Supporting and promoting the Health needs of Looked after Children in Wales

A Practice Guide

LOOKED AFTER CHILDREN HEALTH EXCHANGE [LACHE]

Looked After Children Health Exchange

Children in Wales facilitates this Group which is made up of representatives from a range of organisations and networks who provide services to looked after children in the field of health.

http://www.childreninwales.org.uk/areasofwork/lookedafterchildren/healthoflookedafterchildren/index.html

The Looked after Children Health Exchange (LACHE)
is co-ordinated by

Children in Wales
25 Windsor Place,
Cardiff CF10 3BZ
info@childreninwales.org.uk
www.childreninwales.org.uk

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INTRODUCTION

The health needs of looked after children (LAC) are a corporate responsibility, which requires a multi-agency approach involving local authorities and health agencies. This report is aimed at service providers and practitioners who work with looked after children and for those with an interest in this area. This will include health organisations and their services, local authorities, third sector organisations and the wider services that promote children and young peopleôs health and well-being. It will also be of interest to many carers.

This report is intended to provide an overview and act as an additional support for providers and practitioners. It should in no way be perceived as a substitute for existing national guidance and regulations which outline the statutory duties in respect of the health of looked after children.

This report has been divided into 7 key areas

- The Policy Context
- What Are The Key Issues For Looked After Children?
- What Are The Views Of Looked After Children?
- Who Are The Key Professionals With Responsibility For The Health Of Looked After Children?
- Looked After Children With Particular Needs
- Holistic Health Assessment And The Health Care Plan
- Health Promotion

THE POLICY CONTEXT

It is not the intention of this guide to provide a detailed national policy framework as it impacts on looked after children. Such information is readily available elsewhere. However a number of key international frameworks and overarching Welsh Government frameworks will be referenced.

International Frameworks

United Nations Convention on the Rights of the Child

This guide reflects the principles of the United Nations Convention on the Rights of the Child (UNCRC), which the Welsh Government has adopted as the guiding framework for all policy impacting on children and young people. For children 'looked after', the UNCRC has special relevance. Though they have the same rights as other children, the Convention recognises that in order to attain the same quality of life as others, special attention is required.

In particular:

Article 3

Stipulates that the best interests of the child should be a primary consideration when action is taken

Article 12

Deals with the child's right to express his or her own views freely in all matters affecting the child, and in particular, to be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child

Article 20

States that a child temporarily or permanently deprived of his or her family environment shall be entitled to special protection and assistance, and that due regard should be paid to the desirability of continuity in a child's upbringing

Article 23

Requires that 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

Sets out the right of any child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of ill health

Article 25

Sets out the right of a child placed by competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided and all other circumstances relevant to his or her placement

Article 39

States that all appropriate measures should be taken to promote the physical and psychological recovery and social integration of a child victim of any form of abuse and neglect

These principles are especially important as children looked after are amongst the most socially excluded and vulnerable groups in society. They have significant health needs in comparison with other children when they enter care, and too often, the experience of care does little to redress this inequity.

UN Guidelines for the Alternative Care of Children

Alongside the UNCRC, the UN adopted the Guidelines for the Alternative Care of Children in November 2009. This international framework was developed in recognition of the significant gap in the implementation of the UNCRC for children without, or at risk of losing, parental care. The Guidelines outline the need for relevant policy and practice with respect to 2 basic principles

Necessity ï children should remain with, and be cared for by, their family. Removing a child from their family should be a measure of last resort and be subject to a rigorous participatory assessment.

Appropriateness ï care options should be tailored to individual needs, with placements regularly viewed to assess the continued need to provide alternative care and the viability of potential reunification with the family. A range of suitable care options should be available which the Guidelines define.

The Guidelines provide a detailed framework for ólooked afterô children and those at risk of becoming ólooked afterô with sections on promoting care (including Health issues), involving children in decisions and the role of all agencies including foster and residential carers.

UN Convention on the Rights of Persons with Disabilities

This Convention, which was ratified by the UK in 2009, accords 42 Articles which was developed to provide additional support and protection for disabled persons (including children and young people) to that of existing human rights frameworks.

In particular

Article 7

Concentrates on the need to specifically provide support and protection to disabled children

Article 23

States that Children with disabilities shall have equal rights, shall not be separated from their parents against their will, except when the authorities determine that this is in the childôs best interests, and in no case shall be separated from their parents on the basis of a disability of either the child or the parents

Article 25

States that disabled people have the right to the highest attainable standard of health without discrimination on the basis of disability. They are to receive the same range, quality and standard of free or affordable health services as provided to other persons, and receive those health services needed because of their disabilities,

Other notable Articles concern themselves with issues of accessibility **(Article 9)** including community support and residential services **(Article 19)** and the need for Governments to provide rehabilitation services in areas of Health **(Article 26)**

National Frameworks

Welsh Government 7 Core Aims

The 7 Core Aims, based on the UNCRC, provides the national framework for the planning and delivery of all services in Wales.

All children (including those 'looked after') should

1. **have a flying start in life and the best possible basis for their future growth and development**
2. **have access to a comprehensive range of education, training and learning opportunities, including acquisition of essential personal and social skills**
3. **enjoy the best possible physical and mental, social and emotional health, including freedom from abuse, victimisation and exploitation**
4. **have access to play, leisure, sporting and cultural activities**
5. **be listened to, treated with respect, and have their race and cultural identify recognised**
6. **have a safe home and a community which supports physical and emotional well-being;**
7. **not be disadvantaged by child poverty**

The Welsh Government expects local authorities, local health boards (LHBs) and their partners, through local Children and Young People's Partnerships, to focus on outcomes for children and young people and to ensure that all their partnership working is effective and efficient. All health services and programmes for looked after children should therefore reflect the 7 Core Aims as national priorities and ensure that children in the care of the state are not disadvantaged compared to other children and young people who are not 'looked after'

National Service Framework for Children, Young people and Maternity Services (NSF)

The National Service Framework (NSF) launched in 2005 sets out the quality of services that children, young people and their families have a right to expect and receive in Wales with the aim of improving quality and equity of service delivery through the setting of national standards. The framework was developed as a partnership between health and social care with links to education, housing, leisure, the voluntary sector and other stakeholders including parents/carers, children and young people

The framework contains 21 standards and 203 key actions, based on the UNCRC and WAG 7 Core Aims alongside a Self-Assessment Audit Tool designed as part of a performance measurement system for use by all statutory organizations that deliver services for children and young people.

Chapter 6 in focuses on Children in Special Circumstances which include key standards for services for 'looked after' children. These include

- A health care plan is generated for each 'looked after' child following an effective health assessment
- Peer support groups are jointly funded and facilitated in each locality
- There is joint planning to ensure that 'looked after' children are placed within their local community, whenever possible and appropriate
- All 'looked after' children to have access to a specialist health practitioner in the area in which they are residing to coordinate the health care plan and address their health needs

Further key standards in respect of disabled children are outlined in Chapter 5 of the NSF

Towards a Stable Life and a Brighter Future: Regulations and Guidance

The Welsh Government's Guidance **'Towards a Stable Life and a Brighter Future'** (July 2007) provided to support the implementation of Regulations, introduced new arrangements and duties for local authorities and local health boards to strengthen and improve the placement, health and education of 'looked after' children. The changes form part of a wider range of measures to modernise services and improve outcomes for looked after children (including those placed away from their home area) and other children in need.

Amongst the key changes to the regulatory framework -

- The prime consideration of a child's health and educational needs and in particular any mental health needs
- Planning to begin prior to placement
- Prompt transfer of health and education records
- Arrangements for health assessments
- Responsibility for undertaking health assessments is extended to a registered nurse
- Frequency of health reviews to be considered
- Registration with GP and dentist
- Designation of specialist health practitioner to co-ordinate the child's health care plan and address the health needs of looked after children and care leavers (the clinical nurse specialist for looked after children)

- Responsibility of secondary health care services remains with originating LHB
- Multi-agency ñOut of areaò placement panels

Sustainable Social Services for Wales: A Framework for Action

This document sets out the Welsh Governmentôs current priorities and future vision in respect of social services and social care. There is a commitment to build on *Towards a Stable Life* in accelerating the policy of requiring looked after children to be placed closed to home and community unless there are good reasons not to do so, alongside an emphasis on placement choice, improved contact arrangements and service coordination. There is also recognition that social services are facing an unsustainable demand for services as the numbers of looked after children continue to grow.

Further information

Those wishing to access further information around the national policy impacting on ólooked afterô children ï including the **Children Act 1989** and **2004** ï should visit the publication section of the WG website

WHAT ARE THE KEY ISSUES FOR LOOKED AFTER CHILDREN?

Though many of the key issues which impact on children and young people within the general population will also be shared by children who are looked after, many of these issues and concerns will impact more profoundly because of the nature of their vulnerability.

The Health Status of Looked After Children: Health Inequalities

There are over 70,000 looked after children in England and Wales at any one point in time. Although there witnessed a 2% decrease in the number of children Looked After in Wales from 2007-8, there has been a rising trend in recent years and on 31st March 2010, 5,162 children in Wales were in the care of the local authority. This is an increase of 10% on the previous year and 44% over the past 10 years. In addition, large numbers of children are placed in Wales by local authorities from elsewhere in the UK.

According to the Office for National Statistics (2004) which examined looked after children between the age of 5 and 17 in Wales, found that

- Almost half (49%) have been assessed as having a **mental health disorder**
- Two thirds of the children were reported by their carers as having at least one physical health complaint.

These included -

- **Eye and/or sight problems** (18%),
- **Asthma** (14%),
- **Speech and language problems** (13%),
- **Bed wetting** (12%),
- **Difficulty with co-ordination** (12%)
- **Eczema** (12%).

Other studies have exposed issues around **Dental Health, Immunisation and Teenage Pregnancy** rates and concerns around **smoking use** and **substance misuse.** In addition, it is recognised that children ólooked afterósuffer from more chronic health conditions than non-ólooked afteróchildren of a similar age.

WHAT ARE THE VIEWS OF LAC ?

Children and young people have a right to freedom of expression and the right to have the opportunity to be heard on all matters affecting them (Article 12, UNCRC). All recent legislation and guidance relating to children and young people in public care reiterates that their wishes and feelings should be taken into consideration, which includes issues relating to their physical, mental health and their well being.

A report from the National Children's Bureau in 2009 reports,

“Young people rarely perceive health as simply a matter of access to health services. From their perspective, the most important things affecting their health are their feelings about life, their housing situation, having close personal relationships, their care experience and depression'.

In regard to mental health the report states,

'Children’s concerns may differ from those of their carers: for example a study in one London local authority found that young people in care tended to identify internal emotional problems, whereas their carers predominantly focused on externally visible problem behaviours'.(1)

The challenge is to ensure that legislation, policies and practice, as well as the agenda of the adults caring for children and young people in public care, reflect the issues of concern to those children and young people looked after.

'Promoting the Health of Looked After Children' (DOH 2002*)* identified the following messages from children and young people:

- Young people value the idea of seeing and keeping their own records.
- Young people's experience of medical examination is negative ï the event is often impersonal, lacking in explanation and without recognisable outcomes for them.
- Policies and procedures should be established to ensure that the needs of the system do not intrude on a child's appropriate need for personal privacy.
- Young people feel angry at the failure of professionals to respect the confidentiality of

their health information.

- Information and advice should cover: sexual health, fitness, stress, depression, contraception, drugs, skin and hair care, how to use a GP practice.

- Better information, advice and support should be available for mental health services.

Voices From Care, the national Wales based charity working with and for looked after children, have undertaken consultations with young people on health and well-being issues. As well as the issues already referenced above, many young people said there could be too many professionals involved in their health issues and that they felt there was also too much õlabellingõ young people needing a label in order to access certain services.

Listening to and engaging children and young people in health issues and services will require agencies to:

- Be flexible and creative in the ways they work and services they provide

- Start from the position of children and young people's views of health and health experiences

- Have mechanisms for listening to the views and wishes of children and young people and engaging in dialogue with children and young people about these.

- Including children and young people in decisions about health choices

- Making child / young people friendly guides to services and procedures

- Be able to be clear about issues of confidentiality and privacy, including issues of record keeping and young people's access to these, and their rights to have their own records.

- Ensure that there are mechanisms to regularly inform service planning and delivery about the views and experiences of children and young people.

- Ensure that there is continuity of health care and that children and young people looked after and leaving care are viewed positively.

Local authorities and health bodies should develop systems and standards, which facilitates the effective engagement of looked after children in the service design and decision making process, and ensure that their views are routinely recorded.

WHO ARE THE KEY PROFESSIONALS WITH RESPONSIBILITY FOR THE HEALTH OF LOOKED AFTER CHILDREN?

Different employment practice and models of service delivery are in place across each of the Local Health Boards (LHB). It is therefore advisable to contact the health board which has responsibility for the looked afterôarrangements in your local authority area.

Local Health Boards in Wales

Since the reorganisation of the NHS in Wales during 2008/9, there are now 7 Local Health Boards and 2 NHS Trusts covering the 22 local authority areas. This new structure came into operation on 1 October 2009

Local Authority area	**Local Health Board**	**Website address**
Anglesey	Betsi Cadwaladr University LHB	http://www.wales.nhs.uk/sitesplus/861/
Blaenau Gwent	Aneurin Bevan LHB	http://www.wales.nhs.uk/sitesplus/866/
Bridgend	Abertawe Bro Morgannwg University LHB	http://www.wales.nhs.uk/sitesplus/863/
Caerphilly	Aneurin Bevan LHB	http://www.wales.nhs.uk/sitesplus/866/
Cardiff	Cardiff & Vale University LHB	http://www.wales.nhs.uk/sitesplus/864/
Carmarthenshire	Hywel Dda LHB	http://www.wales.nhs.uk/sitesplus/862/
Ceredigion	Hywel Dda LHB	http://www.wales.nhs.uk/sitesplus/862/
Conwy	Betsi Cadwaladr University LHB	http://www.wales.nhs.uk/sitesplus/861/
Denbighshire	Betsi Cadwaladr University LHB	http://www.wales.nhs.uk/sitesplus/861/
Flintshire	Betsi Cadwaladr University LHB	http://www.wales.nhs.uk/sitesplus/861/
Gwynedd	Betsi Cadwaladr University LHB	http://www.wales.nhs.uk/sitesplus/861/
Merthyr Tydfil	Cwm Taf Health LHB	http://www.wales.nhs.uk/sitesplus/865/
Monmouthshire	Aneurin Bevan LHB	http://www.wales.nhs.uk/sitesplus/866/
Neath Port Talbot	Abertawe Bro Morgannwg University LHB	http://www.wales.nhs.uk/sitesplus/863/
Newport	Aneurin Bevan LHB	http://www.wales.nhs.uk/sitesplus/866/
Pembrokeshire	Hywel Dda LHB	http://www.wales.nhs.uk/sitesplus/862/
Powys	Powys LHB	http://www.wales.nhs.uk/sitesplus/867/
Rhondda Cynon Taf	Cwm Taf Health LHB	http://www.wales.nhs.uk/sitesplus/865/

Swansea	Abertawe Bro Morgannwg University LHB	http://www.wales.nhs.uk/sitesplus/863/
Torfaen	Aneurin Bevan LHB	http://www.wales.nhs.uk/sitesplus/866/
Vale of Glamorgan	Cardiff & Vale University LHB	http://www.wales.nhs.uk/sitesplus/864/
Wrexham	Betsi Cadwaladr University LHB	http://www.wales.nhs.uk/sitesplus/861/

Key Professional roles and responsibilities

Each looked after child on coming into the care of a local authority will be allocated and be the responsibility of a **named social worker.** Whilst the role of the social worker is key in ensuring that the child is supported, their needs are met and well-being enhanced, a social worker will operate as part of a professional team, each with their own specialist role and responsibilities towards the looked after child.

In order to ensure the health needs of children looked after are addressed, it is essential that the service providers are aware of the placement, any change in circumstances and the return home of these children (as applicable). Where circumstances change, it is important that the social worker coordinates any changes that may be necessary in the way that ensures that the health needs of looked after children are met.

The specialist professionals operating alongside the named social worker can include the following

Named Doctor/Medical Adviser for Looked After Children & Fostering

Each Local Health Board (LHB) should have a Named Doctor/Medical Advisor for ólooked afterô children & fostering. The Named Doctor/Medical Adviser in conjunction with the Named Nurse (see below) provides the strategic lead for children looked after within the Board. In some areas this will be the same person as the Named Doctor/Medical Adviser for Adoption (see below) but in others will be a separate professional.

The Named Doctor/Medical Advisor should be a Senior Community Paediatrician with substantial experience of the health needs of children ólooked afterô They should have a sound knowledge of the effects of child abuse and neglect, emotional, behavioural and attachment difficulties, neuro-developmental paediatrics, child protection and adult health issues pertinent to parenting. They should also be active in the clinical management of these children and responsible for managing the service provided by the Board for children looked after.

There should be sufficient protected and dedicated time for the Named Doctor/Medical Adviser to fulfil their responsibilities for all children living in their area.

The role of the Named Doctor/Medical Adviser will include -

- Support and advise the Lead Director and Health Board on issues relating to children looked after

- Ensure policies and procedures are in place to support the work relating to children looked after that comply with legislation and regulations.

- Ensure those working with children looked after have appropriate training and supervision.

- In conjunction with clinical governance systems monitor the standard of service provided for children looked after.

- Have the overall responsibility for ensuring the health needs of children looked after are addressed and met both within and out of county.

- Provide clinical leadership to the Specialist Looked After Children Team.

- Advise the fostering panel on the suitability of potential foster carers.

- Advise the Local Authority on health matters relating to Looked After children

Named Doctor/ Medical Adviser for Adoption

Each LHB should have a Named Doctor/ Medical Adviser for Adoption. In many areas this will be the same person as the Named Doctor/Medical Adviser for Looked After Children & Fostering but in others will be a separate professional. The Named Doctor should be a Senior Community Paediatrician with substantial experience of the health needs of children looked after. They should have a sound knowledge of the effects of child abuse and neglect, emotional, behavioural and attachment difficulties, neuro-developmental paediatrics, child protection and adult health issues pertinent to parenting. They should be active in the clinical management of these children and responsible for managing the service provided by the Board for children looked after.

There should be sufficient protected and dedicated time for the Named Doctor/Medical Adviser to fulfil their responsibilities for the Local Authority Adoption Agency and all children going through the Adoption process in their area.

The role of the Named Doctor/Medical Adviser for Adoption to include ï

- Ensure arrangements are in place for Adoption Health Assessments

- Ensure Adoption Health reports are prepared and presented at Adoption panel

- Monitor the health needs of children going through Adoption and co-ordinate follow up of these children when considered for and subsequently placed for adoption and until the Adoption is finalised

- Advise the adoption agency on the suitability of prospective adopters.

- Advise potential adoptive parents on the health and developmental needs of the child they seek to adopt.

- Advise the Adoption Agency on health matters relating to Adoption

Role of Named Nurse

Each LHB should have a Named Nurse for children looked after. The Named Nurse in conjunction with the Named Doctor/Medical Adviser for Looked after Children/Fostering provides the strategic leadership for children looked after within the Board There should be sufficient protected and dedicated time to fulfil their responsibilities.

The Named Nurse will be an RN and Specialist Community Public Health Practitioner or equivalent and have a minimum of a first level degree in a related subject. They will have knowledge and experience in the field of child health, children in need, children looked after and child protection.

In fulfilling these responsibilities the Named Nurse (together with the Named Doctor) will

- Support and advise the Lead Director and Trust board on issues relating to children looked after

- Ensure policies and procedures are in place to support the work relating to children looked after that comply with legislation and regulations.

- Oversee/manage the nursing services provided for children looked after

- Ensure those working with children looked after have appropriate training and supervision.

- In conjunction with clinical governance systems monitor the standard of service provided for children looked after.

- Receive support from the Clinical Nurse Specialist who has professional knowledge of working with looked after children.

The Specialist Children Looked After Health Team

In many LHB areas, the Named Doctor/Medical Adviser for children looked after will lead a Specialist Looked after Children Team comprising sufficient Clinical Nurse Specialists for looked after children and Community Paediatricians to ensure adequate medical and nurse provision for all Looked After children in their area. They should be available to the members of the Team for advice and support. There should be sufficient protected and dedicated time for the members of the team to fulfil their responsibilities.

Where a child looked after has complex health needs, and is in the care of a medical team as a result, s/he still has an entitlement to the services of the Specialist Looked After Children Health Team. Local arrangements must be made in these cases to ensure that there is good coordination between medical and nursing teams. These arrangements, including lines of responsibilities, should be clearly documented in the Health Plan.

A full list of Specialist Looked after Children Nurses can be found in ANNEX 1

Clinical Nurse Specialist for Looked After Children

Evidence to date indicates that the role of the Clinical Nurse Specialist for children looked after is a key part of delivering minimum acceptable standards of care for children looked after. This accords with the requirement in the National Service Framework (NSF) 6.12 ó All

looked after children have access to a specialist health practitioner in the area in which they are residing to coordinate the health care plan and address their health needs.ô Their role and activities are also in line with the WAG Guidance óTowards a Stable Life and Brighter Futureô

Some Clinical Nurse Specialists work in multi agency teams while others are located within a health setting. Whatever the details of local arrangements, the following principles should always be observed:

Clinical Nurse Specialist for children looked after will work in cooperation with the Named Doctor/Medical Advisor for children looked after (where they exist). There should be a strong relationship between the medical and nursing specialists such that they constitute a coordinated and recognised Specialist Children Looked After Health Team

Clinical Nurse Specialist should always have direct access to specialist medical support via the Medical Advisor role and/or a medical practitioner with specialist expertise (e.g. Community Paediatrician).

Community Paediatrician / Doctor completing health assessments

Where it is in best interests of the child to have their health assessments carried out by a Registered Medical Practitioner, these assessments should be carried out by Community Paediatricians or doctors with relevant experience of the health needs of children looked after. They should have a sound knowledge of the effects of child abuse and neglect, emotional, behavioural and attachment difficulties, neuro-developmental paediatrics and child protection. They should form part of a multidisciplinary team.

Designated professionals

Each LHB should have access to a designated professional for safeguarding children (Child Protection and Looked After Children) who work within the Safeguarding Service, Public Health Wales. The Safeguarding Service, Public Health Wales, is an independent service delivered by designated professionals, providing assistance to NHS Wales in keeping children safe. The Designated Function is a statutory function delivered by both Senior Consultant Doctors and Nurses with expertise in this specialist field.

The Specialist CAMHS professional

Several areas have now established professionals within specialist CAMHS (Child & Adolescent Mental Health Service) teams who have a specific responsibility for children looked after. Such Specialists can play a key role in contributing an emotional health component to the holistic health assessment which can facilitate more timely identification of need. These posts have enabled the holder to develop specific therapeutic skills and knowledge in relation to this population of children and their carers.

The Regulations on the Placement of Children Looked After and Miscellaneous Amendments (Wales) places a statutory requirement on local authorities and health partners to have a particular regard to any mental health needs and services to meet those needs. In addition, panels set up to consider plans to place children outside the local authority where a child normally lives must have available to it appropriate specialist advice. The appointment of a Specialist CAMHS worker is likely greatly to assist authorities to meet these requirements. This also accords with the recommendation in the All Wales CAMHS Strategy, óEverybodyôs Businessô, which states that "We are keen to see new evidence based services developed to assist traumatized and neglected young people..." (WAG, 2002.)

In the absence of a specialist CAMHS worker for looked after children, CAMHS Teams should designate a lead professional for looked after children to help responsible authorities carry out their duties in addressing the emotional and mental health needs of looked after children.

Regardless of their employment arrangements, Specialist CAMHS professionals should work closely with other members of the Specialist Health Team, with clear lines for communication and cross referral, in order to provide a seamless service for children looked after.

Role of the GP and GP practice staff

Primary care teams have an important role to play in the identification of the health care needs of children and young people who are looked after. They may have prior knowledge of the child and young person looked after, of the birth parents and of carers, helping them to take a holistic and child-centred approach to health care decisions. They may also have continuing responsibility for the child or young person when they return home.

Primary Care Teams are typically made up of the following key professional staff (and others)

- Health Visitors
- District Nurses
- School Nurses
- Dieticians
- Counsellors
- Psychotherapists

Primary Care Teams are expected to work alongside responsible commissioners to ensure that:

- looked after children are registered with the carerôs GP within 10 working days of the date of placement
- they are placed under the care of a registered dental practitioner as soon as practicable and no later than 25 days after placement, and is able to receive the full range of NHS dental services
- the registration status of children looked after becomes permanent no later than 4 weeks following the date of placement.
- there is timely, sensitive access to a GP or other appropriate health professional when a child or young person who is looked after requires a consultation
- referrals made to specialist services are timely, taking into account the needs and high mobility of many children and young people who are looked after
- GP services are able to provide, when needed, summaries of the health history of a child or young person who is looked after, including their family history where relevant and appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments, subject to appropriate consents
- GP services maintain a record of the health assessment and contribute to any necessary action within the health plan
- Copies of any existing health reports and any subsequent reports are forwarded to the existing GP and any GP with whom the child will be registered following placement, so that the GP record remains the lead health record for the child
- GP records make the ñlooked afterò status of the child or young person clear, so that their particular needs can be acknowledged

- GP records of a child who is looked after are requested and transferred using the ôFast Trackingôsystem.
- GP services regularly review the clinical records of children looked after and young people who are registered with them. In particular they should gather relevant information and make it available for each statutory review of the health plan
- Where possible, the child looked after is offered a choice of GP within a practice; in particular to choose a doctor of their own gender if they wish.

The GP-held clinical record is unique and can integrate all known information about health and health events during the life of any child or young person. This enables GPs, dentists, nurses, health visitors and others in primary care to have an overview of health priorities, and to know whether health care decisions have been planned and implemented.

Role of Foster Carers

At no point is a foster carer legally responsible for the health of a child or young person they are fostering. This responsibility lies with whoever holds parental responsibility, whether that be the parent(s) and/or the local authority. The only situation in which this might change is if they have taken on parental responsibility for the child, for example as part of a special guardianship order.

However, as a parent would, the foster carer will need to co-ordinate the following health-related activities:

- Access to health services including GPs, dentists and hospitals.
- Access to developmental, growth and dental health assessments, plus immunisations.
- Access to sport and leisure activities, including providing transport and providing equipment.
- Supporting good health by encouraging healthy eating and physical activity as part of a healthy lifestyle.
- Offering sexual health advice and education when appropriate.
- Providing or co-ordinating access to mental health support, if necessary, and promoting emotional health and wellbeing.
- Offering advice on substance use and misuse, or co-ordinating access to support as necessary
- Acting as a positive role model and enabling young people to take responsibility for their own health and well-being.

Foster carers will need to work with a team of other professionals to achieve this, including social workers, specialist nurses, paediatricians, youth services and teachers, along with many others. Co-ordinating this activity between a local authority and the NHS (another large and frequently fragmented service) for any individual child is a complex task.

Some fostered children will need to access a number of different support services. Health histories may be lost, or information may be scant. Professionals may be confused about consent and confidentiality. Some children or young people may be wary of medical care, and refuse treatment. Foster carers will need to meet these challenges in order to assess, address and promote the health and wellbeing of children and young people in their care, whilst negotiating the complexities of the services and remaining an advocate and champion for the children and young people they foster.

The Fostering Network (UK) have produced a booklet entitled ***'Health'*** to help enable foster carers to develop an understanding of their role and to provide better support for children and young people in their care *(see reference section).*

Residential Worker

Registered children's homes are required to appoint a Link Worker for each child / young person under their care. This Link Worker is responsible for the promotion of the child's health and for ensuring that their health needs are met. This will include:

- Assisting to ensure that health assessments are undertaken.
- Ensuring that each child has a clear written health care plan (within their placement plan).
- Working to obtain earlier health records for each child.
- Ensuring that basic health registration and checks such as dentist, opticians, GP are undertaken.
- Ensuring that specific health needs are met and the child is able to attend any appointments with relevant health professionals..
- Engaging the child in health promotion such as healthy activities and in leaning about healthy living.
- Providing advice, guidance and support to each child on health and personal care issues appropriate to their age, needs and wishes, including in relation to issues of sexual health.
- Providing advice, guidance and support to each child in relation to emotional health and well being, and ensuring access to relevant health services.
- Ensuring the residential staff team are working together in regard to the health needs of each child in their care.
- Ensuring that a health record is kept at the home in regard to each child and that this is kept up to date in regard to all information about a child's health and health appointments.
- Ensuring the involvement of the child's parents or significant others in health issues.

Each registered children's home should have a policy and written guidance on promoting the health of children within the home ï these should help the Link Worker in their role. Link Workers will be required to liaise with key health professionals in their role. When the child leaves the home the Link Worker will have a role in ensuring that any health records are passed on promptly to whomever has subsequent care of the child.

Information Sharing

Local authorities and the NHS should have in place protocols, which establish the framework for information sharing at an intra and inter-agency level. The issues to consider would include:

- Who has access to what information, and how data security is ensured
- Arrangements for seeking consent to information sharing
- How children, parents and other third parties are informed of, and allowed to challenge, information that is kept on them
- How carers contribute to and receive information
- Mechanisms for sharing information between Social Services and LHBs

Protocols on information sharing should also cover arrangements for informing and gaining information from other local authorities, health partners and other relevant agencies.

LOOKED AFTER CHILDREN WITH PARTICULAR NEEDS

Within the population of looked after children as a whole will be groups of children who are more marginalised in society and therefore more at risk of achieving poorer outcomes than their peers. Some of these groups include:

- Asylum seeking children who are separated, unaccompanied or with families
- Young people in the criminal justice system,
- Children whose educational needs are not being met
- Travellersôchildren and those from minority ethnic groups
- Young people who are gay or lesbian
- Children and young people who are geographically isolated
- Children leaving care
- Children in poverty
- Young parents and their children
- Disabled children

Whilst it is not our intention to look at each of the above in turn, a number of the key issues for some of the groups will be outlined below

Disabled children and young people

A looked after child with a disability should have any associated special educational needs identified in line with the National Assembly for Wales ñSpecial Educational Needs (SEN) Code of Practice for Walesò (2002). Those with substantial SEN (additional educational needs) requiring provision beyond that which a mainstream school can provide from its own resources will be subject to multi-disciplinary statutory assessment and any additional provision will be set out in a statement of SEN. In some cases, Local Education Authorities and Social Services may decide that a childôs needs will be best met through a jointly funded residential school placement. Tripartite funding arrangements, which include health, may be required for children with very complex needs arising from disability.

For children using short-term breaks the parents will retain the prime responsibility for ensuring the health of their child. These children do not need a full health assessment, but the key issues will be to ensure that carers have appropriate understanding of their childôs disabilities and any medical, behavioural and social consequences. It is also essential that carers know what to do in an emergency and who to contact.

Disabled children in longer-term care should have a very detailed health history and health plan. Many disabled children are well known to consultant paediatricians and other specialists including dentists. Their advice is essential to the health care planning of many disabled children and in most circumstances they will be the most appropriate person to undertake the health assessment and contribute to the health plan. Agencies should employ creative and imaginative approaches, including the use of technologies or non-verbal communication to tackle communication barriers and ensure that the childôs wishes and feelings are represented and respected (NSF Key Action 5.1).

A health assessment of a disabled child should recognise the importance of identifying any disabling barriers in the childôs environment that exacerbate the effects of the childôs impairments. Steps should be taken to ensure that the childôs environment promotes the

development of the childôs potential. Disabled children have the same developmental needs for appropriate social, leisure and recreational activities as other children.

Where disabled children are living away from home in the short or long-term, attention must be given to ensuring the safe installation and use of any equipment and adaptations that may be necessary.

There should be an inter-organisational system to identify children who will require transition into adult services in the year before their fourteenth birthday (NSF Key Action 5.32). The joint organisation transition plan for each disabled young person should be reviewed every six months for young people who are looked after in accordance with Statutory Regulations Children (Leaving Care) Act 2000. During the year before their eighteenth birthday the plan should be reviewed each term (NSF Key Action 5.36).

Eligibility criteria between child and adult services may vary significantly. In some cases, this may mean that a child receiving services up to the age of 18 risks losing that service after their 18th birthday. Leaving Care Teams and others involved in maintaining appropriate support around the time of transition to adult health and social services will require additional flexibility around how to manage this transitional period appropriately

Disabled children are entitled to the same level of service from the specialist children looked after Health Team as other looked after children, regardless of the area or setting in which they are placed. LHBs and Trusts should ensure that arrangements to facilitate a continuing relationship between children in these situations and the Specialist Health Team are in place, clearly identify responsibilities for delivery of specialist care and of órouteôhealth measures (such as statutory health assessments), and are agreed by both originating and hosting health services. The Specialist Health Team should thus be seen as supplementing, rather than supplanting ï or being supplanted by ï any specialist health team that may be leading services to meet the childôs additional specialist medical needs.

Black and Minority Ethnic Children

Black and minority ethnic children who are looked after are likely to have experienced adversity as a result of racism. This is likely to have had an impact on their health and health-related behaviours. In addition, some black and minority ethnic populations are vulnerable to certain hereditary illnesses such as sickle cell anaemia, thalassemia and pre-disposed to certain forms of diabetes. Taking an accurate family health history as part of the health assessment process for a child or young person who is looked after is therefore extremely important.

There is also evidence of high levels of depression among certain groups in the Asian community; African-Caribbean people have been significantly more likely to be diagnosed as schizophrenic than white adults and are more likely to be users of acute mental health services than prevetative services. Less is known about access to CAMHS by children and young people from black and minority ethnic groups, but clearly there may be implications for the assessment of their emotional and behavioural development.

Culture will also be an important factor informing the provision of services since there may be requirements concerning, for example, the gender of the doctor. Prior discussion about any health appointments in order to enable choice is therefore very important.

Children and young people from whom English is not their first language may have difficulty in communicating their needs and experiences. Arrangements should be made to enable them to use the language they feel most confident in. Any translation arrangements will

need to be sensitive to cultural difficulties in use of language and ensure that issues of confidentiality and consent are managed appropriately.

Migrant Children including Asylum Seeking Children and Refugees

Many asylum seeking and refugee children who are looked after will have arrived in this country unaccompanied. Some may have parents or other relatives in this country who are unable to care for them because of illness or other reasons. A few may have been orphaned since arrival. Refugee children coming from countries with a high prevalence of HIV infection and where rates of vertical transmission are also high, may be orphaned when parents die of an HIV-related illness, and are also at significant risk of being infected themselves (Hall and Elliman, 2002).

Many migrant children come from cultural and religious backgrounds with which those in the statutory sector responsible for providing care may be unfamiliar. The children, who may speak little or no English, will often have witnessed and suffered events outside the experience of social workers, doctors and teachers in this country. While many asylum seeking children may be psychologically distressed, and some may understandably exhibit signs of Post Traumatic Stress Disorder, it is important that their resilience and resourcefulness is also acknowledged and respected.

Unaccompanied children are unlikely to have medical records from their country of origin and any medical history they themselves are able to give is likely to be incomplete. Their immunisation status may be unknown and a course of primary immunisation may need to be undertaken. Children may have had no previous child health surveillance and may well not have undergone neonatal screening for congenital abnormalities or inborn errors of metabolism. Children may suffer from malnutrition, and depending on country of origin, conditions to consider include tuberculosis, hepatitis B and C, malaria, schistosomiasis and HIV/AIDS. It should also be remembered that response to stress might manifest itself with physical signs.

Those undertaking health assessments on refugee children require access to good local interpreting services or link workers familiar with the child's culture and able to advocate on their behalf.

The NPHS for Wales have issues specific guidance on healthcare issues for asylum seekers in Wales which included further details on many of the points above, and with reference to current legislation, policy and the emergence of good practice in Wales *(see reference section)*

Care Leavers and Transition to Independence

Preparing to leave care is critically important for all young people. The Children (Leaving Care) Act 2000 requires all eligible, relevant and former relevant children to have a Pathway Plan which will focus on arrangements for the young person's successful transition to independence. The Pathway Plan will take account of the assessed health needs of the young person and set out clearly how these are to be met. Particular attention must be given to helping build supportive social networks to ease the transition for care. This includes peer support and access to social, recreational and sports activities.

High levels of early parenthood, mental ill-health and stress, loneliness and risk-taking behaviours amongst the population of young people leaving care are indicators of the failure of local authorities and health authorities to address the health needs of looked after children. Whilst these factors cannot solely be attributed to experiences and failures within the care

system, young people themselves think that their education on health matters has been inadequate. Helping young people develop and practice self-care skills and promoting their self esteem and self efficiency and easing their access to support services will be important.

Multi-agency approaches are particularly crucial for care leavers as at this stage health needs can not be separated from wider needs. There is an important health promotion and advisory role for health services in supporting care leavers which demands co-operation with local authorities and other agencies to plan and provide integrated services, with the necessary range of resources being made available.

Pathway planning the health needs of care leavers should:

- involve a holistic health assessment and the maintenance of detailed health records which will provide the platform for Pathway Plans to promote health
- ensure appropriate use of primary health care services
- plan access to specialist health and therapeutic services where necessary
- note where a young person is entitled to free prescriptions, free dental treatment, free NHS sight tests and vouchers for glasses
- provide and help to complete HC1 form to access the NHS Low Income Scheme where appropriate
- pay attention to the need for access to information on sexual health and sexuality, any specialist needs of learning and physically disabled young people, as well as the needs of young people from minority ethnic communities

The responsible authority should arrange a Pathway Plan review if the young person or the Personal Advisor asks for one; or at least every six months to ensure that the plan still meets the needs of the young person or to agree any needed amendments to the plan. This will ensure that the Pathway Plan continues to address, amongst other needs, the health needs of the young person. The Pathway Planning process should continue until the young person reaches the age of 21 (or 24 if in full time education).

Children cared for in secure settings

The route by which children and young people enter secure settings will determine with whom responsibility for their welfare and care rests. In secure settings, children and young people in the same establishment will be cared for by the same staff but under different legal frameworks, e.g., welfare and criminal justice. This presents particular challenges for local authorities in respect of the children for whom they act as corporate parent and for secure establishments and staff within them which receive children and young people through different routes.

These children and young people are another very vulnerable group whose placement in a secure establishment poses particular problems in meeting their health needs. Local authorities should pay particular attention to ensuring that the arrangements for providing health assessments and access to a comprehensive range of health services for children for whom they are responsible are in place and are closely monitored. For individual children, as for other children placed outside the area, monitoring and reporting arrangements will be required. For establishments run by the local authority which care for children and young people placed through welfare and criminal justice routes, the local authority will need to pay particular attention to achieving coherence and consistency in securing the delivery of effective and high quality health services for all of them. Reference should be made to key standards and actions outlined within the NSF, which include that *"all children and young people in special circumstances have equitable access to appropriate high quality health and social care irrespective of where they live…"*

It is all too easy for the health needs of children and young people cared for in local authority secure care, secure training centres, and young offender institutions and prisons to become secondary to the need to keep them secure or to address offending behaviour. Health expectations can be lower for such children and young people, yet their health needs are often greater.

A joint strategy agreed with all relevant local agencies such as Social Services, Local Health Boards and the Youth Offending Team (YOT) should be developed to address issues of access to health services for children and young people in secure settings, particularly for specialist services where several visits may be necessary, or for paediatricians needing to make a thorough assessment. Providing continuing care may be difficult when children are placed far from home and records and medical history do not transfer quickly. The health service should co-operate in transferring these as speedily as possible.

Legislative changes mean that children are now being placed in secure settings at a younger age. It is particularly important therefore that attention remains focused on their development needs, including their primary care needs. Children and young people who are looked after in a secure setting will have had a core assessment and will have a health plan available. Actions identified within the health plan must be undertaken.

The very small numbers of looked after children who may be in a secure hospital placement should have a health assessment and health plan as part of their overall care plan.

Further information around the health of children and young people in secure settings can be found in Mooney, A et al (see reference section)

Mental Health: Child and Adolescent Mental Health Services for Children Looked After

When commissioning and providing services for mental health and emotional health, it is important that both local authorities and health agencies bear in mind the following principles:

- A range of treatment options from CAMHS services ï including Level 1 services ï should include a focus on early intervention, especially with children aged 0-12.
- There should be recognition of the need to include carers/parents directly in the therapeutic process.
- Specialist CAMHS have found that addressing attachment related difficulties and symptoms associated with developmental trauma is essential for many children looked after and in post adoption placements
- Interventions should not be provided only where placements are in danger of breakdown. The complexity of need in its wider context should be taken into account.
- Children with disabilities are equally entitled to CAMHS services as others.
- Participating in attachment / trauma focused services should not bar children from access to other Tier 3/4 CAMHS service where necessary.
- Services should be equally accessible to children in post-adoption placements.
- Children and young people should not receive in-patient treatment in adult settings

Children looked after and their carers need access to the full range of child and adolescent mental health services (CAMHS) across the tiers, from promotion, advice and services in primary care/community settings to highly specialist, sometimes residential or inpatient provision. These services will assist in the prevention of mental health problems in children and young people, as well as helping to reduce the impact of established mental health

disorders on their lives. Effective care will reduce the likelihood of children and young people looked after experiencing some of the secondary consequences associated with poor mental health, such as non-school attendance, educational failure, juvenile crime and placement disruption.

All professionals and carers who work with children looked after have a responsibility to promote their mental health and emotional well-being. They may do this by building secure relationships with children and ensuring that their basic needs are met. However, at times they may need to seek additional advice or training from child mental health professionals, in order that they can meet the needs of children they are working with or caring for. All professional who work with children and young people looked after should receive regular ongoing training about promoting their emotional well-being.

All professionals should have a range of knowledge and skills including

- Training in the early identification of mental health difficulties
- An awareness of relevant CAHMS services which are available in their area and be clear about the referral routes
- Care planning where children and young people present mental health difficulties
- Effective strategies for dealing with challenging behavior and promoting resilience
- An awareness of mental health needs in some underrepresented groups, including black and minority ethnic children, asylum seeker and refugee children and disabled children

Whilst a CAMHS professional specifically responsible for looked after children is the service some will need, what most looked after children with mental health problems will require is access to therapeutic services such as child and adolescent psychotherapy, art or play therapy of which there is currently a shortage of these skills in Wales. These routes should not be discounted

A Network of Primary Mental Health workers is being established across Wales who offer a tier 2 service and work within a range of agencies, for example health centres and schools, offering support and training to tier 1 staff and direct input with children and carers where appropriate. They also refer children on to more specialist CAMHS provision where necessary. A school counselling service has established across all Welsh secondary schools, pilots for primary provision are currently underway. Looked after children and young people may benefit from this type of community provision but CAMHS may also offer input specifically for looked after children and their carers in residential units, foster homes and leaving care teams, for example. It is important that as well as developing CAHMS services, agencies develop schemes which allow a child or young person to have someone to talk to which will include the availability where appropriate of peer counselling schemes.

Specialist Child and Adolescent Mental Health Services (CAMHS) for children and young people looked after should be planned through a partnership of health, social services, education and voluntary sector providers and in partnership with young people and their carers. Where children are placed outside their LHB area of origin, the LHB of origin remains responsible for resourcing services required to meet their secondary care needs. This will include specialist CAMHS. This approach to meeting the emotional and mental health needs of children looked after is an area where joint commissioning and joint working arrangements will be particularly appropriate especially regional commissioning.

CAMHS at tiers 2 and 3 (specialist community mental health teams)

Some children and young people will require referral to more specialist services from a multi-disciplinary CAMHS team, including clinical psychologists and psychiatrists. All Local Authorities and Local Health Boards should ensure that children and young people looked after have access to appropriate services without a long wait. Some authorities have established designated services for looked after children to ensure the above, whilst others have funded specific posts within existing teams. In all cases strong links between looked after children's services and mainstream CAMHS are essential.

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

CAMHS may also provide services for some children and young people in adoptive and long-term foster placements who require input from mental health services. This may be provided by mainstream CAMHS, however in some areas specialist teams or posts have been developed to work with children and long-term carers where there are attachment and trauma related difficulties.

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

Tier 4 CAMHS (in-patient provision)

For some young people with high levels of mental health need, there will be a need for highly specialist provision, which may be provided on a regional basis. This will include psychiatric in-patient units for children and adolescents and in some areas specialist outreach teams, which are able to support young people with mental illness in the community. Both social care and education may have input into these health led units through the provision of staff and input into planning for young people on discharge.

Children and young people in secure provision are particularly vulnerable and often have the most complex difficulties. Each unit requires reliable access to specialist CAMHS and to training and consultation for their staff on mental health. This is best provided on a regular and consistent basis rather than purely on request or through spot purchasing.

Some areas specialist therapeutic fostering schemes are being established to try and maintain young people with high levels of need within family based provision. These joint approaches recognize that many young people with high levels of mental health need may also have complex social and educational difficulties.

Young people aged 16+ will be particularly vulnerable at the point of leaving care and managing their lives with fewer supports than other young people and thought should be given to appropriate services for this age group. Leaving care services will need support from CAMHS and adult mental health professionals, both in terms of prevention and access to referral on for some young people. The designated CAMHS professional could also play a valuable supporting role in helping to support the young person in making the transition from CAMHS to AMHS.

HOLISTIC HEALTH ASSESSMENT AND THE HEALTH CARE PLAN

The Statutory Framework for Health Assessments

Under the Welsh Governmentôs ñ*Placement of Children and Miscellaneous Amendments (Wales) Regulations 2007"*, a responsible authority must, before making a placement, make arrangements for a registered medical practitioner or a registered nurse to conduct a health assessment of the child. Such arrangements must be made prior to placement and in any event no later than 14 working days of the placement date (unless an assessment has taken place within the last 3 months).

For children placed in a different authority area, it is particularly important that clear plans and protocols identifying who carries out the assessment are in place. The person undertaking the assessment must have particular regard for the childôs mental health needs and any services required to meet those needs. If the child remains in care, different procedures apply determined by the childôs age. Those under 5 years of age should have a health assessment every 6 months and those over 5 years of age but under 18 years, a health assessment should be undertaken every 12 months. As the initial assessment, review assessments may be conducted either by a registered medical practitioner or a registered nurse

However, assessments should be made more frequently if the childôs welfare requires it. This will ensure greater surveillance and support on a more regular basis. For example, Disabled Children are likely to require more frequent assessment of their physical health The Community Paediatrician may undertake these assessments. However, unnecessary duplication of medical examinations should be avoided.

Chapter 6 of the *"National Service Framework for Children, Young people and Maternity Services"* (NSF) which concerns ó Children in Special Circumstancesô states that:

"A health care plan is generated for each looked after child following an effective holistic assessment which compliments and builds on information obtained through the Framework for Assessment of Children in Need and their Families." (Key Actions 6.1 pp 105)

Holistic health assessments should include

- physical health needs
- mental, emotional and environmental well being,
- potential health risks to themselves and others,
- appropriate health promotion suitable for the individual child
- collect data for audit purposes.

Every local authority area must have written protocols identifying the respective roles of medical advisors, registered medical practitioners and the Clinical Nurse Specialist which identify clear lines of clinical responsibility within the area. These protocols must be in accordance with the Placement of Children and Miscellaneous Amendments (Wales) Regulations 2007, and signed up to by at least the LHB and local authority.

Arising from the health assessment, each child should have an individual holistic **health care plan**. A copy should be always be held by the Social Worker and reviewed under statutory procedures. A copy of the written report arising from the health assessment should also be forwarded to the child's GP, to be retained on the GP record.

The Health Care Plan should contain details of:

- Any identified health needs such as any medical diagnosis or known allergies affecting the child, and the implications for future growth, development or treatment;
- Any developmental problems or special needs which are likely to affect the child in the future and require ongoing intervention or specific provision e.g. a special educational placement
- Any mental health needs, which include consideration around attachment, behaviour and emotional wellbeing
- Any health interventions needed, alongside identifying who is responsible and an appropriate timescale for completion. For example, immunisations, dental checks, specialist referral, therapy assessment etc).

Core Principles for Health Assessments

Information & Consent

A member of the Specialist Health LAC Team should give the child or young person appropriate information concerning the need for a health assessment before the assessment takes place. This should be in the child's language of choice and where this is not available, interpretation should be provided. Local services should produce written information with the involvement of young people for this purpose. The social worker should also take an active role in enabling children to participate in this process.

The child should be given a choice of venue e.g. in clinic, school or other suitable premises which should be provided wherever possible. Consideration should be given to the child's privacy, confidentiality and safety. The child or young person must consent to the assessment. Should a child or young person prefer not to have a medical assessment by a suitably qualified doctor or by a suitably qualified nurse, every effort should be made to provide an alternative that is acceptable to them. Services need to be imaginative and flexible in their approach.

The child/young person must be given the opportunity to identify their own health needs and consider personal health achievements.

Coordination

Health assessment is not an isolated event, but part of a continuous process. Where other assessments have, or are being completed, these should be linked, (e.g. Assessment Framework, Statement of Special Educational Needs etc). Looked after Children should also be included in the routine child health surveillance programmes that operate in the area. Coordination with such programmes will help eliminate unnecessary duplication.

Focus on Needs

Health care plans, derived from the health assessment process, must be óneeds ledôand not óresource ledô However, realistic timescales and achievable outcomes should be established. If resources or services are not available then this should be clearly recorded with the name of the senior manager within the Health Service and the Childrenôs Services/Social Services should be informed.

Systems should be in place that identify Looked after Children as a priority and consider ways in which referrals for service provision may be fast tracked. Organisations should work to developing a seamless service for all Looked after Children living in their geographical area to ensure the health needs of children and young people crossing boundaries are met.

Disability

Disabled children and/or children with a learning difficulty should have a schedule of medical health reviews to meet the individual childôs health needs. This does not replace the need for the child to be offered a holistic health assessment that includes all the components listed above. This would include the opportunity to access health education and promotion provided by the Clinical Nurse Specialist. This should be in conjunction with any specialist service the child is also receiving e.g. specialist paediatric nursing.

Equality

A childôs ethnicity, culture, disability and gender are important elements of their identity. Health assessment must take account of this and consider how far services might need to be chosen which reflect and respect these factors (for example, through gender specific services).

Roles and Involvement

The social worker and the childôs carer should be involved in supporting the child to consider the relevant issues, encouraging them to identify needs and achievements and making arrangements to facilitate the practical implementation of the assessment process (for example, through organising transport to appointments).

Although this may not always be appropriate, the involvement of birth parents in the health assessment process should always be considered. They may often contribute valuable information and their continued engagement in the process can be reassuring for the child.

Advocacy

Children should always be made aware of the opportunity to access independent advocacy services, if they have questions about the health assessments or want to talk to somebody outside of the statutory services.

Confidentiality

While conducting a health assessment the child or young person may request that certain information is kept confidential. Such a request should be dealt with sensitively, respecting their right to confidentiality wherever this would not place the child at risk of harm or seriously compromise their welfare. Where information needs to be shared this should be explained to the child or young person giving clear reasons why it is in their best interest to do so

Process for undertaking the Health Assessments

Before a Looked after Child receives a health assessment, it is essential to bring together as much relevant information as possible. All available information on the childôs health, development and social history should be made available to the health professional undertaking the assessment prior to the appointment

This will, in the main, include information held:

- By social services derived from an assessment undertaken in accordance with the Assessment Framework and which includes the childôs personal history and family history if it is known
- By community dental services and family dentists
- By community health services
- On the child health computer system, especially immunisation status to date and developmental history
- On any parent held or child held record or health ôfaxô
  - On the GP held record
  - Health Visitor Records
  - School Health Nurse
- Within any database in local Accident and Emergency Departments
- Within local hospital record systems, especially where the child is known to have been in contact with services

In the case of GP held records, a summary report should be requested from the GP holding them.

A suitable tool will assist the assessment and provide a written record. A variety of tools are in use by doctors and nurses. Appendix X includes an exemplar for a nurse led assessment. The British Association for Adoption and Fostering (BAAF) have developed a range of tools including an ôInitial Health Assessment for looked after infant, young children and older children with development delayôForm IHA ï C, and the ôInitial Health Assessment on looked after older childôForm IHA ï YP, for use by health professionals completing an assessment. Details of the full range of publications are available from BAAF www.BAAF.org.uk

Mental and Emotional Component of the Health Assessment

There is much evidence (Minty ô99, Delfabro and Cooper 2001, Scholte ô99) that emotional health problems are an important aspect in placement outcome. The absence of problems is frequently identified as a factor in successful outcomes. The *Placement of Children and Miscellaneous Amendments (Wales) Regulations 2007* state that the responsible authority must take into account prior to placing a child the placement meets the childôs holistic health needs and **in particular any mental health needs.**

Mental health problems in children and young people are broadly defined as disorder of emotions, behavior or social relationships sufficiently marked or prolonged to cause suffering or risk to optimal development in the child, or distress or disturbance in the family or community (Rutter et al, 1970).

There are a number of factors which impact on a childôs mental health. Some of these are related to the child and some to family and community factors. Additional factors for Looked after Children include I) stability and quality of care, and ii) childôs links to family, friends and peers.

It is crucial to promoting the welfare of Looked after Children that their needs around attachment trauma are assessed, recognized and treated. Evidence suggests that many mental health difficulties are missed in this group of children and young people, in particular the effects of grief and loss and resulting depression in younger children.

Health assessments should include validated tools to assess emotional and mental well being. The use of *Goodman's Strengths and Difficulties Questionnaire*, when adequately informed by specialist understanding, is an effective means of initial screening for potential problems prior to more detailed assessment

There should be no assumption that because children and young people are looked after that they have mental health problems, as such an assumption is not only stigmatizing but may lead to the failure to investigate possible organic causes for difficulties.

In the regular schedule of health assessment, it is recommended that children are screened for emotional and mental health difficulties using the following tools:

- listening to the child or young person themselves, their feelings, experiences and sense of self
- using a validated screening tool, such as the Goodman's Strengths and Difficulties Questionnaire
- through discussion with parents, carers and other professionals, and in particular through discussion with a mental health professional with specific expertise with regard to Looked after Children

Where children are thought to have significant emotional and/or mental health difficulties, they should always be referred to a specialist service for full assessment.

It is important that, once a need is recognised, there is swift action is taken to arrange for the provision of an appropriate service. Putting children and young people through assessment procedures when there is no realistic prospect of providing an appropriate response is of dubious value, and shows a lack of respect for the integrity of the child.

The Initial Health Assessment

At the initial health assessment, the Specialist Health LAC Team will advise on the health care plan. A copy of this will be provided to the key social worker. Following review and consultation, the health team will be responsible and accountable for deciding who will complete the next assessment. This will be dependent on the best interests of the child, his/her health and development and emotional well-being. The child's wishes and feelings must be taken into consideration when making any arrangements.

The health care plan should fully inform the social services 'Looked after Child Care Plan' through the sharing of health information. Protocols for sharing information must be in place which balances the sensitive and confidential nature of the child and young person's health information while ensuring it is appropriately integrated into the overall care plan. This should comply with Welsh Health Circular WHC (2003) 50 *'Guidance on Protocols for Sharing Information'*.

Consent should be obtained from the person with parental responsibility and or from a young person of sufficient age and understanding with regard to and with whom confidential health information may be shared, together with an explanation of why this material is to be shared.

Information relating to child protection matters with regards to the child's best interests may need to be disclosed without the child's consent

The health action plan will form an important part of the regular scheduled Reviews. Health action plans should be monitored regularly; where referrals or follow up health assessments have been identified they must be implemented in a timely way.

The initial 'Looked after Child Care Plan' will be reviewed 4 weeks after entering care as part of the statutory meeting. A member of the Specialist Health Team will attend the first review or they must receive a copy of the minutes, including the care plan.

Subsequent Health Assessments (reviews)

The initial health assessment and the subsequent review assessments will continue to be completed by a suitably qualified health professional. It is recommended that this is a medical practitioner who specialises in this area, such as a community paediatrician, Clinical Nurse Specialist, Specialist LAC Nurse, Health Visitor or School Nurse with expertise and experience of working with looked after children. Again, if the child or young person expresses a choice of professional and this is consistent with their best interest, then this should be accommodated whenever possible.

Retention and Distribution

Following all health assessments, a copy of the assessment may be retained by the specialist medical practitioner/ medical advisor and the Clinical Nurse Specialist. The Specialist Health Team, in accordance with local protocols, will be responsible, in conjunction with the Social Worker, for overseeing the implementation of the health care plan.

Local arrangements should ensure that a copy of the Health Assessment and Health Care Plan should be sent to the:

- Child's GP - and placed on the GP record.
- Community Child Health Record
- Clinical Nurse Specialist (or Trust lead for LAC) if child is in an out of county placement.

The Health Action/Care Plan will also be sent to:

- Social Worker
- Foster carer
- Child/young person (if appropriate)
- Independent Reviewing Officer
- Parent with PR (when this is appropriate)

Leaving Care

When the child leaves care, the health care plan should continue. The Specialist LAC Health Team will co-ordinate the rapid transfer of the community records for the child and liaise appropriately with the key services, in line with local protocols

When a child is placed for adoption, the child/young person's status remains that of 'looked after' until the adoption is finalised by the courts. It is recommended that a Community Paediatrician and/or Adoption Medical Adviser complete or supervise any health assessments scheduled during that period to ensure that the Adoption Medical details are updated. However, discussions should take place with the LAC health care team to help identify the most appropriate professional.

HEALTH PROMOTION

Health promotion is an integral part of the health assessment and health care planning process. In addition to the following key areas, the National Children's Bureau in England have developed a number of briefing papers which outline the health promotion needs of looked after children (NCB 2005)

Healthy Eating and Physical Activity

There is little research evidence about physical activity and healthy eating in relation to children looked after. However, obesity, poor diet and lack of physical activity are increasingly a cause for concern for all children and young people. Healthy eating and adequate physical activity are essential for all children and young people to ensure proper growth and development. Taking proper account of these issues in health care plans will improve health outcomes for Looked after Children both during childhood and in later life.

Those responsible for Looked after Children can incorporate health-promoting practices in a wide variety of ways, including:

- having a policy on healthy eating and drinking for residential children's homes
- providing reduced cost and 'easy access' schemes to local leisure facilities for children and young people and foster carers
- working with community dieticians to provide healthy cooking and nutrition skills, especially for care leavers
- including children and young people themselves in meal planning
- encouraging foster carers to recognise and participate in healthy exercise and healthy eating initiatives through training and other incentives

Sexual Health

All young people, including those who are looked after or are care leavers, can face a range of obstacles to accessing contraception and sexual health services including embarrassment, confidentiality, inaccessible locations and rigid opening hours, the atmosphere and environment, and also confusion about the legality of seeking contraception if under 16. In delivering contraceptive and sexual health services for Looked after Children, it is vital that those factors are taken into consideration and addressed.

There is a significantly higher rate of teenage conception among Looked after Children than amongst the non-care population, with teenage young women more likely to become young mothers than young women in the general population.

Many vulnerable young people may, through lack of self-esteem, feel less able to make their own choices about early or unwanted sex. Social work professionals and foster carers should therefore offer young people support to develop assertiveness and negotiating skills to help them resist any pressure to have early or unwanted sex. The wish to become a parent at an early age might also reflect a perception that few other rewarding life courses are open to looked after young people as they reach their teenage years.

Social work professionals and foster carers have a key role, and professional duty, to ensure that looked after young people (including under 16 year olds) and care leavers are encouraged to seek contraceptive and sexual health advice if it appears that they are, or are likely to be, sexually activity.

Particular attention should be paid to boys and young men who currently form a small percentage of clients of sexual health services. In addition, many young people from black and minority ethnic groups face multiple disadvantages which may impact on their capacity to access services.

Young people who are lesbian, gay, or bisexual, and/or who are in same sex relationships may also have need of additional support. Service providers should be sensitive to the possibility of stigmatisation and homophobic bullying and offer support, including challenging discriminatory behaviour and practice, and providing contact details of suitable support groups to young people in these situations.

Other practical strategies for promoting the sexual health of young people looked after can include:

- ensuring that local policies relating to sexual health and to sex and relationships education specifically include looked after children and young people
- joint projects between youth services and community health services targeting looked after children and young people and involving young people as peer educators
- providing training for leaving care staff as sexual health educators and condom distributors
- provide support and training for foster carers in dealing with sexual health issues
- involving young people in an audit of sexual health services and in planning local initiatives around sexual health.

Substance Misuse

Many looked after young people use drugs for recreational reasons, just like many other young people amongst the non-care population. Yet there is also evidence that looked after young people may use drugs ôto forget bad thingsô reflecting their often traumatic personal histories.

Although the research is limited, some studies illustrate that young people looked after are four times more likely than those living in private households to smoke, drink and take drugs.

When children and young people are abused through sexual exploitation, alcohol and other drugs are often involved in the grooming and enticement process. One study for example

found that 78 per cent of sex workers who were also problematic drug users had been in care (Cusick et al, 2004).

There is some evidence that looked after young people may ómature outôof their drug use earlier than young people not in care. This seems to be associated with well-managed and supported transitions to independence.

Specialist health workers are ideally placed to provide alcohol and drug education. However, drug education is part of the role of all carers working with looked after children and young people. Residential social workers and foster carers are well placed to provide drug education and support to Looked after children and young people around drug use and other related risky activity. Carers will need management support and training and, most importantly, a clear policy guidelines on alcohol and other drugs in order to undertake this work competently and confidently. Some areas have developed policies for all children and young peopleôs services to enable a consistent approach by professionals and staff. Other authorities have developed specific policies for looked after children and young peopleôs services and have consulted carers, staff, and children and young people about what the policies should cover.

Resilience

The experience of being ólooked afterôis a challenging one in itself. In order to help looked after children deal with these challenges, it is of crucial importance that emotional health promotion promotes resilience.

A resilient child is one who adapts better to risky and difficult circumstances. They are better able to overcome adversity, sustain competence under pressure, and adjust and adapt successfully to traumatic events. Professionals and carers can help looked after children to develop resilience through a combination of enhancing their individual qualities, and by providing a supportive environment (Gilligan 2001).

Promoting a sense of permanence and stability in the lives of children is thus a key part of promoting their health, with partnership working to monitor placement movements key as part of the implementation of the WAG document *'Strategic Framework for Placement Choice and Stability' (2004)* an integral part of the health agenda. Action to promote stability and continuity in education not only enhances a sense of security and achievement, but will also provide opportunities to extend peer relationships and out-of-school recreational activities.

Support to help looked after children develop peer relationships, social networking opportunities and leisure pursuits is an important part of emotional health promotion agenda. Carers should be helped to actively engage with teachers and school activities and be given support to help children participate fully in leisure and recreation opportunities.

Funding for peer mentoring schemes, leisure passes and activities that target access to out of school clubs, play schemes and outdoor pursuits should be seen as a routine part of funding provision for looked after children.

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ANNEX 1

LAC Nurses – Wales

Area	Names		Address and office Tel. number	Mobile Telephone
Anglesey	Llinos Edwards	LAC Nurse	Children and Families Team Social Services Dept Ynys Mon Council Offices Ynys Mon LL7 7TW **01248 751 861**	Llinos -
Bridgend	Teresa Erasmus Sandra Powell	Health Visitor for LAC Community nurse	Looked After Children's Team Level 4 Children's Services Bridgend CBC Sunnyside Bridgend CF31 4AR **01656 642423**	Teresa ï 07973 906 687 Sandra - 07969 749 716
Cardiff and the Vale of Glamorgan	Chris Chiplen Judith Bryon Nikki Williams Jen Thomas	Specialist LAC Nurses	Children First Team, Corridor 200, Lansdown Hospital CARDIFF CF11 8PL **029 2093 2838**	Chris ï 07812 244 796 Judith- 07812 242 092 Nikki - 07973 336 063 Jen- 07973 336 061
Carmarthen	Janet Edmunds	Lead Nurse LAC	Safeguarding Office Glangwili Hospital Dolgwili Road Carmarthen SA31 2AF **01267 227060**	Janet - 07815837874

Conway	Bethan Lloyd and Janet Duddle	CNS LAC	Childrenôs Services Civic Centre Annexe Conway Colwyn Bay -N Wales **Janet 01492575111**	Bethan ï 07826 876 904
Denbighshire	Jane Church	Public Health Practitioner LAC	64 Brighton Road Rhyl **Denbighshire** **Jane - 01824 712216**	
Flintshire	Sian Cork	Public Health Practitioner LAC	County Offices Connahs Quay Flintshire CH5 4HB	Sian 07789 891 861
Gwent - Monmouth	Penny Davies	CNS for LAC	Chepstow Hospital Tempest Way Chepstow Gwent NP16 5YX **01291 636628**	Penny ï 07766 133 709
Gwent - Torfaen	Jocelyn Haynes	CNS for LAC	Social Services County Hall Croesyceiliog Cwmbran Gwent NP44 2WN **01633 648728**	Jocelyn ï 07786 982 408
Gwent ï Blaenau Gwent	Jenny Beswick	CNS for LAC	Divisional Health Office Bridge Street Ebbw Vale Gwent NP23 6EY **01495 353040**	Jenny -07904 017 837
Gwent - Newport	Jane Keoghane Kathy Stokes	CNS for LAC	Bettws Health Centre Monnow Way, Bettws Newport NP20 7TD	Jane -07766 257 753 Kathy - **********

			01633 855132	
Gwent - Caerphilly	Jane Dove	CNS for LAC	Trethomas Clinic William Street Trethomas Caerphilly Gwent CF83 8FX **029 2086 4676**	Jane -07947 828 908
Gwynedd	Vacant	Specialist HV LAC	**Post to be filled**	
Merthyr	Deb John	CNS LAC	Social Services Dept Post Office Lane Merthyr Tydfil CF47 8BG **01685 724545**	Deb ï 07879 696 382
Neath Port Talbot	Cath Vaughan Marie Davies Tricia Thomas	CNS for LAC Community Nurse LAC Community Nurse LAC	Conference and review Office 1st Floor Neath Civic Centre Neath SA11 3QZ **01639 685711 / 685712**	Cath -07866 731 857 Marie -07970 453 787 Tricia -07875 505 653
Pembrokeshire and Ceredigion	Sonia Edwards	Specialist Nurse for LAC	Child Health Dept. Whithybush General Hospital Fishguard Road Haverfordwest Pembs SA61 2PZ **01437 772341**	Sonia ï 07887 931 448
Powys North	Jayne Garfield	Specialist Nurse LAC	Ynys y Plant Plantation Lane Newtown Powys SY16 1LH **01686 617457**	Jayne G -07973 448 026
Powys Mid	Mary Morton	Specialist Nurse LAC	The Annexe, Llandrindod Wells Hospital Temple Street Llandrindod Wells LD15HF **01597 828 773**	Mary ï 07791 955 265

Powys South	Jayne Snare	Specialist Nurse LAC	The Childrenôs Centre Brecon Hospital Cerrigcochion Road Brecon LD3 7NS **01874 615 604**	Jayne S ï 07977 242 196
Rhondda Cynon Taf	Louise Mann Paula Cunvin Anthony John	CNS LAC CNS LAC CPN LAC	Promoting Health for LAC Ymbarel Ty Trevithick Abercynon Mountain Ash CF45 4UQ **01443 744099**	Louise - Paula - Anthony -
Swansea	Jenny Israel Sian Cosgrove Caroline Nee		Bungalow B Gorseinon Hospital Brynawel Road Gorseinon Swansea SA4 4UU **01792 703219**	Jenny ï 07775 994 812 Sian -07976 633 269 Caroline -07908 373 096
Wrexham	Judith Moore	Lac Nurse	Looked After Childrenôs Team Crown Buildings Ground Floor 31 Chester Street Wrexham LL13 8BG **01978 295343**	Judith ï 07789 706 414