	ITEM: 6
Corporate Parenting Committee	
Health of Looked After Children	
Wards and communities affected: All	**Key Decision:**
Report of: Andrew Carter, Head of Care and Targeted Outcomes	
Accountable Head of Service: Andrew Carter, Head of Care and Targeted Outcomes	
Accountable Director: Carmel Littleton, Director of Children's Services	
This report is public	

Executive Summary

Meeting the healthcare needs of Looked After children is a significant priority for Children's Social Care. Many children who become looked after will do so following a period of parental neglect or abuse, and may not have had their health needs addressed appropriately.

1. Recommendation(s)

1.1 The members of the Corporate Parenting Committee are asked to note the contents of the report, acknowledging where progress has been made, whilst supporting officers in their efforts to improve where necessary, especially in facilitating inter-agency cooperation. This applies particularly to strengthening the working relationship with Health colleagues, utilising their specialist knowledge to improve our reported performance in the areas of immunisations and developmental checks for younger children.

1.2 Members are also asked to support a proposal that Health colleagues are invited to take the lead role in the preparation of future reports on Health matters to the Committee.

2. Introduction and Background

2.1 Looked After Children and in particular care leavers, have historically tended to have poorer health outcomes than other young people their age. This has led to a heightened profile around the performance of local authorities in meeting their obligations to ensure all checks are carried out in a timely fashion.

2.2 This report will therefore focus specifically on the most recent data available; identify some of the key challenges that need to be addressed; and outline the main areas of focus for the Looked After Children's Health Steering Group during 2014-2015.

3. **Reported Performance**

3.1 In December 2014 the Government published the latest figures for all local authorities, which were essentially generated from the annual SSDA903 return. For Health checks figures are reported on two specific cohorts of children, those who have been looked after for at least twelve months at 31st March and the subset of these children who are under 5 at that date, who should be receiving developmental checks.

3.2 The expectation is that all children should have an Initial Health Assessment (IHA) on entering care and a Review Health Assessment (RHA) each year thereafter. Children under the age of 5 are expected to have a Review Health Assessment twice a year.

3.3 Thurrock's reported performance for completion of yearly Review Health Assessments for 2013-14 showed significant improvement on the previous year. There were 190 children who formed the cohort. Of these 165 (86.8%) had had their check recorded (compared to 81.8% the previous year). This was marginally above the East of England Average of 86.4%, but below the National average of 88.4%.

3.4 The same statistical release also publishes the figures for children who have a recorded dental check in the previous period and those whose immunisation records are up to date.

3.5 For dental checks the reported figure (taken from the same cohort) is 84.2% (Regional average – 82.8%; National – 84.4%). For the previous year the figure recorded was 78.7%. (Regional average – 80.7%; National 82%). This therefore reflected an increase of 5.5%, bringing Thurrock closer to the National average.

3.6 The published statistics for Immunisations is a cause for concern, as the published figures would suggest that only 57.8% of the cohort are up to date, compared with 84.9% regionally, and 87% nationally. In practice we know from Health colleagues that the reported figure does not reflect reality and there is a problem that the electronic records held by Health do not "talk" to the LCS system used by Children's Social Care. In addition the LCS system can be confusing to update for non-health professionals, which has led to under-recording.

3.7 We now have agreement for health colleagues to have direct access to our system (LCS) and a commitment from them to assist with the updating process. This should enable them to assist us in reconciling the two records

and with a clear target of completing this work before the submission of the next SSDA903 return. We are confident that next year should show a significant improvement in the reported figures.

3.8 Thurrock has previously also appeared to be under-performing against the requirement for children under 5 to have developmental checks. New processes have been introduced to ensure that we capture the full range of developmental checks carried out with this age group. As with immunisations we expect to see an ongoing increase in performance.

3.9 Because of the way the figures are collated across the year, taking a snapshot prior to the end year date can be misleading. However current recorded completion rates on RHAs for over 5s for the year 2014-15 are showing as 68.9%, compared to 61.8% around the same time last year, which suggests we are on track for a degree of improvement. However as there are a few weeks to go for the reporting period the combination of Review Assessments that are arranged but still to be undertaken and those which have taken place but are not yet recorded on the system should push this figure significantly higher by March 31st. We will be using the remaining weeks of the municipal year to challenge any cases where it appears appropriate urgency has not been shown.

3.10 A further significant improvement has been to establish a new daily report which shows not just the SSDA903 cohort but the “live” position for all currently looked after young people. This creates better monitoring of Initial Health Assessments being instigated in a timely fashion for children recently accommodated.

3.11 Another outcome which is reported on nationally is our completion of the “Strengths and Difficulties Questionnaire”, which is a widely used tool, recognised for its value is evaluating the emotional well-being of children. Local authorities are expected to ensure that these are completed on young people aged 5-16, and in care for over a year.

3.12 For 2013-2014 Thurrock had 145 young people who formed part of the reported cohort for an SDQ score. We achieved 100% completion on making sure these were done, against a National average of 68% and an Eastern Region one of 66%.For both the previous years we achieved 99% completion, against National averages of 71% both years and Regional averages of 70 and 75% respectively.

3.13 We continue to review children and young people with high SDQ scores (those over the midway point) at the MALAC group meeting (Multi-Agency Looked After Children) to identify whether concerns have been raised about a young person not already receiving appropriate support.

3.14 The commentary for the nationally released data for health checks repeated the previous finding that performance for all authorities was poorest for young people aged 16+, and therefore targeting improved performance for this age

group will continue to be placed as a high priority for 2015-2016. Considerable success has already been achieved in 2014-15 through the flexible & personal approach used by the Specialist Advisor Looked After Children's Nurse to engage some initially reluctant young people.

3.15 Amongst the 16+ age group are a small but significant proportion of Unaccompanied Asylum Seeking young people. These young people will often have had particularly traumatic experiences and may face specific emotional, mental health and physical health needs. We will continue to target this group for support and improving health outcomes in 2015-2016.

4. Issues, Options and Analysis of Options

4.1 Thurrock has a well-established Looked After Children Health Steering Group chaired by the Service Manager for Placements and Support Services, who has the lead responsibility on health matters. The Steering Group meets on a bi-monthly basis, and has a multi-agency representation, bringing together a number of key individuals involved in health care provision. The Group has its own work plan, refreshed on a regular basis, to identify specific issues to be addressed to promote the health and well-being of looked after children.

4.2 To supplement the work of the wider forum a Core Group, consisting of the Chair, Social Work Team Manager and representatives of the Looked After Children's Nursing service, as well as other co-opted members as appropriate, meet in between the Steering Group meetings to monitor and progress specific issues.

4.3 The proposed Actions within the work plan for 2014-2015 were grouped around four main themes:

- Children in care with emotional and behavioural health needs, and their carers, are supported and positive mental health is promoted.
- Young people leaving care know and understand their health history and know how to access services.
- Promote the physical, mental, sexual and social health of looked after children and young people
- Ensure appropriate systems are in place that enable the Department to record data for IHAs, RHAs , dental & optician checks, and immunisation records, for looked after children that take account of the latest clinical guidance.

4.4 The first three of these were chosen to be compatible with of the Quality Standards for looked after children and young people developed by the National Institute for Health and Care Excellence (NICE), and the fourth has been significantly reflected in the discussion above.

4.5 Despite some changes in personnel, at a local level working relationships between Social Care staff and NHS staff, particularly the Designated Nurse for LAC (Commissioning) and the Named Nurse for LAC (Provider), are sound

and cooperative. One example of this approach was demonstrated in a joint audit exercise undertaken in late 2014, in which a small sample of Health Assessments were examined by both Health and Social Care professionals.

4.6 The findings were that every child whose case was audited had received a health assessment. Health stated that in 100% of the cases audited the assessment covered all the areas required. Both health and social care also agreed that the voice of the child was evident in the all cases of children over 2 years. Over half of the requests for health assessments were received within timescale and where they were not 42% had a reason documented by social care for the delay. All children had received age appropriate PHSE advice.

5. Reasons for Recommendation

5.1 To ensure members are adequately informed of the challenges and successes in delivering appropriate health care to looked after children.

6. Consultation (including Overview and Scrutiny, if applicable)

7. Impact on corporate policies, priorities, performance and community impact

7.1 The content of this report is compatible with Health and Well Being Strategy Priority 12: *Provide outstanding services for children in care and leaving care*

8. Implications

8.1 Financial

Implications verified by: Kay Goodacre
Consultant, Corporate Finance

There are no immediate Financial Implications arising from this report.

8.2 Legal

Implications verified by: Lindsey Marks
Principal Solicitor

There are no immediate legal implications arising from this report

8.3 Diversity and Equality

Implications verified by: Natalie Warren
Community Development and Equalities Manager

The significant Equality and Diversity implications arising from this report stem from the need for carers to have awareness of medical conditions which disproportionately affect different sectors of the community, such as Sickle Cell Trait, as well as professionals generally recognising both the physical and emotional needs of Unaccompanied Asylum Seeking young people.

8.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

9. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright): None

10. Appendices to the report

None

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