

# Healthy futures

Supporting and promoting  
the health needs of looked  
after children

# Foreword

Looked after children are our children. We in local government are their corporate parents. Children can come into our care for a variety of reasons. It may be as a result of neglect or abuse or illness or death in the family. Whatever the reason, it can have a traumatic impact that can last for years. It may be apparent early, or not manifest itself until later – but it is the cause of a much higher rate of emotional and mental health needs than amongst children as a whole. Looked after children and young people also have higher rates of poor physical health, sometimes the consequence of the disruption in their lives. Unless properly identified and supported, these increased needs can contribute greatly to a range of worse outcomes than can persist well into adult life.

Sometimes the way that health, education and social care services are provided can make it difficult for looked after children to get the help they require to address their health needs. They may miss school-based interventions such as immunisations through unstable schooling, and increased absence. Those placed outside their local authority area can face problems accessing health services for a variety of reasons. And the limited resources of mental health services may mean it is difficult to respond to the unrecognised or undiagnosed mental health needs of looked after children – who may also suffer mental health stigma.

So, children and young people in care, on the edge of care or who have been in care are doubly disadvantaged. Not only are they more likely to have health needs but the services they need to help and support them are often harder for them to access.

And local authorities not only have public health responsibilities towards these children and young people but also, of course, our vital corporate parenting responsibilities.

This unique dual role brings challenges, not least over resources. But it also enables us to influence directly, and to improve the historically poor outcomes for those in care and care leavers. And there are grounds for optimism. The proportion of looked after children who are up to date with immunisations, dental checks and development and health assessments is increasing, and we are at the beginning of a period of unprecedented investment in mental health services for young people – with 85 per cent of local transformation plans (LTPs) identifying specific activity for looked after children and care leavers. The LTPs provide the baseline against which we will be judged in future.

Increasingly, councils and councillors are talking – and listening – to the looked after children and young people in their area about their experiences of services; we need to do more of this. We must aim for a future in which the care and support we offer, enable looked after children and young people to enjoy the same levels of health as their peers.



A handwritten signature in black ink, appearing to read 'Izzi Seccombe'.

**Cllr Izzi Seccombe**  
Chair, Community Wellbeing Board



A handwritten signature in black ink, appearing to read 'Richard Watts'.

**Cllr Richard Watts**  
Chair, Children and Young People Board

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# Introduction

**“If we can get it right for the most vulnerable, such as looked after children and care leavers, then it is more likely we will get it right for all those in need.”**

**Future in mind,  
DH/NHS England, 2015**

All children have health needs, and local authorities now have a major role in meeting these. But looked after children<sup>1</sup> and young people have higher levels of health needs than their peers, and these are often met less successfully – leading to poorer outcomes. In particular, they have significantly more prevalent and more serious emotional and mental health needs (mainly because of the frequency with which these children enter care with problems arising from poverty, abuse, neglect, or trauma from other family circumstances).

This does not mean that every child or young person who is looked after has greater needs. But practitioners providing services to children and young people, and to families with children, should be aware of the increased likelihood that this might be so. And ‘the system’ must be able to identify those individuals whose needs are greater and to provide the support they need, both in a timely manner. Getting this right can change lives.

Local authorities have a twofold responsibility for looked after children: their corporate parenting role; and their public health role, which applies across the whole community, but requires particular consideration in respect of looked after children and young people.

There are around 70,000 looked after children in England, according to government statistics, the majority (60 per cent) of whom become looked after due to abuse or neglect; most (75 per cent) are placed with foster carers. Fifty-six per cent of placements (38 per cent of foster placements) are outside the placing local authority’s boundary; 18 per cent (14 per cent of foster placements) are over 20 miles from the child’s home. The relevance of these statistics will become apparent below.

The following sections cover some key statistics on the main additional health needs looked after children and young people experience; some underlying themes and key messages; local councils responsibilities and some questions for members to raise locally.

In recognition of the work that is already underway in many local areas, there are seven case studies of positive initiatives in local authorities around the country. These provide a useful starting point for local councils to take practical action in their own areas.

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<sup>1</sup> Children and young people up to age 18 in the care of a local authority

# Key statistics

## Numbers and circumstances

- There are over 70,000 looked after children in England.
- Six per cent of looked after children are unaccompanied asylum seekers.
- The majority (75 per cent) of looked after children are placed with foster carers.
- Over 60 per cent of children in care are looked after due to abuse and neglect.

## Physical and mental health

- The majority of looked after children (87 per cent) are up to date with immunisations and their annual health check (90 per cent), as well as having their teeth checked by a dentist (84 per cent). Figures are lower for children aged over 16.
- Two thirds of all looked after children have at least one physical health complaint.<sup>2</sup>
- Almost half (49%) of children looked after had 'normal' emotional and behavioural health, 13% had 'borderline' scores and 38% had scores which were a cause for concern.<sup>3</sup>
- Looked after children are around 10 times more likely than their peers to have significant learning difficulties.
- In 2012, it was reported that looked after children and care leavers were between four and five times more likely to self-harm in adulthood.

<sup>2</sup> It should be noted that this data is taken from the 2002 ONS Survey The Mental Health Needs of Children Looked After by Local Authorities in England

<sup>3</sup> Scores referred to are from the Strengths and Difficulties Questionnaire.

## Health and risky behaviours

- Four per cent of looked after children are identified as having a substance misuse problem and eleven per cent of 16-17 year old looked after children are identified as having a substance misuse problem.
- Almost a quarter of looked after girls become teenage mothers.
- Young people who have been looked after are three times more likely to be a parent by 18.

# Themes and key messages

A number of common threads run through the wide range of research, reports and publications looking at the health and wellbeing of looked after children and young people, including:

- Health (especially mental health) outcomes for looked after children are significantly worse than for the child population as a whole. It is now widely recognised that this has been the case for too long, and the level of activity (and investment) to improve the situation has recently increased a great deal.
- There is significant local variation in outcomes which is the result of differences in the organisation and effectiveness of services, so in most areas there is scope for improvement – and there is a growing number of areas from which to learn.
- It is essential to involve children and young people both in their own health and wellbeing and in improving the services they use.
- Improving the mental health and wellbeing of young people is not just a job for CAMHS, it is a task in which all practitioners in contact with children and families have a role to play. It is also vital to raise awareness and knowledge of mental health issues in the community, including in schools, to improve outcomes and reduce stigma. Staff training and development is obviously vital, but so is development and support for foster carers (and post-adoption support where needed).
- Children, young people and families benefit most from an integrated approach to support provision, which follows them through their 'life journey'. Treating their physical and mental health needs holistically, through services which are properly 'joined up', avoids the problems of negotiating a fragmented system.
- Children in care generally have fewer problems accessing services if they are placed in their 'home' authority, which also helps to maintain important social relationships. Support is especially important at times of transition.
- Early identification and support of health needs, particularly mental health needs, greatly reduces escalation of problems, the costs of which – both personal and economic – can have a major impact both on individuals and wider society.

# What are local councils' responsibilities?

## Public health commissioning: the Healthy Child Programme

Local authorities<sup>4</sup> now make a major contribution to health provision in their areas, through a range of roles and functions. They are responsible for public health, which includes responsibility for commissioning the Healthy Child Programme 0-5 and 5-19 programme.

Councils' commissioning responsibilities in the early years mean they are well placed to work with health visitors and council staff to identify families with children who are potentially vulnerable and at risk of poorer outcomes before children enter the care system. Health visitors can provide targeted support themselves and/or work with other professionals to provide intensive and multi-agency targeted packages of support where additional health needs are identified. This makes sense from both a "human" and "economic" perspective for councils.

### The need to upstream intervention

- Returns of four to one are reasonable to expect by shifting to preventative spending.
- 75 per cent of children's social care spending is "protective" as opposed to "preventative."

A stitch in time, the case for early support

The Healthy Child Programme 5-19 focuses on school aged children. It offers children and young people a schedule of health and development reviews, screening tests,

immunisations, health promotion guidance and tailored support for children and families with additional support needs; this includes identification of children, young people and families with problems that might affect their chances later in life.

School nurses work in partnership with other professionals such as school leaders, teachers and youth workers to deliver the programme, supporting children and young people to become healthy decision-makers in lifestyle choices, particularly in relation to physical activity and healthy eating, emotional wellbeing, smoking, sexual health, alcohol and substance misuse. Particular attention is paid to vulnerable children who experience worst health outcomes, such as children in care.

## Role of the Health and Wellbeing Board

At a leadership and strategic level, local authorities' public health role is exercised through health and wellbeing boards (HWBs). The HWB needs to consider the health needs of looked after children in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). The information gathered as part of this process should be used to identify gaps in provision to meet the physical and mental health needs of looked after children and inform strategic commissioning priorities.

HWBs have been working with clinical commissioning groups (CCGs) to develop local transformation plans (LTPs), which set out the full spectrum of interventions for CAMHS, from prevention to support and care for existing, or emerging mental health problems in an area.

<sup>4</sup> Public health responsibilities lie with upper tier and unitary authorities, while some health protection functions lie with lower authorities (in two-tier areas)

Eighty-five per cent of plans identify looked after children and care leavers as a priority group. Whilst plans are being led by CCGs, HWBs are a key partner in overseeing and developing them and ensuring local accountability for how money is spent.

## Council's corporate parenting responsibilities

As well as their public health responsibilities, councils act as the corporate parents of children in their care. A corporate parent should have the same aspirations for a child in care or a care leaver as a good parent would have for their own child.

### The Children and Social Work Bill

The Children and Social Work Bill, introduced in the House of Lords in July 2016, proposes a set of corporate parenting principles to which local authorities in England would have to regard in respect of looked after children and young people. At the time of writing, the Bill had a long way to go before becoming an Act.

Corporate parenting responsibilities include having a duty to safeguard and promote the welfare of looked after children, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

## Working with health partners

It is the responsibility of the local authority that looks after a child to arrange their health assessment in partnership with health professionals. Information about the child's physical, emotional and mental health needs should be recorded in a health plan.

As corporate parent, the local authority must ensure that children and young people receive the health care services they require as set out in their health plan. This includes medical and dental care treatment as well as advice and guidance on personal health care and health promotion issues.

The local authority must also ask the main carer of a looked after child to complete a strengths and difficulties questionnaire (SDQ). This is to help understand the emotional wellbeing of a child or young person. Information from this should be available to inform and feed into the health plan.

Where a looked after child, child entering the care system, or a child leaving care moves out of the CCG area, councils need to notify their CCG and the child's GP. In the case of an out of borough placement, they must also notify the CCG where the child is moving to. Looked after children should never be refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.

## Working with schools

Councils also need to work closely with schools. In particular, they are required to appoint a virtual school head (VSH) to promote the educational attainment of looked after children. In recognition of the relationship between health and educational outcomes, councils must make sure that the VSH and designated teacher for looked after children are aware of any physical, emotional or mental health needs that can impact on learning.



## Care leavers

The Government's Care Leavers Strategy identifies five outcomes for children leaving care, including a specific outcome on improved access to mental health and wider health support. It is recognised that access to support for care leavers can be particularly challenging, as leaving care coincides with a transition from children's health and wellbeing services such as CAMHS to adult's services. Local authority commissioners need to make sure there are clear pathways in place which identify what happens at key transition points, such as when a child leaves care.

An Expert Working Group has been set up by the Government to produce care pathways, quality standards and models of care for looked after children and care leavers with mental health problems. This will consider the best way of improving outcomes for care leavers on the evidence available. Guidance for professionals working with care leavers and for local authority commissioners, is due in October 2017.

Any young person who is at increased risk of substance misuse, including those who are leaving care, should be provided with targeted prevention support which focuses on reducing risks and strengthening resilience. Through commissioning of public health services, local councils should ensure they have clear referral pathways into specialist substance misuse services for those young people who are assessed as requiring structured drug and alcohol interventions.

### Substance needs of children in residential care – Matrix and South Tyneside

"Matrix work to a protocol developed in partnership with the children's homes to ensure all young people coming into the homes have their substance related needs considered and addressed. We have also provided an education work book that key workers in the homes can do with the young people if they decline Matrix intervention.

To ensure those in foster care placement have equitable access to address any needs, we also provide specific training to foster carers and have developed direct referral pathways.

We try to provide creative ways of engagement and support staff with the work book. We also provide support to foster carers. As we move towards an edge of care model, Matrix will continue to play a significant role both with those on the edge of care and those children who are looked after."

Melanie Soutar, Manager, Matrix Young People's Service

### A framework for supporting looked after children who are teenage parents

In 2016, Public Health England (PHE) with the LGA published a framework for supporting teenage mothers and young fathers. It includes specific actions that councils at a local level with their partners can implement to ensure that looked after children and care leavers who are parents get the support they need. This includes sexual health included in the annual health check for young men and women; training for social workers to provide consistent support for looked after young people on sexual health and pregnancy; and tailored antenatal and postnatal support groups if looked after young parents are reluctant to access mainstream services. A number of actions are highlighted for partnership working, including arrangements with the sexual and reproductive health service to provide contraception and advice for young parents who have been looked after.

# Some questions you can ask locally

## On improving outcomes...

How do outcomes for looked after children in your local area compare with those in other areas? (Data are available from the National Statistics website)

What role does the health and wellbeing board play in ensuring that the council and its partners are working together to improve outcomes for looked after children?

Are the health needs of looked after children (including their emotional and mental health needs) adequately recognised in:

- the Joint Strategic Needs Assessment?
- the planning, commissioning and delivery of services provided?

Do you review the effectiveness of services you provide based on outcomes?

## On delivery...

What initiatives are there to help identify “at risk” children and families as early as possible, and prevent the need for care proceedings?

Are health care and development assessments for looked after children up to date?

Are looked after children a priority group for getting access to child and adolescent mental health services (CAMHS) and how long are waiting times for referrals?

As an at-risk group, what access do looked after children and young people get to services to help with substance misuse, sexual health and teenage pregnancy?

What support is given to foster carers and young people themselves about promoting healthy lifestyles?

Are birth parents, foster carers and care staff (and, if necessary, adoptive parents) provided with adequate training and support on emotional and mental health issues to enable them to both recognise and respond to needs?

Does the authority make sufficient effort to avoid out-of-area placements, and to ensure adequate contact when such placements are made?

### **On involving children and young people...**

What are the views of children and young people on how well their physical and mental health needs are met?

How do professionals working with children and young people ensure they are involved and have a “voice” in their own health and wellbeing, including how their identified needs are met?

Are children and young people (and parents/carers) routinely asked about their experience of services and how is this feedback used?

### **On integrated service provision...**

Are local services yet sufficiently ‘joined up’ to provide easily accessible care and support when it is required; if not, are adequate plans in place to bring this about?

Do the council and its partners have arrangements in place to ensure continuity of care and support through key transition points in a child’s or young person’s life?

Is there an agreed local protocol on information sharing within and across services?

# Case studies

## Leeds City Council: the journey to 'good'

"The greatest single challenge facing staff at all levels is finding the space to simply 'stand still' and reflect on their own personal effectiveness, and the collective effectiveness of their service area... We know that our most expensive service is the one that doesn't work. We simply cannot rely on service failures to tell us which ones these are. We must create the space within our working worlds to critically reflect on our effectiveness, whether this is in one-to-one sessions, our team meetings, our staff conferences and our service review processes."

**Head of Integrated Safeguarding Unit  
Leeds City Council**

In March 2015, Ofsted judged Leeds City Council's services for children in need, looked after children and care leavers as 'good' and the leadership, management and governance as 'outstanding'. Only five years earlier, inspectors had found safeguarding 'inadequate' and services to looked after children 'adequate'; an Improvement Notice was placed on Leeds and an Improvement Board established. So, how was this transformation achieved?

Leeds undertook a wholesale service restructure. This included a new senior leadership team (operational and political) and a clear strategic vision for children's services in the city: Child Friendly Leeds.

From the outset, Outcomes Based Accountability (OBA) was adopted as the means through which the council and the wider partnership would manage and judge their collective efforts, asking: how much did we do? How well did we do it? Is anyone better off?

Three fundamental behaviours were adopted to guide every aspect of work with children and families: listening to the voice of the child to guide practitioners' decisions; using approaches, techniques and language that work with families to solve problems; and using OBA to consistently question whether anyone is better off as a result of the work, and shape and improve services accordingly.

There was a particular emphasis on the use of OBA across the 25 local area 'clusters'. A range of partners including schools, children's centres, health professionals, youth services, voluntary sector organisations, police and local elected members worked together to provide a holistic approach to improving outcomes for children and young people in their locality.

In addition, feedback – including the views of children and families, performance data, and practice wisdom and knowledge (from staff working with children and families, and the findings of external and internal inspections, audits and evaluations of practice) – was used to underpin a quality improvement framework to improve outcomes for children and young people in Leeds.

Overall, the approach is to embed the processes of audit and quality assurance where they belong – within the services themselves. The risk in this approach is acknowledged, (and some central audit capacity is maintained), but the principle is clear.

"We believe that if we create the right cultural conditions, managers and staff should be able to sit down together and use their collective knowledge, experience and wisdom to see patterns and connections in this feedback and to use it as a starting place for an honest and inclusive conversation about how to improve 'the child's journey.'"

**Head of Integrated Safeguarding Unit  
Leeds City Council**

As part of its effort to build a common understanding of different roles, responsibilities and services across the children's workforce, Leeds has produced a series of 'one minute guides'; this includes one outlining its therapeutic social work team, and another on multi-systemic therapy (widely used in the city), and how they fit with other provision. All guides are available on the Leeds Council website.

### Contact

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# East Sussex County Council: AdCAMHS (Adopted child and adolescent mental health service)

“It’s about making sure that right from the start the child’s views are heard, the adoptive parents are given all of the support they need, and the family has the help and support to make sure that adoptions are as successful as possible... services such as AdCAMHS play such an important role in making sure adoptive families are able to access the support they need as and when they need it.”

**Children and Families Minister Edward Timpson, official launch November 2014**

AdCAMHS is a jointly commissioned specialist service developed and established between East Sussex County Council and Sussex Partnership NHS Foundation Trust. The council and NHS established the service to meet the psychological and emotional needs of adopted children and young people who present with complex difficulties, but do not necessarily meet the threshold to access CAMHS. Social care and health staff work closely together to provide assessments and treatments to adopted children, young people and their adoptive families who are struggling emotionally.

The AdCAMHS team receives referrals from the post-adoption team. Referrals present a range of issues affecting children and their families, usually related to the child’s early, pre-adoption experiences. The process begins with a joint consultation with the adopted young person, to try and understand as fully as possible their history and the nature of the current difficulties in order to make a sound assessment; this is usually followed by consultation with the adoptive parents, to ensure that they are involved in the process.

The service is currently working with 64 families. The team includes four psychotherapists and two social workers (part of the post-adoption support team).

In addition, two part-time staff with education backgrounds (paid for through the Adoption Reform Fund) are located in the ‘virtual school’ to work specifically with adopted children, and to support adoptive families on dealing with schools; they also provide training to schools on attachment issues. They attend meetings at the child’s school, along with the school’s SEN Coordinator and other AdCAMHS staff, and take part in therapy reviews.

‘Multi-treatment interventions’ may include individual psychotherapy, family work and couples work; psychological assessment clinics; and group therapy for adolescents and families. The majority of sessions are held in clinics, but other possible locations include at home, ‘woodland days’ and at a local theatre.

The service aims to provide ‘tailor-made’ packages of care and support for adoptive families, contributing to adoption stability and promoting positive attachments.

“The AdCAMHS team have been very supportive to us as a family. As specialists in their field we feel that they totally understand our issues and act as a voice to other services on our behalf.”

**Survey respondent to East Sussex Healthwatch questionnaire**

AdCAMHS also has a research component, in liaison with Sussex University, which involves recording emerging patterns within families of relating and interacting throughout the duration of receiving the service. This will help to understand what is effective in terms of future service provision.

## Contact

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## Essex County Council: 'Open up – reach out'

Essex County Council, Southend-on-Sea Borough Council and Thurrock Council – with seven clinical commissioning groups (CCGs) have used their local transformation plan (LTP) to bring about 'a major change...to improve the emotional wellbeing and mental health of children and young people' across the whole Essex area.

The plan, Open Up, Reach Out, is underpinned by engagement with young people, parents and practitioners.

To understand the views of young people, Healthwatch Essex delivered the YEAH! Project (Young Essex Attitudes on Health and Social Care) working with Essex Boys and Girls Clubs (a registered charity supporting 140 voluntary youth groups and clubs). Through the project, they were able to understand the 'lived experience' of a representative sample of over 400 children and young people who highlighted the following messages:

- Young people don't know enough about mental health, or the services available; there is still a strong stigma attached to mental health problems, which could be reduced by moving away from institutional style services towards familiar and friendly settings – with support in schools the most popular choice.
- 80 per cent of young people don't know where to get mental health support, and 90 per cent want to learn about mental health.
- Young people need help for self-harm and eating disorders, but often those who try to get help have to wait too long.

This feedback has been reflected in decisions in the LTP, which sets out how £3.3 million of additional funding for Essex, Southend and Thurrock is to be invested to make more services available and easier to access.

"We are moving from a traditional tiered service delivered by fragmented, multiple providers to a single integrated services across seven localities. Over the next five years, we are promoting a cultural transformation from a traditionally reactive service to one that invests in prevention, early intervention and resilience for children, families and communities."

**Head of Commissioning Essex County Council**

The new plan is built on six agreed principles:

1. Early action – avoiding and preventing mental health problems
2. No judgement, no stigma – with care that is right for each individual, delivered in safe places and with children and young people having a say in decisions
3. Support for the whole family – with care as a part of daily life, backed up by professionals and specialists when needed
4. Inform and empower – with simple to access, information for everyone providing the tools for self-care and resilience, as well as recovery
5. Joined-up services – efficient, effective and clear for all to understand
6. Better outcomes – through evidence-based care and listening and responding to feedback.

Since 1 November 2015, all CAMHS across Essex, Southend and Thurrock have been re-named Emotional Wellbeing and Mental Health Service (EWMHS). Services are provided by North East London NHS Foundation Trust (which also provides similar services to four north east London boroughs), through delivery of preventative programmes in schools; advice, training and support for other health and social services; and a range of services from parenting and family groups to crisis support (and hospital admission if needed).

Online and digital services are also being rolled out, with a booklet published to describe and publicise the service.

**Contact**

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## Tower Hamlets Council: “Let’s talk about teeth” project

The “Let’s talk about teeth” research project in 2014/15 assessed the dental health needs of looked after children in Tower Hamlets, and explored foster carers’ dental health attitudes, knowledge, behaviours and experiences of looking after children’s dental health and care.

While it is known that looked after children are more likely to experience physical, mental and sexual health problems than other children, there is little evidence about their dental health because they are not identified in local or national dental health surveys. Annual dental checks (which are part of the annual health assessment of looked after children) only document if children have had a dental visit in the past year, so little is known about what problems looked after children have or what treatment they have or need. No previous research had looked at foster carers’ experience of managing and supporting looked after children’s dental health.

The research comprised a dental health survey of five to 15 year-old looked after children placed by Tower Hamlets in foster homes, with contact arranged through social workers. Short dental survey check-ups were carried out in their foster homes by a specially trained dentist using the UK 2013 Children Dental Health Survey protocol. Twelve to 15 year-olds also completed a survey questionnaire. The second part of the project involved focus group interviews with long-term foster carers in Tower Hamlets, to explore their knowledge, attitudes and experiences and identify training needs, which could be fed back to foster carers or included in training resources.

Key findings from the survey included:

- 36 per cent of five to 11 year-olds had experienced tooth decay in their primary (baby) teeth; 9 per cent had had a primary tooth extracted because of decay
- 19 per cent of 12 to 15 year-olds had had one or more untreated decayed permanent tooth

- 27 per cent of 12 to 15 year-olds had had a permanent tooth extracted because of decay
- 12 to 15 year-old looked after children in Tower Hamlets had a higher number of decayed, extracted and filled permanent teeth than 12 year-olds in Tower Hamlets, London and England in 2008/9 reported in the NHS dental epidemiology programme
- Teenage looked after children had high plaque and calculus levels despite most reporting twice daily brushing, suggesting that ineffective brushing may be more of an issue than infrequent brushing
- 18 per cent of five to 11 year-olds and 15 per cent of 12 to 15 year-olds had an untreated tooth fracture; 37 per cent of 12 to 15 year-old girls had a tooth fracture compared to 6 per cent of 12 to 15 year-old boys; and a higher proportion of looked after children in Tower Hamlets had a tooth fracture compared to children in England reported in the Children’s Dental Health Survey in 2013
- 46 per cent of 12 to 15 year-olds had a definite need for orthodontic treatment based on dental health and aesthetic reasons – a higher rate than for [all] 12 year-olds in Tower Hamlets, London and England in 2008/9
- 32 per cent of 12 to 15 year-olds felt that a dental problem had affected their daily lives in the preceding three months.

A final report and a forthcoming peer-reviewed scientific publication describe the project in full. Tower Hamlets Council and Barts and the London School of Medicine and Dentistry have published a booklet, “Ten key questions for foster carers,” that answers the questions most frequently raised by foster carers during the project. The full report and booklet are available on request.

### Contact

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# Greater Manchester: 'Handle With Care' commitments adopted

"In Greater Manchester we're committed to supporting young people in care, especially when a move out of their local area is necessary. Moving into a new area can be a difficult experience at the best of times but for young people in care it can mean losing contact with friends, family, their school and social workers. We want to put an end to this, ensuring that young people are only moved when absolutely necessary and, if a move is necessary, they are fully supported and involved in the process. These recommendations have come through engagement with young people who have experience of care, so will undoubtedly make a real difference."

**Councillor Cliff Morris, GMCA Lead for Children's Services**

The Greater Manchester Combined Authority (GMCA), comprising the leaders of the 10 city region's councils (and the interim elected Mayor), has agreed a set of commitments to looked after children and young people who are placed outside their own local authority areas.

The measures will improve the level of support that they receive, to help overcome the difficulties that often accompany such placements. The Children's Society drew up the proposals, working with young people affected and drawing on their experiences. They then worked for their adoption across the city – under the campaign 'Handle With Care'. Councils were urged to place looked after children and young people out of their local community only where this was absolutely necessary, or was in the best interests of the young person; for example, where they would otherwise be at risk of abuse or neglect, where there is a suitable placement available with a relative or friend, or where there is an appropriate opportunity for adoption.

When they are placed out of their local authority area, the commitments include:

- Ensure young people can contact family and friends, and receive appropriate support from their social worker – with all arrangements to be reviewed.
- Make sure social workers always have a discussion with the young person about the reasons for the move and give them at least one month's notice where possible.
- Avoid arranging any move out of area at a time which could disrupt a young person's education, unless totally necessary.
- Explore the possibility of creating a 'Welcome Pack' for young people including details about their new area, transport information, services available, etc.
- Make sure the young people have the luggage needed to move and discuss arrangements for transport.

Young people told The Children's Society staff about the problems that can arise with being moved out of the area, even if it is for good reasons. Moves sometimes come with little notice, leaving little time for preparation; it's often difficult staying in touch with friends and families; and settling into new schools can be challenging. Sometimes there is a reduction in face-to-face time with social workers and independent visitors, or restricted access to specialist support.

Rob Jackson, Greater Manchester Area Director at The Children's Society, said: "While there is good practice in Greater Manchester, there are also clearly many instances in which support could be better and we are delighted that our local councils have made this commitment."

## Contact

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# Norfolk County Council: rapid quality improvement cycle for health assessments

“Descriptions of promoting health and addressing lifestyle issues (such as hygiene, healthy diet and exercise) were improved, and there was evidence of good quality and appropriate brief interventions, referrals and action planning across all age groups; the majority of health assessment summaries recorded that the child or young person’s concerns and comments about their health and wellbeing were sought and recorded; and most of the summaries were informed by a range of sources and methods to assess emotional wellbeing.”

**Public Health Officer, Norfolk County Council**

These observations were ‘quick wins’ from a piece of focused work initiated early in 2016 across Norfolk services for looked after children and young people, to improve the quality and timeliness of health assessments. A multi-disciplinary project team, supported by audit specialists from children’s services and Public Health, undertook an evidence-based, rapid, quality improvement cycle. This followed a recognised, four-phase process:

1. scoping, planning and preparing a collaborative audit
2. measuring performance against current evidence-based criteria and standards
3. communicating results to providers, combined with collaborative action planning for improvement
4. planning of re-audit and improvement.

Drawing together national standards, statutory guidance and recent service reviews from Ofsted and Care Quality Commission led to the identification of four key areas which required a focused initiative to bring health assessments up to the highest possible standard:

- documenting mental health and wellbeing
- standardising the documentation and discussion of consent

- making assessments age appropriate
- documenting the child or young person’s involvement in their health assessment.

The team developed audit standards and criteria, and piloted a data collection tool. They calculated the overall case note sample size, and the LACYP Designated Nurse and Designated Consultant from Norfolk Community Health and Care reviewed the final standards and criteria. An appropriately experienced and qualified team from Children’s Services and Public Health collected the data, which were analysed by the Public Health Intelligence team.

The results were presented to stakeholders at an action planning meeting within two weeks of the audit. During the period between the scoping (in March) and the audit (in May), a number of improvements were observed in both the quantity and quality of observations, outlined above.

Several general areas for more focused improvement were also identified:

- making use of the strengths and difficulties questionnaire (SDQ) to optimum benefit of the looked after child or young person
- documenting the assessment of the child or young person’s ability to give consent for sharing the information from the health assessment
- standardisation of practice on documenting the child or young person giving explicit consent.

Stakeholders made recommendations for a number of further improvements at the action planning meeting, many concerning the interface between agencies and the flow of information between them. Re-audit and further action planning were scheduled for September 2016.

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# Bristol City Council: Drugs and Young People Project (DYPP)

“...helping me move into my first flat, helping me stop my weed addiction, helping me to get my first job. Wouldn't've done it without [worker]'s support.”

## Young person supported by the programme

The Department for Education (DfE) cost-benefit analysis shows that specialist substance misuse treatment delivers a total benefit of £4.66 to £8.38 for every £1 spent, making the case for the work of the Drugs and Young People Project (DYPP) in Bristol both a “human” and “economic” one.

The project works with children and young people affected by substance misuse – their own and that of parents and carers. They are referred by social workers, and the project is jointly funded by Bristol City Council and Public Health England.

In 2015/16, 131 young people (including 76 new referrals) received a service from one of the project's two parts: ‘At Risk’, working with young people who are using drugs or alcohol; and ‘Hidden Harm’, working with children and young people affected by the drug or alcohol use of parents or carers.

Two thirds of the 26 new referrals to At Risk are looked after children; the others are the subject of a child protection plan/order or are children in need. Their average age is 14.2 years (ranging from 12 to 17). Young people referred for an At Risk service are offered an appointment within 15 working days, but usually much sooner. Those accessing the service include young people who also experience parental substance misuse, domestic violence and offending, and some where sexual exploitation is a concern; a number are in transition, moving into independent accommodation.

Hidden Harm promotes resilience and reduces risk with children and young people affected by their parents' substance use (mostly heroin and crack cocaine or alcohol). The majority of these parents are chronic users, many with social work involvement over a long period. A key aim is to minimise the number of children and young people who replicate parental patterns of misuse. Fifty-eight per cent of new referrals to Hidden Harm are subject to a child protection plan, 14 per cent are looked after (two are both), and the rest are children in need. Their average age is 9.9 years (ranging from 5 to 14).

Hidden Harm has a Groupwork programme, which has been running for eight years, and ran three times in 2015/16. This covers safety planning, understanding addiction, confidence building, relationships and issues of identity, and First Aid (with St John's Ambulance).

An independent evaluation of Groupwork ‘provided positive evidence of the very real benefits that carefully designed group work can provide for young people affected by the substance misuse of their parents.’

Evaluation of Hidden Harm's work by Public Health Bristol in 2014 identified the particular importance of positive activities with young people: “these activities contribute to reducing risk and building resilience, particularly in the areas of health, family relationships, feelings and friendships.”

The programme seeks to involve young people in shared decision making about their care and how services could be improved. Each young person, their parent or carer and their social worker are given evaluation forms at the end of their involvement, and feedback – which is overwhelmingly positive – contributes to planning and development of the project.

Some tangible outcomes and achievements of the project include young people reducing and ceasing alcohol and drug use; returning to school full time, completing courses and passing exams; taking up apprenticeships, college places and jobs; and demonstrating significant improvements in emotional wellbeing.

As with some other services, DYPP's budget is being reduced, this will bring additional challenges in managing capacity. Currently waiting times are managed through rigorous review and closure procedures, and by prioritising those most in need.

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