioners and provider organisations are urged to take account of the framework to ensure workers maintain knowledge and skills to improve the outcomes for looked after children and young people.

13.4 LAC training is delivered throughout the year for all LCFT staff involved with LAC including UCLAN's student nurses.

13.5 Presently ELHT offer induction to all Paediatricians joining the Community and Neurodevelopmental Paediatrics. Training on carrying out LAC medicals and achieving quality are routinely offered as part of this and many of the Registrars now able to undertake LAC medicals easing the burden on regular staff. The registrars have access to the designated doctor for advice and guidance. They are also offered educational programs through regional meetings and a recent LAC teaching day in Manchester was well attended by the Paediatric trainees.

13.6 The designated doctor intend on initiating a "*get to know"* survey of educational needs on health issues from the Paediatrians, School Nurses and Health Visitors, Social workers and foster carers involved in BwD with a view to contributing to training needs/ organizing a training day with the participation of LCFT,ELHT and Social Services. A resource folder will also be initiated to aid the clinicians.

14. Statutory Initial Health Assessments (IHA) (ELHT)

14.1 The Local Authority has a responsibility to ensure that initial and review health assessments are carried out and that health care plans are made, reviewed and delivered. Children coming into care should receive an IHA within 20 working days of becoming Looked After.

14.2 Each child or young person should have a holistic health assessment on entering care. The initial assessment should be undertaken by a registered medical practitioner and review health assessments may be carried out by an appropriately qualified registered nurse or midwife.

- The initial health assessment should result in a health care plan by the time of the first review (four weeks or 20 working days after becoming looked after).
- Children up to 5 years of age should have twice yearly health assessments that take into account their developmental checks.
- Children above the age of 5 years should have annual review assessments.

14.3 There is a statutory requirement for Initial Health Assessments (IHA's) to be undertaken within 20 working days of a child becoming looked after by the Local Authority. Table 5 summarizes the Initial Health Assessments carried out during each quarter from April 2015 to March 2016. The total number of children seen has doubled (Total of 122) when compared with the previous year (April 2014 to March 2015, a total of 61). This coupled with increased demand in other areas neurodevelopmental Paediatrics, staffing levels and impact from cancellations and DNAs had a significant impact on the ability to provide timely health assessments. During the middle 2 quarters, the percentage of children seen within statutory target

of 20 working days has been below 20%. However this figure rose to 58% in the last quarter following increased capacity, early notification by social services and other immediate measures implemented. During the same period there were issues with access to electronic health records, which limited the number of patients seen in each clinic. Staff sickness, complexities of administrative support also contributed to the delays.

Chart 5:- Initial Health Assessments –LAC placed by BwD in BwD, April 2015 to March 2016

		April-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-Mar 2016	Total (Apr 2015-Mar 2016)
Total		29	37	32	24	122
<28days		9 (31%)	5 (13%)	6 (19%)	14 (58%)	34 (28%)
>28 days	Total	11 (38%)	25 (68%)	16 (50%)	8 (33%)	60 (49%)
	Late Notification	7	10	2	1	20
	Late Appointment	4	15	14	7	40
Not determined		9 (31%)	7 (19%)	10 (31%)	2 (8%)	28 (23%)

14.4 During the last 2 quarters the impact on delays due to late notifications by the social services has significantly reduced. It is also important to note that in 28/122 or 23% of cases, the date of placement could not be determined due to not getting the placement plan or data not entered into the system. This emphasizes the need for a better data collection system to support our clerical staff. Although not highlighted above previous audits clearly indicate that any child not brought for the appointed offered through DNA or Cancellation invariably end up breeching the statutory target.

14.5 An issues log and action plan was prepared in March 2016 and shared with the strategic group by the divisional management and designated doctor of ELHT in collaboration with the CCG to ensure early recognition and implementation of actions. These measures included improved administrative support with cover for absences, clarity on data collection and statutory targets, development of internal escalation processes, cooperation between LAC lead of BwD and East Lancashire, representation of divisional leadership at LAC strategic group level, identifying additional capacity and measures to reduce cancellations and DNAs, development of alternative roles to supplement work currently done by doctors etc. Further strengthening of these processes including re-negotiation of pathways that involve a number of care providers will be required in the coming year.

14.6 Meeting statutory targets has been a standing agenda item at the quarterly CCG Looked after Children Strategic Group meeting and a breakdown of reasons for

delayed assessments has been provided at each meeting by the designated doctor. However the designated doctor is facing challenges in collecting the data accurately from a complex system of data recording and sometimes with figures that do not tally between various providers. Hence it is crucial that a better model of data collection and availability with the expertise of our IT colleagues will be looked into and this will be taken at a strategic group level.

14.7 During the year there were 7 children placed in BwD by other boroughs with requests for initial health assessments. They were from Blackpool (3), Bolton, Chorley, Sefton and Oldham. No placement plans were received in 5 instances and therefore the date of these children coming into placement could not be gathered. The remaining 2 were seen outside the statutory target due to delayed notification. These were due to late notifications.

14.8 Quality of Health Assessments: The quality of IHA's is part of quality assurance process. Standards are linked to the requirements of the national tariff criteria for payments. Presently completion of quality assessment is undertaken for children placed within borough from out of area by the doctor completing the medical. Time spent in data gathering from health records, duplication of information having to be recorded in BAAF form and overstretching on the part of doctor's work on the whole does not presently allow additional completion of a quality assurance form for all children seen. Discussions are taking place at a regional level to address this issue and further guidance is required on implementation.

14.9 The standard required is that 100% of Health Action Plans should be assessed as "Good". This is achieved when adequate completion of all sections, Health needs have an action stated, review date set, immunisation details listed and current status given correctly, HAP legible and sufficient contact details of health professional completing the assessment given.

14.10 An audit by Dr D Ratnaweera (Community and Neurodevelopmental Paediatrics – ELHT, Oct – Dec 2014) looking at quality of initial health assessments recorded satisfactory in 19/20 cases audited. A more recent audit was undertaken by Dr Rinku Agarwal (Registrar in Community Paediatrics- ELHT) during Jan – May 2016 of 61 cases is yet to be published and will be used for performance evaluation and implementation of any action/s when available.

14.11 Information availability for initial health assessments: It is common knowledge that a good medical assessment depends a lot on health history. In the case of LAC obtaining a history from carer or child is extremely limited for obvious reasons.

This remains a significant concern for the paediatricians carrying out medicals, as they frequently experience difficulties in pinpointing where certain information is stored within the electronic care record (ECR). This means that the paediatricians need to trawl through large volumes of notes to get to the relevant information in most instances, e.g. birth details, developmental screening etc. This has had a big impact on statutory timescales and as a result paediatricians had to reduce the number of patients seen in each clinic session. The presenting issues were addressed during the fourth quarter, however the increased administrative time

required and the potential impact on clinic time will need to be monitored closely over the next few months.

14.12 An audit by Dr D Ratnaweera and Dr T Yasawardena (ELHT - March 2014) on availability and adequacy of information at IHAs in BwD identified several issues. Availability of information from the PCHR or Red Book[19] 12/20, Health Care Passport maintained by carer 1/30, Consent 30/30, Placement Plan completed by social worker 21/30 but sometimes only partly completed, SN/HV Records available 27/30, Accessed hospital records when deemed necessary 5/30, Information from GP requested – 0/30. These gaps were then reported to the strategic group for action and it is important to re-visit this important area to have an idea of the present status.

14.13 Certain localities in the region are requesting information from the GP in all cases prior to the IHA. There are localities where the LAC nursing team does ensure that the Paediatricians are provided with vital information prior to medicals. At a recent clinical forum meeting in ELHT the difficulties faced by Paediatricians in completing IHAs were discussed and one of the key elements was lack of adequate information from partner services. Issues around availability of past health history remains an issue and will be discussed at a strategic level during the present year.

14.14 Review Health Assessments (RHAs) (LCFT)

14.14.1 Review Health Assessments take place annually or bi-annually for under 5's. Health Visitors complete the bi-annual assessments for the under 5's and school nurses over 5's.

14.14.2 Timely completion of RHAs, immunisation and dental screening rates are used as indicators for the health of LAC nationally and locally. LCFT healthcare is accountable to, and reports to, BwD Clinical Commissioning Group (CCG) and the local authority. Particular attention is to be paid to the children and young people's emotional wellbeing and mental health with links to the strengths and difficulties questionnaire (SDQ). This is a validated and widely used questionnaire which can be completed by carers, young people and school staff to provide a picture of the emotional wellbeing and social and behavioural functioning. It is a requirement that the SDQ is completed for all young people in care between the ages of 4 and 16 years, and that is to be used to inform their health care plans.

15. Mental Health

15.1 The mental health of all children is important. With half of adult mental health problems starting before the age of 14, early intervention to support LAC and young people (LACYP) with mental health and emotional well-being issues is very important. Under Section 10 of the Children Act 2004, local authorities have a duty to co-operate to promote a well-being among LACYP.

15.2 The cross Government Mental Health Strategy, 'No Health without Mental Health[20], identifies LAC as one of the particularly vulnerable groups at risk of developing mental health problems. Inclusion of this indicator for looked after children will send

[19] PCHR. The personal child health record (also known as the 'Red Book')

[20] https://www.gov.uk/government/uploads/system/uploads/...data/.../dh_124058.pdf

out a message that this group of young people are a priority for the NHS and local authorities in their new public health role.

15.3 Future in Mind (Norman Lamb, March 2015[21]) the report of the CAMHS taskforce has made forty nine recommendations to support the CAMHS service transformation to improve young people's mental health over the next five years. The recommendations are grouped under five headings of which 'Care of the Most Vulnerable' identifies Looked after Children (LAC) and young people. Due to the complexities of LAC we are responsible for providing the appropriate mental health and emotional wellbeing services ensuring availability and accessibility at the earliest opportunity for these children and young people.

15.4 Vulnerable LAC may have been exposed to domestic violence, neglect, self-harm and substance misuse, which can impact on the growing child and lead to long term chronic problems into adulthood. Reducing health inequalities and providing early intervention and evidence based outcomes that can improve LAC and young people's mental health and wellbeing is a supported within the CAMHS Transformation Plan[22]. The aim is to support staff who work with vulnerable groups by providing access to high quality services when and where they are needed. Co-ordinated services to provide ways in which children and young people feel safe, and build their resilience, ensuring evidence-based interventions and care, drawing on the expertise and engagement of all the key agencies involved.

15.5 A new way of working is being introduced to the Children's and Adolescents Mental Health Service known as Thrive, which looks at every child as an individual and provides services and treatments around the child or young person. The Thrive model will ensure that the mental health and emotional wellbeing of LAC will be addressed at the earliest opportunity of which could result in this vulnerable population experiencing a reduced risk of self-harm, risk taking behaviours, substance misuse and pregnancy.

15.6 Without an indicator covering this group, there would be a risk of an even greater increase in rates of undiagnosed mental health problems, placement breakdown, alcohol and substance misuse, convictions and care leavers not in education, employment or training (NEET)

16. Strengths & Difficulties Questionnaire (SDQ)

16.1 Since April 2008 all Local Authorities in England have been required to provide information on the emotional and behavioural health of children and young people in their care. The SDQ is a short behavioural screening questionnaire. It has five sections that cover details of emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also positive behaviour. The SDQ data is collected by Local Authorities and a summary is submitted to the DCSF through

[21] https://www.gov.uk/government/uploads/system/.../Childrens_Mental_Health.pdf
[22] www.blackburnwithdarwenccg.nhs.uk/.../Lancashire%20CAMHS%20Transformation.

the annual SSDA903 return. This is a screening tool used with 5-16yr old children to identify five areas associated with emotional health (Goodman et al 1998);

- Emotional symptoms
- Conduct problems
- Hyperactivity and inattention
- Peer relationships
- Pro-social behaviour.

16.2 For this report, the definition of a 'looked after child' is a child who has been continuously looked after for at least 12 months up to and including 31 March 2015. This definition has been used because 12 months is considered an appropriate length of time to gauge the possible association of being looked after on educational attainment. It is also the cohort of children for whom information on outcomes such as health, wellbeing and offending are collected through the Social Service Departments Activity (SSDA903).

16.3 The Department for Education publishes annual statistics on looked after children in England. These statistics are taken from the SSDA903 return that local authorities submit for the children they are responsible for[23]

16.4 Performance Indicators. Data for health assessments is collected by the Department for Education annually for all children looked after for a year or more on the 31st March

16.5 National performance indicators are produced in partnership with social care. These indicators provide data for the Children's Annual Performance Assessment required by central government from Social Care Department (SSDA903).

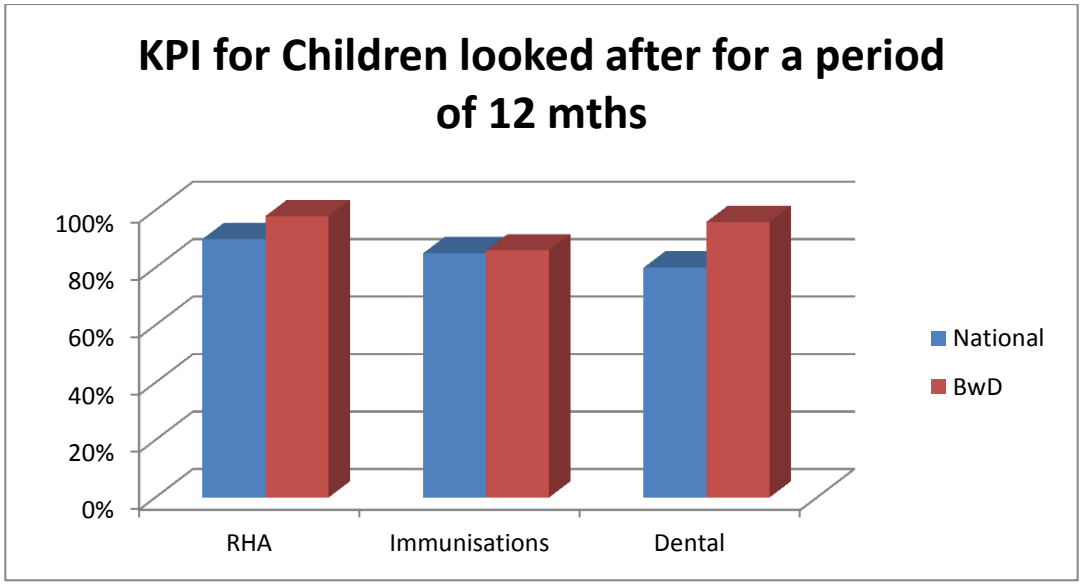
16.6 The indicators request quantitative data on:

- Annual health assessments
- GP registration
- Annual dental checks
- Development checks
- Lifestyle issues

17. Government Data SSDA 903 for Blackburn with Darwen

17.1 Chart 6: SSDA903 Health care and development assessments of children who have been looked after continuously for at least 12 month: Years: 2015: Coverage: England

[23] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption--2



17.2 **Dental**

17.2.1 Oral health remains an area of neglect for children coming into care. The 16-17 year old age range is a particularly challenging group to encourage attendance of dental check-ups. The leaving care team personal advisors & specialist nurse for care leavers actively accompany young people to improve take up or liaise with the social worker to arrange a carer to support this. Ineffective oral hygiene, protruding or missing teeth can often be less attractive socially and cause anxiety particularly for teenagers in care. Provision of dental care is generally good in BwD, with the majority of LAC being seen by a local NHS dental practice near their placement. If this is not possible the nurses are able to refer children in care as a priority to the Community Dental Service. This is particularly pertinent for children with a disability, who may require general anaesthetic to complete treatment.

18. PUBLIC HEALTH

18.1 During 2015/16, BwD Public Health department commissioned Liverpool John Moore's University (LJMU) to undertake research in BwD on the health and wellbeing of Looked after Children and young people (LACYP). The projects aims were to:

- describe the epidemiology of health outcomes for LACYP in BwD
- identify gaps in current service provision
- assess the quality of service experienced by LACYP

This was done through:

- A rapid systematic literature review
- Logic modelling to explore the frameworks and processes in place in BwD to enable the routine monitoring and identification of health, emotional and social outcomes
- Review and analysis of local data and intelligence on LACYP
- Qualitative methods were used to gather evidence regarding knowledge, perceptions, attitudes and experiences of the LACYP with a specific focus on health and wellbeing.

The main findings are summarised below.

18.2 Health Status

18.2.1 LACYP in BwD appear to have a good understanding of health and the importance of a healthy lifestyle. LACYP primarily viewed health in terms of nutrition and physical activity, although happiness and stability was discussed by some as an important contributor to health. No LACYP and few carers or stakeholders discussed alcohol, drugs or sexual health. The care leavers associated health with wellbeing, recognising the influence of health on educational attainment, social support and parenting; these young people acknowledged that positive supporting influences were particularly important for health.

18.2.2 Although evidence from quantitative data and interviews with young people suggest - reported health behaviours are good, carers described how young people would enter their care with very poor eating habits and dental health. This finding highlights potential discrepancies in the recording of data via the health assessment, and the overall assessment of the health and wellbeing of LACYP in BwD.

18.2.3 The LACYP felt they had appropriate access to health services and described their GP, school nurse, foster carer or school staff as the main source of support and signposting. Care leavers described that their personal advisor would provide them with help in seeking support for health needs, if required. Carers and stakeholders described the important emotional support needs of vulnerable children and young people, as a result of the problems which have characterised their lives. Stakeholders felt that access to CAMHS in BwD could be disjointed and that a more coordinated approach between services could be developed. Carers felt that mental health support was often not available until the young person had reached crisis, and participants from both stakeholder and carer groups acknowledged that LACYP may not recognise when they require emotional support.

18.3 Health Assessments (HAS)

18.3.1 A review of HAs found that completion of HAs in BwD was good, with the majority of all LACYP having a HA recorded (89.1% of those living outside of BwD and 93.5% of those living in BwD). Whilst data were not available for all LACYP (either because it was not recorded on their HA or their latest full HA was not available to researchers), analyses suggest that around a fifth of LACYP in BwD reported having worries about their health. Where data were available, analyses show that a quarter of LACYP aged 10 and over reported smoking, and just over one in ten drank alcohol and/or used drugs. More young people living in BwD reported drug use (20%, 7/35) compared to those living outside the area (8.2%, 4/49). Despite the low HA figures, data provided by Young Person's Drug and Alcohol services show that an average of 35 LACYP had been referred to the service each year between 2012 and 2014.

18.3.2 Care leavers, carers and stakeholders expressed concerns that LACYP, especially adolescents, do not like their health assessments; they find them intrusive, repetitive and feel they set them apart and make them 'different' from other children and young people.

18.4 Interventions to Improve Health and Wellbeing

18.4.1 The evidence base for interventions to improve the health and wellbeing of LACYP in both the short and longer term has expanded considerably in the last decade. BwD already have the most effective programmes in place and no appropriate effective programmes were identified that are missing in BwD. However carers and some stakeholders felt there was a gap in the provision of services and interventions to support LACYP to learn life skills and to build psychological resilience. Resilience and life skills were thought to be important to ensure care leavers could maintain emotional, mental and physical health and were able to deal with living independent lives.

18.5 **Placement Stability, Outcomes and Continuity**

18.5.1 Stakeholders involved in mapping the journey of children in the care of BwD all agreed that referrals to services were most often multifactorial and very complex. Stakeholders highlighted a number of issues for consideration when understanding the journey of LACYP, particularly noting the complexity, trauma and challenges that children have faced upon entering care. Achieving permanency at an early stage was felt to be very important in terms of attaining positive outcomes for young people, including good health and wellbeing.

18.5.2 Stakeholders agreed that there were very positive local relationships between partner agencies, and that statutory and voluntary support was provided as necessary, dependent upon need. LACYP who took part in the qualitative engagement viewed access to support as important to ensure they achieved positive outcomes. All LACYP felt they had someone to speak to if they needed help or support, describing that they could speak to their carer and that they had good access to their social worker. The school was recognised by the LACYP as a particularly important source of support and stability. The importance of continuity of social work support was highlighted by young people in care in BwD and all described disliking when they had to change social worker. BwD have retention rates for social workers in line with local and national rates. Some young people reported they found the annual review process distressing and were reluctant to be open about their feelings in front of carers or parents. LACYP living outside of BwD who participated in the qualitative research felt that their area of residence did not impact on the quality of the care they received.

18.5.3 Recommendations from this research have been addressed through the Local Authority multi-agency Looked after Children Strategy and Action Plans.

18.5.4 Section 1: Summary of Achievements (LJMU research, 2015).

- Positive engagement with care leavers who historically have not engaged with health services
- Implementation of amended health passport
- Weekly drop in
- Action plan from care leavers questionnaire 2015

- Health promotion delivered via social networking as requested by care leavers
- Development and implementation of health snapshot questionnaire
- Criteria met and application submitted for investors in children membership – for the health and well-being of our care leavers

18.6 **Joint Working**

18.6.1 The specialist nurse for care leavers has developed and established professional working relationships with the following services:

- Youth Nurse
- Youth Offending Team Nurse
- Brook Sexual Health Team
- Child Looked After Team
- Designated Nurse for Children Looked After
- The Leaving Care Team Manager and Personal Advisors
- The Everybody Centre young peoples' resource centre
- Foster Carers
- Placement Providers
- Residential Care Providers
- Mental Health Treatment and Assessment Team
- HMP Kirkham – Supporting the health needs of care leavers serving custodial sentences
- Coppafeel (Breast/Testicular Screening Charity)
- Care Leavers Association
- Adult Services
- Children's' Services
- Learning Disability Teams

18.7 **Young People Leaving Care: Government initiative**

18.7.1 The Care Leavers' Strategy (2013[24]) recognises that children often enter the care system with a poorer level of physical and mental health than their peers, and their longer-term outcomes remain worse. Two thirds of looked after children have at least one physical health complaint, and nearly half have a mental health disorder. Care leavers frequently tell us that they encounter a lack of support in accessing appropriate services. They often feel that the professionals working close to them do not have an understanding of their needs, particularly in respect of mental health. Care leavers also face difficulties around the transition from Child and Adolescent Mental Health Services (CAMHS) to adult services.

18.7.2 Promoting the Health and Well Being for Looked after Children 2015, acknowledge that transitions from children's to adult services proves to be a particularly vulnerable time for care leavers as their health needs are often unmet. It is recommended that care leavers are equipped to manage their own health needs wherever possible. Care leavers should be given a summary of their medical history and advised how to

[24] https://www.gov.uk/government/uploads/.../Care_Leaver_Strategy.pdf

access a full comprehensive copy if required. Care leavers should be given the opportunity to discuss their historic and present health with a health professional. Young people leaving care should be able to continue to obtain health advice and services, and know how to do so.

19. Staying Put

19.1 The Government is committed to supporting children in care and the unique challenges that they often face. That is why they have put in place a comprehensive package of support, including the introduction of the Pupil Premium Plus and compulsory Virtual School Heads to champion the attainment of LACYP. The Children and Families Act 2014 introduced a new duty on local authorities to support young people to continue to live with their former foster carers once they turn 18 (the 'Staying Put' duty[25]). This duty came into force on 13 May 2014. The duty means that local authorities must advise, assist and support both the young person and their former foster carers when they wish to stay living together. This supported arrangement can continue until the young person's 21st birthday. The Government is providing £44million to local authorities over three years (2014/15- 2016/ 2017) to help support these arrangements. A Staying Put arrangement is one where the young person is a former relevant child who was looked after immediately prior to their 18th birthday (as an eligible child) and continues to reside with their former foster carer once they turn 18.

20. The Leaving Care Team

20.1 All young people are likely to need support during the transition to adulthood. Young people leaving care are likely to be particularly vulnerable due to their previous life experiences and the limited immediate family support.

20.2 The team aims to:

- Encourage the personal development and practical living skills of young people leaving care;
- Work with young people leaving care to find employment/training;
- Work with young people to access education;
- Work with young people to maximise their income;
- Work with young people to find suitable housing;
- Work with young people in times of emergencies;
- To involve young people in all assessment, planning, review and decision making arrangements for leaving care;
- Meet the requirements of the Children Act and Blackburn with Darwen policies in relation to young people leaving care.

[25] Staying Put. https://www.gov.uk/government/uploads/system/.../file/.../Staying_Put_Guidance.pdf

20.3 **Pathway Plans**

20.3.1 The Pathway Plan should be pivotal to the process whereby the young people map out their future, articulating their aspirations and identifying interim goals along the way to realising their ambitions. Each young person will be involved in compiling their own plan, setting out their own goals and identifying with their personal advisor how the local authority will help them. The Pathway Plan will require multi-agency input to ensure effective transition into adulthood and the provision of appropriate adult based services. This will be done in consultation of the young person`s wishes and feelings. PHWB (2015) - The participation of care leavers is fundamental to effective pathway planning. Young people should be central to discussions and plans for their futures and it will be exceptional for decisions about their futures to be made without their full participation. They must be active participants in building their future.

21. Pathway Plans in relation to Health and Well-Being

21.1 The Pathway Plan includes former and current health information as recommended in the Children's Act (1989) – See below

21.2 Use of primary healthcare services.

Arrangements for the young person's medical and dental care according to their needs making reference to the health plan established within the care plan in place when the young person was looked after.

21.3 Access to specialist health and therapeutic services.

Arrangements so that young person understands the actions they can take to maintain a healthy lifestyle.

21.4 Opportunities to enjoy and achieve and take part in positive leisure activities.

22. Developing Health Services and the Role of the Specialist Nurse

22.1 The LA successfully recruited a specialist nurse for care leavers in November 2015. The funding was secured via Public Health for a period of 18 months. The specialist care leaver nurse is co-located with the leaving care team in Darwen. She works closely with the leaving care team personal advisors (PA's) to provide ongoing support to care leavers to ensure they have access to universal health services on a full-time basis.

22.2 Over the past six months the specialist nurse has developed many professional relationships with the care leavers. This has been achieved with the support of the Leaving Care Team personal advisors and the leaving care team manager. The specialist nurse has accompanied personal advisors on home visits, attended focus groups, football groups and the young advisors forum. She has participated in the training delivered by care leavers and made contact with care leavers via letter, telephone, text message and email. All care leavers have now been made aware of the service and have been given the opportunity to meet/have dialogue with the specialist nurse. The engagement with the specialist nurse varies on an individual basis. For example some care leavers meet with the nurse on a weekly basis, some

fortnightly, some only via email/text. Care leavers are provided with the contact details of the nurse and are encouraged to complete a health snapshot with their personal advisor at their statutory 8 weekly visits. The purpose of the health snapshot is to gain an insight into the current health and well-being of the care leaver and to identify any potential health issues that may deteriorate if no intervention is facilitated.

23. Health Needs of the Care Leaver

23.1 Whilst the historic and ongoing health needs of the care leavers is well documented on pathway plans and health plans, a proportion of care leavers rely on the leaving care team and the specialist nurse to support and advise them with acute and chronic health conditions. Health needs have been assessed and addressed through direct work, referrals and signposting. Key areas have been supporting young people accessing universal and specialist health services including dental and GP appointments, mental and sexual health and drugs and alcohol misuse. Focus has also been on promoting healthy eating and lifestyles. The health needs vary in severity for example, supporting a young person who requires dental treatment to supporting a young person to attend appointments with the consultant to discuss emergency treatment for renal failure. The care leavers will contact the specialist nurse directly or via their personal advisor to seek support with a health need. This would typically lead to a discussion with the young person via telephone or text and a meeting at a location of the care leavers' choice, (depending on risk) would be arranged so that they can be supported/advised in a more personable manner. The level of input for each care leaver differs as some require recurrent support and some only a telephone conversation. This relaxed approach is welcomed by the care leavers as they are appreciative and grateful of the support and are aware that it's there for them to access whenever they require.

23.2 **Overall Contacts**

23.2.1 Total number of contacts with care leavers between November 2015 and April 2016 = 131

23.2.2 Total number of group contacts with care leavers e.g. football club, young advisors and total respect training session = 6

24. Key Themes/Trends

24.1 Referral and access to universal services

- 1:2:1 support and advice in relation to healthy lifestyle
- Sexual Health
- Information and advice re ongoing health condition
- Referral to mental health services
- sessions re emotional health and well-being
- Health passport completion
- 17 Participation and Consultation

24.2 Prior to the specialist nurse commencing the role in November 2015. A health questionnaire was circulated amongst the care leavers to seek their views/opinions on the health services within the borough. In January 2016 the specialist nurse collated the results and produced an action plan that focused solely on the views expressed by the care leavers.

Objective:
To increase awareness of health conditions and how these impact on daily life. To ensure young people are empowered to manage own health condition proactively
To establish if there are any underlying health needs that are not being met
To increase awareness of what constitutes a healthy lifestyle – on a personal level as there are many contributing factors that may require explanation, further information/support and guidance
To ensure pathway plans continue to highlight and reflect the health needs of the care leaver.
To ensure all care leavers are in receipt of a health passport which will provide a brief indication of universal health services, local and specialist services, immunisation status, allergies and any relevant health information.
Care leavers to have access to a GP, Dentist and Optician when required. Regular dental check-ups and minimum of two yearly optician checks to be encouraged
To promote and support the emotional wellbeing of the care leavers. Identify those care leavers who are at risk and encourage participation and engagement in services/activities that will contribute towards raising emotional well-being.
All care leavers to be registered and be able to access universal services as and when required.
Care leavers to be encouraged and supported to attend health appointments and access health services if they are in need of intervention
To enable care leavers to access support for minor ailments without the need of GP/Out of hours services. To provide information to care leavers which will inform and educate care leavers on the ‘role of the chemist’ and how they can help with many minor ailments
To work closely with the school nursing team and the care leaver to ensure a consistent approach to the health needs of the care leaver and how best to support. To ensure a smooth transition from school nursing service into the leaving care team prioritising pathway plan and health passport completion based on the most recent health assessment and information held from the school nursing team.
Care leavers to be given the opportunity to access confidential health support/advice.

To inform and educate care leavers on the resources available to support and enable them to stop smoking
To inform and educate care leavers on the resources available to support them with their alcohol use/misuse
Determine the underlying reasons why the care leavers are using drugs.
Care leavers to access appropriate services to ensure their sexual health needs are identified and treated accordingly. Awareness of services and sexual health conditions to be shared with care leavers on a regular basis with the aim of encouraging engagement
Raise awareness of specific services and support care leavers to participate/engage in services if necessary.
To promote and support the emotional well-being of the care leavers. Identify those care leavers who are at risk and encourage participation and engagement in services/activities that will contribute towards raising emotional well-being.
To ensure all care leavers are informed and advised on what to do and where to access help should they become a victim of domestic abuse/bullying
To ensure that all care leavers are able to access support and services in relation to self-harm and mental health.

25. Successes within this reporting period

25.1 Increased interactions and engagements with care leavers

Health passports, completed in consultation with the young people

Final visit prior to closing to the leaving care service to allow opportunities for discussion regarding health

Positive feedback received from care leavers in relation to the specialist nurse role

Submission of application to investors in children award *health specific

26. Example good practice; Investing in Children Award

26.1 Investing in Children Membership gives national recognition for your good practice and active inclusion of children and young people in dialogue and change. The Investing in Children Membership Award recognises and celebrates examples of imaginative and inclusive practice. Investing in Children members are those services that can demonstrate a commitment to dialogue with young people that leads to change. Dialogue is an interactive, ongoing process, not a one off event. A distinction needs to be made between ‘consultation’ where powerful people consult the powerless, and ‘dialogue’ where young people are seen as partners with a valid contribution to make to the design and delivery of services. To achieve Investing in

Children status, services will also have to demonstrate that this is an inclusive process and that some young people are not prevented from making a contribution.

26.2 Organisations can achieve membership if they meet the following criteria:

26.3 They can demonstrate that you have dialogue with children and young people.

26.4 They can show that changes have happened as a result.

26.5 Children and young people who use the service agree that this is the case.

26.6 Organisations who receive the award are able to evidence how dialogue with young people has led to change. It is a children's and young people's award; therefore the young people who are supported by the service have provided the evidence for the organisation and have also endorsed the membership.

26.7 We are delighted to announce that the specialist nurse for care leavers was successful in gaining the 'Investing in Children' award on the 31st May 2016

26.8 The fact that she achieved this award due to endorsements from the young care leavers she supports is a credit to her personally and professionally. We as health professionals are privileged to work with such inspiring young people and we are proud that they know that they can really talk to us and that they will be listened to.

27. Care leaver's comments recorded by the investors in children assessor

"It's a brilliant service, I love it! Before we had too many nurses but Helen has stayed and built relationships with young people which is so important"

"She is consistent, honest and trustworthy!"

"I meet with her fairly regularly, twice a month or more regularly if things are going on"

She has made a big difference to my life. She motivates me and helps me make my appointments. It would be a bit pointless if she wasn't around!"

"I feel I can trust her, she is kind hearted, never over steps the boundaries and always asks if we can talk about things. She has every intension to help young people and is quite organised which is a good thing as I always forget things so she messages me to remind me!"

"She is also professional in her job"

"We always get options for where and when we want to meet"

"I usually meet Helen in a café or in the doctors. She always gives me an option to meet in a few places or she will say she will come to me. She always works around you!"

27.1 **Leaving Care Team Priorities Moving Forward**

- Continue to embed health snapshot within leaving care team
- Continue to be innovative in terms of engagement and capturing the voice of the care leaver
- Provide care leavers the opportunity to participate in service development and delivery, ensuring they remain at the centre of the service
- Continue with the post of specialist nurse
- Clear protocol for care leavers health intervention at the beginning and end of the leaving care service
- Continue to focus on building relationships with the care leavers at the earliest opportunity, support the multi-disciplinary team with the completion of review health assessments
- Contribute to the smooth transition from children's – adult services

28. Engage Multi-Agency Sexual Exploitation Team.

28.1 Some young people who are looked after have been the victims and sometimes the perpetrators of sexual abuse and may at times enter into abusive relationships that reproduce these early experiences. It is important to work with them to look at ways of helping them make and value healthier relationships. A young person who has been sexually abused is likely to have a distorted view of what a good sexual relationship is about. They need to be helped to see what the differences are between healthy and abusive relationships.

28.2 The Designated LAC Nurse works closely with the specialist nurse practitioners from the Engage Team to ensure the health needs of the young people are met without duplication of services. Sexual Exploitation is a major issue which involves physical, emotional and sexual abuse of young people. The effects are devastating to the victims and their families. BwD are at the forefront of addressing this issue and the multi-agency Engage team is recognised as a model of good practice. Prevention underpins the work of the Engage team and in order to reduce the numbers of young people suffering this form of abuse members of the Children's Trust acknowledge that prevention is a shared responsibility.

28.3 It is important to acknowledge that many of those same factors which place some young people at risk of exploitation place others at risk of developing exploitative behaviours. There is well documented evidence to suggest that young people who display sexually harmful behaviour may also have suffered from difficult childhood histories that include domestic violence, familial child abuse, neglect, emotional abuse, time spent in care, disrupted schooling and low educational attainment. Evidence indicates that a significant proportion of sexual offences are committed by adolescents and that low levels of inappropriate sexual behaviour can develop into serious and exploitative behaviour which persists well into adult hood. Agencies

require clear guidance about the difference between experimental and harmful sexual behaviour demonstrated by children and young people behaviour and when and how to take action to address (Blackburn with Darwen Sexual Exploitation Prevention Strategy)[26].

29. Missing From Home

29.1 LACYP may run away from a problem, such as abuse or neglect at home, or to somewhere they want to be. They may have been coerced to run away by someone else. There are particular concerns about the links between children running away and the risks of sexual exploitation. Missing LACYP may also be vulnerable to other forms of exploitation, to violent crime, gang exploitation, or to drug and alcohol misuse. LACYP missing from their placements are particularly vulnerable.

29.2 BwD uses its missing children protocol and offers a return interview to all children and young people returning from a missing episode. This interview is carried out by the most appropriate worker who is a children's services professional and independent of the LACYP home situation.

29.3 BwD LACYP are interviewed by a social worker, although a choice of professional is available where young people would prefer this to be someone other than their social worker.

30. Summary of Key Areas of Achievement

- Awarded the 'Investors in Children' Award for care leavers
- Specialist nurse for care leavers appointed until March 2017
- KPIs for immunisation and dental achieved.
- All RHAs quality assured by the Designated Nurse for LAC
- SDQs - the process in BwD for the collection of SDQ data is now firmly embedded into the RHA process.
- Care Leavers receive their Health Passport as part of their transition to adult services.
- Designated Doctor Role in place and working alongside Designated Nurse to meet statutory responsibilities for the CCG and health providers.
- Consultant Clinical Psychologist for LAC recruited and commissioned via BwD LA

31. Priorities 2016-17

[26] Sexual Exploitation. www.lancashiresafeguarding.org.uk/media/4890/CSE-Strategy-Revised-Feb-2015.pdf

- To ensure that the outcomes outlined within the intercollegiate document 2015 for the Designated Nurse LAC function are able to be successfully delivered.
- To ensure that the revised Designated Doctor LAC service specification with clearly defined reporting arrangements is formally agreed and operational.
- NHSE to ensure findings from the Benchmarking tool are implemented by CCG's
- A continued drive to improve the timeliness of Initial health assessments, with a focus on partnership working arrangements to ensure that accurate and timely information sharing on children coming into care to support improvement in the numbers of children for whom assessments can be completed within the statutory timescale.
- Maintain and further improve the percentage of review health assessments completed within statutory timescales
- Secure funding for the Specialist Nurse for care leavers on a permanent basis.
- Re-evaluation, improving and implementation of pathways for LAC clinical assessment process
- Developing effective data collection and reporting
- Looking at ways to improve information availability to the clinicians at the time of medical assessments
- Continue joint working including promotion of services for emotional behavioural health who do not qualify for direct involvement of Clinical Psychology or ELCAS services.
- Identifying training needs of the clinicians and delivering training and encouraging clinicians to attend regional and national training days.

32. Conclusion

32.1 The CCG, LA, LCFT and ELHT have well imbedded procedures in place to ensure that the health needs of all looked after children are prioritised. Our overall performance is monitored through key performance indicators, Care Quality Commissioning (CQC) and Ofsted inspections. It is a challenging performance area but one in which BwD performed well in the last CQC/Ofsted inspection being awarded 'Good'. However, in order to achieve good in the next inspection due this year multi-agency partners need to continue working closely together to promote the health and emotional wellbeing of all LACYP.

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