

A Guide to Meeting the Statutory Health Needs of Looked After Children through a Standard Approach to Commissioning and Service Delivery.

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Contents

1	Guidance Statement	3
2	Introduction	4
3	SMART Planning, Provision and Co-commissioning of health services to promote the Health of Individual Looked After Children	5
4	Notification of Placement by Local Authority (LA)	2
5	Information Sharing	3
6	Statutory Health Assessments, Health Care plans, Reviews and Care Leavers Health Summaries	4
7	Care Leavers Health Summary.....	11
8	Mental Health Services	13
9	Special Educational Needs (SEN)	14
10	Children in Custody	15
11	Corporate Parenting: the role and responsibility of the CCG and Provider Executives, Designated LAC Doctor and Nurse, and Named Health Professionals for LAC	16
12	The Responsible Commissioner – Standard approach to Out of Area/Authority/Borough Placement of a LAC.....	19
13	The Contribution of Primary Care Teams	21
14	Supporting Foster Carers and Children’s Residential Care Providers to promote the Health Needs of LAC	22
15	Distribution and Implementation	22
16	Monitoring	22
17	Equality and Health Inequalities.....	22
18	Concluding Statement.....	23
19	Appendix A	24

1 Guidance Statement

This guidance has been developed by the NHS England National Steering Group LAC Forum with the aim to improve the health outcomes of Looked After Children (LAC) across England by reducing the unwarranted variation in the health delivery and commissioning arrangements for this group of vulnerable children. The Project Manager for Unwarranted Variation worked in partnership with members of the LAC Forum to co-produce and consult on each element of the document in March 2017, with wider National Consultation across the Regions in September 2017. It should not be read in isolation by CCG's, Local Authorities and Public Health commissioners and Designated and Named Professionals, as it aims to translate the science outlined in the statutory guidance and key documents outlined below into a standard approach to the commissioning and delivering outcome focused health services to meet the complex health needs of LAC. In addition, the reader should review examples of commissioning and delivery tools, as well as job descriptions, accessed via their Regional LAC Forum Representative, located on the NHS England Central LAC Repository. This guidance should be read in conjunction with:

[Caldicott Committee - Report on the Review of Patient-Identifiable Information \(1997\)](#)

[Children and Social Work Act 2017.](#)

[Children's Homes Regulations, including Quality Standards: Guide \(2015\).](#)

[Children Looked After by Local Authorities in England. Guide to the SSDA903 collection 1 April 2016 to 31 March 2017.](#)

[House of Commons Education Committee Mental health and well-being of looked-after children Fourth Report of Session 2015–16.](#)

[Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers \(2015\).](#)

[Looked After Children: Knowledge, Skills and Competences of health care staff. Intercollegiate Role Framework, 2015\).](#)

[National Tariff Payment System.](#)

[NICE Quality Standard QS31 Looked after children and young people 2013 \(Hyperlink\).](#)

[Not Seen Not Heard: A review of the arrangements for Child Safeguarding and health care of Looked After Children in England \(CQC, 2016\).](#)

[Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\).](#)

[Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies \(2013\).](#)

[The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review.](#)

[The Children Act 1989 Guidance and Regulations Volume 3: Transition to Adulthood.](#)

[The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services.](#)

[Who Pays? Determining responsibility for payments to providers \(2013\).](#)

2 Introduction

Every child should grow up safe, happy and be able to reach their full potential. However, for some children this means that they need to be taken into the care of the Local Authority (LA) (either on a voluntary basis or under Court Order) due to abuse, neglect, abandonment or as Unaccompanied Asylum Seeking Children (UASC).

Local Authorities take children into care to improve outcomes for them and, as 'Corporate Parents', the health system should have equally high aspirations for these children and young people, as outlined in the Children and Social Worker Act (2017).

LAC are at greater risk of not realising their full potential and having poorer outcomes in terms of physical health, emotional health and educational attainment. There is an increased risk of offending, substance abuse and an increased likelihood of young pregnancies in these children and young people.

The primary areas of unwarranted variation are:

- Access to timely and quality health services regardless of where LAC are placed in the United Kingdom.
- The health commissioning pathways to meet the statutory duties for all LAC are not fully understood and are complex, particularly impacting on children placed out of area, UASC and Children on remand.

This guidance will seek to provide commissioners and providers of services across the health economy with a 'user guide' to all the guidance outlined in Section 1. Experts in the commissioning and delivery of services to LAC have contributed to the production of examples in this document, which can aid in the reduction of unwarranted variation for LAC. In addition, it provides a framework to map services against and suggests ways of addressing unwarranted variation across the system. Areas of best practice have kindly shared their resources and processes.

The key statutory guidance, '[Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)](#)', has been used to inform this document. This guidance will focus on the art of 'how' to decrease unwarranted variation and promote positive outcomes for LAC.

3 SMART Planning, Provision and Co-commissioning of health services to promote the Health of Individual Looked After Children

Key Highlights

- SMART Planning – Using the Joint Strategic Needs Assessment (JSNA) to inform the joint local strategic commissioning priorities for LAC.
- SMART Provision – Understanding all LAC Health needs, including those placed into area.
- SMART Co-commissioning – Looked After Service specifications and service delivery should focus on the qualitative outcomes for the children, not purely metrics relating to timescales and activity.

SMART Planning, Provision and Co-Commissioning is the key to addressing the unwarranted variation across the health economy. Commissioners from Local Authorities, Public Health and Clinical Commissioning Groups (CCGs) should assure themselves they are able to meet the statutory duties for all the LAC placed in and out of their area/borough, and that the commissioned arrangements that impact on LAC capture qualitative outcome measures in addition to quantitative metrics.

For the purpose of clarity, SMART outcomes are outlined below:

- **S** - specific, significant, stretching.
- **M** - measurable, meaningful, motivational.
- **A** - agreed upon, attainable, achievable, acceptable, action-oriented.
- **R** - realistic, relevant, reasonable, rewarding, results-oriented.
- **T** - time-based, time-bound, timely, tangible, trackable.

SMART Planning – Strengthening the Joint Strategic Needs Assessment

Planning health services for looked-after children should be identified within the statutory Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) as per guidance, '[Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies \(2013\)](#)'.

Planning health services using the JSNA to meet the statutory needs of LAC is a potential area of unwarranted variation across the system, with commissioning arrangements from Public Health differing in England; especially relating to School Nursing and Health Visiting provision to support the review health assessment process for 0-18's. To address this variation, CCG's, Local Authorities and Public Health (Commissioners of School Nursing & Health Visiting) should review the JSNA (with the support and influence of Designated and Named LAC Professionals) and JHWS to inform the joint local strategic commissioning priorities for LAC, and

address any commissioning decisions that impact on service provision within this strategic forum.

SMART Provision- Mapping all LAC Population Needs

Identify that sufficient resources and key personnel (Looked After Children: Knowledge, skills and competences of health care staff. Intercollegiate Role Framework, 2015) are allocated to meet the identified health needs of the looked-after children population, including those placed in their area by other local authorities, based on the range of data available about their health characteristics. Unwarranted Variation for LAC placed out of area is a system wide issue. Areas that have successfully addressed this variation have introduced a whole population approach to profiling the health needs of LAC, irrespective of originating authority, with re-charging arrangements secondary to meeting the health needs of children.

- App 1 – An example of mapping and gap analysis of LAC population.

SMART Co-commissioning – Looked After Service specifications and service delivery should focus on the qualitative outcomes for the children, not purely metrics relating to timescales and activity. It should be agreed through co-commissioning to recognise that the service specification and delivery gives greater parity to mental and emotional health needs of LAC not purely physical, and the views of LAC, their parents and carers, to inform, influence and shape service provision. The CQC Thematic review of Safeguarding and LAC, '[Not Seen Not Heard \(2016\)](#)', outlines the unwarranted variation in the quality of the assessment completed as part of the Initial Health Assessment and of mental health commissioning arrangements for LAC nationally. To move to address this unwarranted variation, some areas have: co-produced service specifications for LAC & CAMHS involving service users and stakeholders; Commission mental health assessments for LAC at the outset of care; Use Strengths and Difficulties Questionnaires as a baseline from care entry (including 16 and 17 year olds) and track the scores longitudinally annually for all LAC population.

Below is one example of a co-commissioned LAC service specification for LAC in an area. This area has commissioned its local health Provider to undertake statutory duties on a National footprint.

- App 2 – An example of a co-commissioned Physical LAC Service Specification.

4 Notification of Placement by Local Authority (LA)

Key Highlights

- Notification form sent to Health within 48 hours of placement.
- Consent form sent to health within 4 working days to appoint for Initial statutory health assessment.
- Changes in placement notification form sent to health within 48 hours.
- All CCG's and LAC Health teams should use a generic nhs.net account for transfer of LAC data between health and LA.

[‘Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England \(2015\)’](#), outlines the notification process to health - When a child starts to be looked after or changes placement, the LA must, before the placement is made, notify the child's GP, parents (except where clearly inappropriate) and those caring for the child.

When a child starts to be looked after, changes placement or ceases to be looked after, the LA must also notify in writing electronically:

- The CCG for the area in which the child is living.
- The CCG and the LA for the area in which the child is to be/ has been placed.

Prompt notification by LA and appropriate information sharing will enable CCG's to fulfil their duties and meet timescales for health assessments.

The Originating LA should use **secure** electronic means (gcsx to nhs.net generic accounts) to notify health, within 48 hours of a child/ young person being placed in care or moving placement. The consent form and demographic details to arrange the appointment to meet statutory health assessment requirements should be forwarded within 4 working days of the child becoming looked after.

The Originating LA should also notify health of all changes of placement, giving reasons. This should also include episodes of respite.

5 Information Sharing

Key Highlights

- An Information Sharing Agreement should be in place that underpins all information transfer.
- All CCG and LAC Health teams should have a generic nhs.net account for transfer of data.

Working Together to Safeguard Children (2015) outlines the key principles of information sharing:

- Effective sharing of information between professionals and local agencies is essential for effective identification, assessment, decision making and care planning arrangements when placing looked after children with birth parents, as well as service provision.
- Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:

- All organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the LSCB; and
- No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with LA children's social care.
- A process in place to expedite the transfer of Primary records.

Practitioners should be aware of the, '[Caldicott Committee - Report on the Review of Patient-Identifiable Information \(1997\)](#)', regarding principles of information sharing, as well as roles and responsibilities of the Caldicott Guardian in their organisation; and they should be able to identify who this is.

In addition, '[Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers \(2015\)](#)', supports frontline practitioners, working in child or adult services, who have to make decisions about sharing personal information on a case by case basis. The advice includes the seven

golden rules for sharing information effectively and can be used to supplement local guidance and encourage good practice in information sharing.

- App 3 – The 7 Golden rules of information sharing.

6 Statutory Health Assessments, Health Care plans, Reviews and Care Leavers Health Summaries

Key Highlights:

- Using the Pre-LAC phase to extend statutory timescale to co-ordinate Initial Health information collation and assessment.
- Robust Initial Health Assessment and Review Health Assessment standards in operational processes, including a decliner pathway.
- Quality assurance processes to meet statutory timescales and promote consistent quality.
- Commissioning Key Performance Indicator targets (KPI's) that are outcome focused, as well as promoting statutory timescales.
- Robust escalation processes to address issues with quality and timeliness.

In accordance with, '[The Care Planning, Placement and Case Review \(England\) Regulations \(2010\)](#)', social workers must make arrangements to ensure that every looked-after child has their physical, emotional and mental health needs assessed; a health plan describing how those identified needs will be addressed to improve health outcomes and their health plan reviewed in line with care planning requirements, or at other times if the child's health needs change.

Initial Health Assessment (IHA) – Address Unwarranted Variation of Timeliness & Quality factors

Standard – The Initial Health Assessments should be commissioned and service delivery processes put in place in line with, '[Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)](#)', to ensure that the Initial health assessment & health care plan is completed by a Registered Medical Practitioner (who has the appropriate competencies laid out in the 2015 Intercollegiate guidance), **and returned** to the LA in time to inform the first LAC Review meeting scheduled at day 28 (working day 20) after the child comes into care.

- App 4 – An example of a Process map to complete the Initial Health Assessment within the statutory timescale of 20 working days/by the first LAC Review meeting.

Consideration of utilising the 'Pre- LAC' phase of a child care journey to complete the Initial Health Assessment (IHA)

'Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England (2015)' states that the health care plan should inform the first statutory review of the child's care within 20 working days from when the child started to be looked after, therefore the (LA) and CCG have up to 20 working days to complete a comprehensive assessment and care plan, and return it to the LA to inform the first LAC Review meeting. There is significant unwarranted variation across the system in relation to this timescale, with a dip sample audit conducted by the NHS England LAC Forum in December 2016, which highlighted that 65% LAC IHA's in this sample did not achieve this timescale for a variety of reasons including delayed notifications from LA, delays in the scheduling of Initial Health Assessment appointments and delays in returning the completed Summary Report and Health Care Plan to the LA.

Although a challenge in the current climate, the LA, Health Commissioners and Providers could explore the use of the Pre-LAC period to complete this statutory duty. In most cases, there is a plan for the child to come into care, with planning meetings in place to agree the planned accommodation of some children up three weeks before they come into care. This Pre LAC period could be used to review health records by the LAC Team and to schedule Pre-Health Assessments (with consent in place), allowing clinicians timely collation, review and analysis of health data; to not only determine a health assessment/plan, but also contribute to the Placement matching process, to ensure the care provider will be able to meet the child's health care needs. In areas where this process is in operation, a robust information sharing agreement is in place from the LA to the CCG who are included on the electronic distribution email that is sent to the Placements team to identify a placement. This 'Notification to Accommodate' is shared with the commissioned LAC Provider. This notification triggers a Pre-LAC collation of all known health information by the LAC Provider and an outline Initial health care summary and health care plan.

If, in addition, the LAC consent form is received by the LAC Provider, the child/young person could be appointed to receive a Pre-LAC health assessment. The caveat of implementing this process is that some children may be seen for assessments that do not become LAC. Involving parents in the Initial Health Assessment would increase the opportunity to gain consent to access parental records (Parental Health Form PH). This would inform a more robust capture of the genetic and familial health history that may impact on the child's current and future health needs. This additional 10-15 day time would allow the LAC Provider to schedule an Assessment, especially important for children where there is a plan to place them outside the commissioned area. A 'Non Accidental Injury' clinic model is in place in some areas to schedule 'virtual' clinic slots to facilitate this process, with demonstrated improvements in statutory timescale compliance and informed placement matching.

The Initial Health Assessment request should be accompanied by all relevant information:

- App 5 – A best practice example of Information from Local Authority required to arrange an Initial (and Review) statutory health assessment.

Other considerations to reduce unwarranted variation at IHA's:

- An accelerated vaccination programme should be instigated at the Initial Health Assessment for children identified with incomplete vaccinations, via liaison with Primary Care (Practice Nurse) and School Immunisation team – see section on immunisations for more details.
- Consideration of conducting a mental health screening using the Strengths and Difficulties Questionnaire (SDQ) to establish a baseline measurement at the outset of care.
- An expedited mental health assessment should be considered for children coming into care, especially for children that may be placed out of area and UASC (This is being explored by the Mental Health Pilot Project currently being scoped).
- UASC should have an NHS number assigned on arrival to the UK and arrangements in place to register with a GP. If this has not been completed, this should not affect the Providers scheduling of the child's statutory health assessment, with liaison in place to ensure NHS Numbers are assigned in time for the face to face assessment. Interpreters should be arranged via Social Care.
- A robust screening pathway for Tuberculosis (TB) and Blood Borne virus should be in place, in partnership with Public Health.
- Access to health records to allow analysis of the impacts to the child/young person in the short and long term of genetic history, substance and environmental exposure in utero including Foetal Alcohol Syndrome; Substance/Drug exposure; Domestic violence; Sibling & Parental Genetic Factors; and Parental Health History.

Review Health Assessment

Standard – The Review Health Assessment and Health Care Plan update should be commissioned and service delivery processes in place in line with, '[Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)](#)', that the Review health assessment & updated health care plan is completed for children for the duration of their time in care; a minimum of every 6 months for children aged 0-5 years and every 12 months for children aged 5-18 years.

The information requirements from the LA are as per Initial Health Assessment and the Review of the health care plan can be undertaken by a Registered Nurse or Midwife. Consent form arrangements can vary, but this is a warranted variation. Some LA's gain consent for each health assessment, and other areas use an enduring consent model, with consent gained at the outset of care, with informed consent in place for all statutory health requirements, including health assessments, throughout the duration of the child's time in care. Both are warranted variations, so long as there is no delay associated with the consent process.

Timeliness and Quality Assurance for Statutory Health Assessment

To determine the qualities of a good standard IHA & RHA, there should be an internal robust quality assurance process in place in the Provider. Best practice would be that the examining General Medical Practitioner should self-assess the completed IHA to ensure against a standard of good quality. The Registered Nurse or Midwife completing the RHA would replicate this process at each RHA. The Quality Assurance (QA) template below, based on Annex H, provides an example of a standardised template which determines consistent quality.

In addition, this information could be captured on a Health Outcome Data Base, with an example below. The output from this data base could be used to generate QA audit reports for Internal Performance Monitoring Meetings, as well as for LSCB, CCG Governing Body and Corporate Parenting meetings.

- App 6.1 – A best practice example of a Practitioner self-assessed quality assurance template for statutory health assessments.
- App 6.2 – A best practice example of a Health outcome recording database for Health Provider.

In addition, quality assurance and audit via dip sampling from a Designated LAC Nurse and Doctor perspective could be in place, to assure the CCG that they are meeting their regulated duties. Some areas have adopted a regular Peer Review Audit process schedule with Designated Professionals from neighbouring CCG's, quality assuring all returned IHA and RHA that were returned to the LA within a specified month, and utilising a quality assurance template. The audit findings are shared with the Local and External Providers, as well as at Strategic and Operational Health of LAC meetings, and Corporate Parenting Board. The establishment of Strategic and Operational meetings increases the opportunity of partnership working to resolve issues, and ensures an assurance platform for all commissioning and delivery stakeholders to help reduce unwarranted quality variation, via jointly agreed decisions and processes to deliver positive outcomes for LAC.

- App 7 – A best practice example of Terms of Reference for Strategic and Operational Health of Looked After Children Meetings.

Using a Decliner Pathway to Assess and Meet the Statutory Health Needs of LAC who Decline to Engage

Best practice is that every effort should be made to involve the child and young person with their health assessment and care planning. There are challenges to achieving this when young people are reluctant to engage in assessments or subject to influencing factors which may affect their ability to understand or make an informed decision, at that point in time, about their health needs.

In order to facilitate access to effective health planning for children and young people who assent to health assessment and in the event of a young person not assenting, the following standards should be in place:

- That professionals, multiagency partners, families and carers should ensure that children and young people feel valued and listened to.
- Specialist professionals should utilise evidence led 'best practice' strategies for health assessments and care planning in a timely and holistic manner.
- Professionals should ensure children and young people are offered assessments at a place they feel comfortable.
- That professional's ensure there is a defined pathway in place with children/young people who are reluctant to engage (decliners).
- That, as part of the decliner pathway, in the case of a young person refusing assessment, a response would be triggered to gain consent from the person with parental responsibility in order to complete health care planning in the best interests of the child /young person.

- App 8 – A best practice example of a Decliner Pathway.

Outcome Focused Key Performance Indicator Targets and LA Reporting of LAC Health Indicators to the Department for Education

All LA's report to the Department for Education (DfE) on metrics outlined in '[Children Looked After by Local Authorities in England. Guide to the SSDA903 collection 1 April 2016 to 31 March 2017](#)', local arrangements should be in place between the LA and Health partners to support the accurate capture of these key metrics for reporting data for children that have been in care over 12 months as of 31st March annually. The DfE metrics that are captured include Immunisations, Dental check, Health Assessment, Substance misuse, LAC who received Intervention for substance misuse, LAC who were offered Intervention for substance misuse, Strengths and Difficulties Questionnaire (4-16 years), and Developmental checks. The reporting metric is binary – either the child has had or has not had the metric. The following metrics could be considered in addition to the DfE metrics to understand LAC individuals and population data.

Immunisations

This reporting metric is binary: the child is either up to date or not up to date at end of year. In addition, LA's and CCG's should establish a standard that reflects measures that understand individuals health outcomes, as well as the LAC population as a whole, especially those children who are Unaccompanied or have delayed immunisation schedules due to not receiving these prior to coming into care and who follow an accelerated vaccination schedule; and teenagers that decline to assent to vaccinations. Therefore, there is a cohort of children that will never be up to date whilst in care, and the following metrics could be additionally captured by LA and Health to reflect this to understand individual and population outcomes, which can be shared and trends understood via annual reports and at Corporate Parenting Board.

Number & % of LAC fully vaccinated for age as per National Schedule- Classed up to date	Number and % of LAC not vaccinated as per National Schedule	Number and % of LAC completing accelerated Vaccination Schedule (Children with in-complete vaccination history including UASC (Unaccompanied Asylum Seeking Children) – UP TO DATE AS PER REVISED SCHEDULE	Number and % of LAC completing accelerated Vaccination Schedule (Children with in complete vaccination history including UASC (Unaccompanied Asylum Seeking Children) identified as NOT UP TO DATE AS PER REVISED SCHEDULE	Number and % of LAC declining to assent to vaccination
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Dental Check

All children are included in this reporting cohort, and the recording is binary that the child has either had a dental check or not. Children under 24 months should have an oral examination including gum check, even if their teeth have not yet developed, All LAC should be referred to a dentist. To understand individual and population needs, the following metrics could be additionally captured and targeted health outcomes measured and understood. For example ensuring oral health examinations are outlined in the Service Specifications for LAC Health Services and Health Visiting Public Health contracts, referral to Phobic Dental Service, and so on.

Number & % of LAC that have had a dental check by a dentist	Number and % of LAC that have not had a dental check	Number and % of LAC declining to attend for dental check
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Annual Health Assessment Up to Date

This metric is recorded for children who have been in care a year, and captures Review Health Assessment data, that under 5's have received 2 assessments and 5-18's have received one assessment. The enclosed example KPI's could be used to measure individual and population data.

- App 9 – A best practice example of Outcome Focused Key Performance Indicator Targets.

LAC Identified as having a Substance Misuse Issue; LAC who received Intervention for Substance Misuse; LAC who were offered Intervention for Substance Misuse

There are three metrics reported regarding Substance Misuse. It is defined as illegal drugs, illicit prescription misuse, volatile substances and alcohol, but excludes smoking. Health Providers, CCGs and LAs should all use locally agreed substance misuse screening tools within the Health Assessment process, as well as to refer to services to support their identified substance misuse needs, recording this explicitly in the LAC Health Care plan, which can inform health partner's assessment and intervention to capture this data metric.

Strengths and Difficulty Questionnaire (SDQ 4-16 years)

Completed and scored Strengths and Difficulties Questionnaires (SDQ) should be available for all 4-16 year old LAC to inform the Review Health Assessment, Carers, Social Workers and Independent Reviewing Officers should be aware of the impact to the child of the score, and changes in the score.

- App 10 – Best practice example of a Guide to Strengths and Difficulty Questionnaires (SDQ)'s for Professionals and Carers.

Developmental Check

This metric could be strengthened by capturing the developmental assessment conducted during the Statutory LAC Health Assessments, as well as identifying any missed developmental assessments in the health care plan and liaison by the examining clinician with the child's Health Visitor.

Vision Testing

Vision tests are not captured in the DfE returns, but guidance is available to outline the frequency of vision testing to ensure a standard approach is recommended by health and social care professionals for all LAC.

<http://www.fodo.com/resource-categories/frequency-of-sight-tests>

7 Care Leavers Health Summary

Key Highlights

- CCG's and LA's should have in place commissioned arrangements to furnish all eligible 16-17 year olds with a Leaving Care Health Summary, adopting a standardised approach, using a standard template and a robust quality assurance process.

Standard – All children aged 16-17 years should receive a summary of their health records in line with, [‘Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)’](#).

This guidance states that CCG's and Local Authorities should have in place commissioned arrangements embedded within the LAC service specification, to meet this statutory requirement to furnish all eligible LAC aged 16-17 years, with:

- A summary of all health records (including genetic background and details of illness and treatments);
- How they can access a full copy of their health records, if required.
- Information needs to be given to care leavers sensitively and with support, with an opportunity to discuss it with health professionals.
- Young people leaving care should be able to continue to obtain health advice and services, and know how to do so.

In some areas that have commissioned leaving care health summaries, this has been jointly 50/50 funded by the CCG/LA, as it is presented as a joint requirement in, [‘Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)’](#). In addition, the summary has been collated and delivered by the Local Provider Specialist LAC Team for all responsible children placed in and out of area, with local arrangements determining who collates this output.

Timeliness and Quality Assurance Process for Care Leavers Health Summary

To determine the qualities of a Care Leavers Health Summary, there should be an internal robust self-assessed quality assurance process in place by the Provider. Best practice would be that the clinician completing the summary should self-assess against a standard of good quality using a standard assurance template; with quarterly dip sampling by the Named Nurse for LAC in place as internal assurance. In addition, quality assurance and audit from a Designated LAC Nurse and Doctor perspective could be in place, to assure the CCG that they are meeting their statutory duties. Adding a Care Leavers Health Summary audit alongside a bi-annual Peer Review Audit process with Designated Professionals from neighbouring CCG's

of all returned IHA and RHA could be adopted, utilising the quality assurance template below. The audit findings should be shared with the Provider, as well as at Strategic and Operational Health of LAC meetings, Internal Performance Monitoring Meetings, as well as for LSCB, CCG Governing Body and Corporate Parenting Assurance meetings.

Best practice examples:

- App 11.1 – Leaving care health summary template.
- App 11.2 – Leaving care health summary process.
- App 11.3 – Leaving care health summary self-assessed quality assurance tool.

A free innovative app is available to allow children leaving care to take responsibility for their health via a portable and secure electronic health record. The young person downloads the app free onto a portable device, registers and enters a password. The young person enters the data themselves from the health summary provided from the LAC Health Team.

- App 12.1 – A best practice Care Leavers Health App.
- App 12.2 – Press release – Portable Health App for Care Leaver.

8 Mental Health Services

Key Highlights

- Robust arrangement should be in place to meet the commissioned arrangements for LAC placed in and out of area.
- Arrangements should be in place to ensure LAC placed into area can access mental health care uninterrupted and contracts are amended to facilitate this.

Standard – CAMHS provision is commissioned to provide equity of service provision for ALL LAC

[‘Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)’](#), outlines that Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning of child and adolescent mental health services (CAMHS), and in commissioning services to meet the emotional and mental health needs for ALL LAC, including those children placed into area from other LA’s, with recharging arrangements in place as per Responsible Commissioner guidance.

They should also plan for effective transition and consider the needs of care leavers. Understanding the emotional and behavioural needs of looked-after children is important. Local Authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional well-being of individual looked-after children. SDQ scores can be aggregated to help quantify the needs of the local looked-after children population and should be used by local authorities and CCGs as they develop their Joint Health and Wellbeing Strategies (JHWSs). It also states, that if they wish, local authorities may use other tools to supplement the SDQ.

CRIES 8 is a screening tool that has been used in some areas with UASC, measuring children at risk for post-traumatic stress symptoms, and is designed to be used in children aged 8 and above.

<http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/>

9 Special Educational Needs (SEN)

Key Highlights

- Education and Health Care (EHC) Plans and the statutory LAC Health Assessments should be commissioned and co-ordinate in harmony to avoid duplication.

Standard – Streamlining the commissioning & service delivery processes of the Education Health Care Plan (EHC) and the Statutory Health Assessment

Two-thirds of looked-after children have Special Educational Needs (SEN) and key legislation outlines the statutory duties of local authorities in meeting these needs. Of those, a significant proportion will have a statement or a learning difficulties assessment. From September 2014, statements were replaced by Education, Health and Care (EHC) plans, with the transition process to be complete by 2016.

[‘Promoting the Health & Wellbeing Needs of Looked After Children \(2015\)’](#), outlines Health & Education’s statutory duties in relation to EHC & the statutory duties of the CCG & LA. There is an unwarranted variation in the integration of these assessments across the health economy. The guidance states that the looked-after child’s EHC plan works in harmony with their care plan, to outline how the child’s health needs in relation to accessing education are being met. CCG’s and Education Commissioners should review these arrangements to assure themselves that Providers are commissioned to co-ordinate assessments and reviews of the child’s care plan and EHC plan; without duplicating health appointments or commissioning two assessments, when only one is required to fulfil both statutory functions.

- App 13 – A best practice example of an EHC Plan Process for LAC.

10 Children in Custody

Key Highlights

- Children detained in youth custody are dis-applied from the statutory health assessment process (CHAT process in place), unless detained in Specialist Foster Care.

Youth Justice and the Secure Estate

The responsibility of the LA to promote the welfare of looked-after children who are so detained remains. That includes its responsibilities to maintain and review the child's health plan as part of his or her care plan. There is unwarranted variation related to Health Providers duplicating the standardised and validated Comprehensive Health Assessment Tool (CHAT) for young people in the youth justice system, with additional assessments or review of the CHAT to 'convert' it into an IHA or RHA. The example flow chart outlines the standard for the health assessment process for children on remand, and the Triax briefing states the LA responsibilities for Children on Remand.

- App 14.1 – A best practice example Flow chart of children on remand.
- App 14.2 – Triax Briefing: Local authority responsibilities towards children looked after following remand: Care Planning, Placement and Case Review (England) (Amendment) Regulations 2013.

Details of the Youth Justice Estate are outlined in the look up tool below:

<https://www.gov.uk/government/collections/secure-estate-for-young-people-contact-details>

11 Corporate Parenting: the role and responsibility of the CCG and Provider Executives, Designated LAC Doctor and Nurse, and Named Health Professionals for LAC

Key Highlights

- Assurance at Executive Board in CCG's, Providers, Local Authorities, LSCB's and NHS England of a robust and clear framework to ensure that LAC and Care Leavers (CL) wherever they are placed, are provided with a timely health service that promotes safeguarding, physical and emotional health needs.
- Designated LAC professionals, as clinical experts and strategic leaders, provide specialist advice and guidance to the Board and Executives of Commissioner Organisations on all matters relating to LAC and should be a member of the Corporate Parenting Board, influence the Health and Well-Being Board/Children's Trust Board, LSCB.
- CCG's demonstrate that their designated clinical experts are embedded in the decision making of the organisation with line management siting with the executive lead.
- Named and Designated professionals are distinct roles and as such should ideally be separate post holders' and the roles, responsibilities and accountabilities are explicitly defined in job descriptions aligned with expectations laid out in statutory and intercollegiate guidance.
- LAC Supervision should be in place, underpinned by local policy.

When a child comes into care, the LA becomes the Corporate Parent, as outlined in the Child and Social Work Act 2017. Health is not the legal corporate parent but is a partner in the corporate parenting role as per guidance below:

Children Act 1989 as taken NICE quality standards

A term used to describe the responsibility of any Local Authority as 'Corporate Parents' to all the children and young people who are in the care of that local authority (children and young people who are 'looked after' or 'in care'). A 'Corporate Parent' has a legal responsibility to ensure that the needs of children and young people in their care are prioritised in the same way as any concerned parent would want for their own children. The term covers all the members of the local council and any services provided by the local council.

Children Act 2004

The Children Act 2004 places local partner agencies (including the police and health services) under a duty to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.

The LA and partners have responsibility to act for that child in the same way that a good parent would act for their child. CCG's and Health Providers should identify an Executive Lead with responsibility for LAC. In addition, CCG's should have in place arrangements for a Designated Nurse and Designated Doctor; and Health Providers have in place Named Nurse and Doctor for LAC, as outlined in, ['Promoting the](#)

[health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)](#)’, [‘Looked After Children: Knowledge, Skills and Competences of health care staff. Intercollegiate Role Framework, 2015](#)’), and [‘Working Together to Safeguard Children \(HM Gov. 2015\)](#)’.

Designated Nurse for Looked After Children

A minimum of 1 dedicated WTE* Designated Nurse LAC for a child population of 70,000. A minimum of 0.5WTE dedicated administrative support to support the Designated Nurse LAC.

*While it is expected that there will be a team approach to meeting the needs of looked after children and young people the minimum WTE Designated Nurse LAC may need to be greater dependent upon the number of Local Safeguarding Children’s Boards, sub group committees, unitary authorities and clinical commissioning groups covered, the requirement to provide LAC supervision for other practitioners, as well as the geographical areas covered, the number of children looked after and local deprivation indices.

- App 14.3 – Best practice example of a Designated Nurse job description.

Designated Doctor for Looked After Children

A minimum of 8 hours per week or 0.2 WTE per 400 LAC population (excluding any operational activity such as health assessments). Activities include provision of strategic advice to commissioners/service planners, preparation of annual health report along with Designated Nurse, advice regarding policies, adverse events, training and supervision of Named Doctor.

- App 14.4 – Best practice example of a Designated Doctor for LAC Service Level Agreement and job description.

Named Nurse for Looked After Children

A minimum of 1 dedicated WTE Named Nurse for LAC for each LAC provider service. If the Named Nurse has a caseload, the maximum caseload should be no more than 50 LAC in addition to the operational, training and education aspects of the role. A minimum of 0.5WTE dedicated administrative support.

- App 14.5 – Best practice example of a Named LAC Nurse Job Description.

Named Doctor for Looked after Children

Minimum requirement includes one administration session per clinic (see British Association of Community Child Health Guidance), seeing up to four LAC for Initial Health assessment per clinic; 42 clinics scheduled per annum (168 IHA per year). Minimum of 1 PA (equivalent to 0.1 WTE or 4 hours per week) for named doctor role per 400 looked after children. This would include training, audit and supervision.

- App 14.6 – Best practice example of a Named Doctor LAC job description.

Specialist Nurse for Looked After Children Supervision

- App 14.7 – Best practice example of a Specialist Nurse LAC job description.

Safeguarding children supervision is central to safe care and therefore supports all practitioners to meet their professional standards to promote safe and effective practice in their place of work. Each organisation should have in place an agreed Safeguarding Supervision Policy that includes LAC. All professionals working with LAC are expected to receive supervision, and given the stressful nature of the work, the employing body must ensure that safeguarding focused supervision and support is provided. Supervision is a complex activity, it must acknowledge the stressful nature of child protection work, the functions and the elements of supervision, and also address the requirements of several stakeholders.

It is the Designated LAC Professionals responsibility to source appropriate supervision from outside their organisation, to provide supervision to colleagues across the health community, including the Named LAC Doctor and Nurse/s. Named LAC Professionals provide supervision to those delivering the service.

Below are supervision examples for consideration for use in practice:

Best practice examples:

- App 15.1 – Terms of Reference for Group/Action Learning set supervision
- App 15.2 – Supervision Template (Provider).
- App 15.3 – Action Learning Set/Records of Group supervision.
- App 15.4 – Group supervision contract.
- App 15.5 – Supervision for Specialist LAC Nurses support paper.
- App 15.6 – Level 5 Individual/Group supervision template.
- App 15.7 – Level 5 Supervision contract.

12 The Responsible Commissioner – Standard approach to Out of Area/Authority/Borough Placement of a LAC

Key Highlights

- Arrangements should be in place to ensure Looked After Children placed into area can access health care uninterrupted and contracts are amended to facilitate this.
- Arrangements should be in place between Providers and CCG's to facilitate payments as per 'Who Pays?' to meet health needs, but this should not delay the child accessing services and the needs of the child should be the first consideration.

NHS England guidance, '[Who Pays? Determining responsibility for payments to providers \(2013\)](#)', provides the framework for establishing responsibility for commissioning an individual's care within the NHS. Local authorities and CCGs should have agreed local mechanisms to ensure this guidance is followed when making placement decisions for looked-after children and for resolving any funding disputes that may arise. This is essential to avoid delays in looked-after children being assessed for, and accessing, the services they need.

'[Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)](#)', outlines that:

- When a child is first placed, the LA looking after them has a shared responsibility with the relevant CCG to ensure that a full health assessment takes place and that a health plan is drawn up and implemented.
- The LA should inform, among others, the relevant responsible CCG in writing of its intention to place a child in its area and advise whether the placement is intended to be long or short-term. The LA is expected to notify the relevant responsible CCG within five working days or as soon as reasonably practicable.
- Out of authority/area/borough placements of looked-after children; Where a CCG or a LA, or both (where they are acting together), arrange accommodation for a looked-after child in the area of another CCG, the "originating CCG" remains the responsible CCG. That is the case even where the child changes his or her GP practice.
- The originating CCG is responsible for commissioning the child's statutory health assessment(s) - see below the Example of a Service Level Agreement (SLA) for Initial and Review Health Assessment, including Market Forces Factor uplift. Also included is a calculation guide to Market Forces Factor (MFF) and MFF calculation spreadsheet to mitigate any delays and promote arrangement and agreements across the system.

- App 16.1 – Best practice example of letter to schedule statutory health assessment for LAC placed in area/borough.
- App 16.2 – Best practice example of letter to schedule statutory health assessment for LAC placed in area/borough.
- App 16.3 – Calculating costings factsheet.
- App 16.4 – Market Forces Calculation spreadsheet – National costing (April 2016-March 2017).

- Arrangements for primary healthcare are determined by GP registration.
- CCGs and NHS England should ensure that a child is never refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.

Of particular note in the Statutory Guidance is Point 18, which outlines the following:

'When looked-after children move placement or move into another CCG area and are currently receiving, or on a waiting list for, health services, their treatment continues uninterrupted. Looked-after children should be seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service. The length of a placement should not affect a child's access to services'.

Local contracts with Providers should be reviewed and amended to meet this standard.

All commissioners of health services should have appropriate arrangements and resources in place to meet the physical and mental health needs of ALL looked-after children, both those originating from the area and those placed into area. Therefore, access to services for LAC should be accessible for both Originating and Receiving LAC, with the commissioning and payment arrangements with CCG's and Providers secondary to meeting the needs of the child. Read codes and alerts should be used by Providers to determine commissioning responsibility and have recharging arrangements in place, as per, ['Who Pays? Determining responsibility for payments to providers \(2013\)'](#).

On occasion, issues may arise regarding timeliness and quality issues of IHA and RHA's. A standard approach to raising and escalating is outlined in the exemplar escalation pathway below.

- App 17 – Best practice example of an escalation process.

13 The Contribution of Primary Care Teams

Key Highlights

- Register the child as a permanent patient at the Primary Care Practice and ensure there are robust arrangements in place to use read codes to identify children LAC or as care leavers.
- Ensure there is a process in place to transfer records from the previous GP practice and if the child moves, arrangements are made to transfer records to the new practice.
- Liaison with the child's Social Worker and current Carer by the GP, as well as reviewing the historical notes of the child and 'learn the child', reviewing a copy of the most recent LAC health care plan and addressing any outstanding health needs.
- For the GP to be ready to offer continuity of care to the child, even if this means overbooking clinics or offering support via home visits for hard to reach young people.
- To maximise positive health outcomes, everyone needs to work creatively together and share information.

Primary care teams have a vital role in identifying the individual health care needs of looked-after children and those leaving care. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions. They may also have continuing responsibility alongside other members of universal health services for the child when he or she returns home.

- App 18- Best practice example of Primary Care expectations for LAC.

14 Supporting Foster Carers and Children’s Residential Care Providers to promote the Health Needs of LAC

Key Highlights

- LA and External Provider carer contracts should explicitly outline the expectations of foster carers and residential carers.

The LA, as commissioners of Foster and Residential Carers, should ensure that their contracts explicitly outline the expectations to meet the health needs of LAC, as per [‘Promoting the health and wellbeing of looked after children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England \(2015\)’](#).

- App 19 – Best practice example of a contract amendment for Providers of health care to meet the health needs of LAC.

15 Distribution and Implementation

This guidance will be made available for all Commissioners and Providers of health services.

16 Monitoring

This guidance will be overseen by the LAC Forum, with updates made to reflect any changes in statutory guidance.

17 Equality and Health Inequalities

Equality and diversity are at the heart of NHS England’s values. Throughout the development of the guidance and best practice cited in this document, we have given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in the Equality Act 2010). This policy and procedure will not discriminate, either directly or indirectly, on the grounds of the 9 protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation).

This guidance forms part of NHS England’s commitment to create a positive culture of dignity and respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice with regard to the characteristics.

18 Concluding Statement

NHS England welcomes the opportunity to participate with patients and members of the public. This guidance has sought to blend the science of the statutory underpinning legislation and the art of commissioning and service delivery. To decrease unwarranted variation, and promote positive outcomes for LAC through the production of an expert developed and peer reviewed suite of standard commissioning and delivery processes that promote standardisation of commissioning and provision to meet regulated duties.

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With thanks to the members of the National LAC Forum (and co-opted members) representing all 4 Regions of NHS England for their active contributions to the peer review of the best practice examples and critical appraisal of the document as a whole.

19 Appendix A

Best Practice Examples

Best practice examples are outlined below:

- App 1 – Mapping and gap analysis of LAC population & aligning services.
- App 2 – Physical LAC Service Specification.
- App 3 – The 7 Golden rules of information sharing.
- App 4 - A Process map to complete the Initial Health Assessment within the statutory timescale of 20 days.
- App 5 – Information from Local Authority required to arrange an Initial (and Review) statutory health assessment.
- App 6.1 – Practitioner self-assessed quality assurance template for statutory health assessments.
- App 6.2 – Health outcome database for Health Provider.
- App 7 – Terms of Reference for Strategic and Operational Health of Looked After Children Meetings.
- App 8 – LAC Health Assessment Decliner Pathway.
- App 9 – Outcome Focused Key Performance Indicator Targets.
- App 10 – Guide to Strengths and Difficulty Questionnaires (SDQ)'s for Professionals and Carers.
- App 11.1 – Leaving care health summary template.
- App 11.2 – Leaving care health summary process.
- App 11.3 – Leaving care health summary self-assessed quality assurance tool.
- App 12.1 – Care Leavers Health App.
- App 12.2 – Press release – Portable Health App for Care Leaver.
- App 13 – EHC Plan Processes for LAC.
- App 14.1 – Flow chart of children on remand.
- App 14.2 – Triax Briefing: Local authority responsibilities towards children looked after following remand: Care Planning, Placement and Case Review

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(England) (Amendment) Regulations 2013.

- App 14.3 – Designated Nurse for LAC Job Description.
- App 14.4 – Designated Doctor for LAC Service Level Agreement and Job Description.
- App 14.5 – Named LAC Nurse Job Description.
- App 14.6 – Named Doctor LAC Job Description.
- App 14.7 – Specialist Nurse LAC Job Description.
- App 15.1 – Terms of Reference for Group/Action Learning set supervision.
- App 15.2 – Supervision Template (Provider).
- App 15.3 – Action Learning Set/Records of Group supervision.
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- App 15.5 – Supervision for Specialist LAC Nurses support paper.
- App 15.6 – Level 5 Individual/Group supervision template.
- App 15.7 – Level 5 Supervision contract.
- App 16.1 – Letter to schedule statutory health assessment for LAC placed in area/borough.
- App 16.2 – Letter to schedule statutory health assessment for LAC placed out area/borough.
- App 16.3 – Calculating Market Forces costings guide.
- App 16.4 – Market Forces Calculation spreadsheet – National costing (April 2016-March 2017).
- App 17 – Escalation process.
- App 18 – LAC & Primary Care expectations.
- App 19 – Contract amendment for Providers of Health Care to meet the health needs of looked after children.