

# **Guidance on Health Assessments for Looked After Children and Young People in Scotland**

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## MINISTERIAL FOREWORD



The Scottish Government's vision for children and young people is clear. We want Scotland to be the best place in the world for them to grow up; a place where rights are respected and where children can access all the opportunities and support they need. We want Scotland to be a place where children have the best start in life and live longer, healthier lives.

All children should have the chance to fulfil their potential and there should be no difference between the outcomes of young people in care and their peers.

I am delighted to introduce this guidance, which has been produced on behalf of the Looked After Children Strategic Implementation Group, to assist those involved in carrying out health assessments of our looked after children and young people. This document sets out the minimum standardised elements of a health care pathway which we would expect Boards to implement in collaboration with local authorities and other organisations. I would like to thank everyone involved for their contribution and re-emphasise the importance of recording and reporting on the health and well-being of looked after children and young people.

Looked after children and young people share many of the same health risks and problems as those who have not been in care. But in addition, they may have been exposed to additional risks to their well-being including poverty, abuse and neglect. They often experience multiple placements and daunting statutory processes which can be detrimental to their emotional and physical well-being whilst in care.

Good health makes an active and enjoyable life possible, as well as underpinning achievement in school and, in due course, the work place. It is therefore crucial to identify a child or young person's health needs early in their care planning in order to ensure as far as possible that the health outcomes of children and young people who are, or have been, looked after will be as good as those who have not.

As corporate parents, we have a duty to improve the support to our most vulnerable children and young people. These children are our responsibility, are in our care, and we need to do the best for them that we possibly can.

A handwritten signature in black ink that reads "Aileen Campbell".

**Aileen Campbell MSP**  
Minister for Children and Young People

## PURPOSE AND AIMS OF GUIDANCE

Scottish Health Boards are required by the Scottish Government (through Chief Executive Letter 16, 2009) to provide all children who become looked after children with a health assessment within 4 weeks of notification.

This guidance has been developed to assist NHS Boards and local authorities with the discharge of that obligation. It sets out the process that should be followed, and provides a template for the health assessment itself (including details of the specific data which should be recorded). **The guidance will be of interest to anyone involved in organising or delivering health assessments to looked after children**, including strategic and operational managers in health and local authority children's services, public health colleagues, doctors, nurses and social workers.

The guidance applies to all territorial health boards and local authorities in Scotland.

The **aims of this guidance** are:

- To ensure that every looked after child or young person receives a comprehensive health assessment within four weeks of the NHS Board receiving notification (that an individual has become 'looked after').
- To provide strategic and operational managers in NHS Boards with information and advice in respect to planning and delivering holistic health assessments for looked after children (in the context of Getting it Right for Every Child).
- To provide healthcare professionals with a practical guide to completing a health assessment for a looked after child or young person, by stating what aspects of health should be assessed.
- To ensure that the health assessment provided to looked after children and young people is delivered consistently across Scotland, in respect to both content and approach.
- To suggest items for a comprehensive data set on looked after children's health, to be collected at local level.

As a corporate parent, NHS Boards should view the looked after children's health assessment as an opportunity to assess an individual's overall health and wellbeing, including behavioural and emotional development and risk taking behaviour.

Compliance with this guidance will be monitored through regular multi-agency inspection, carried out by the Care Inspectorate, Healthcare Improvement Scotland and their partners. The Scottish Government may also monitor provision and access to health assessments for looked after children at various intervals.

This guidance has been written by the Scottish Government working group on 'Health Assessments for Looked After Children'. The group was chaired by the Scottish Government's Senior Medical Officer (Children and Young People), and included representatives from nursing, general practice, paediatrics and health service commissioners. The guidance fulfils a commitment made by Scottish Government in the Chief Executive Letter 16, 2009, to provide a template health assessment for looked after children.

## SECTION 1: STRATEGIC CONTEXT

### Introduction

The Scottish Government has 5 objectives underpinning its core purpose – to create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.

The strategic objective for health is to help people to improve and sustain their health, especially in disadvantaged communities, ensuring better, local and faster access to health care. Of the 16 National Outcomes, a number are particularly relevant to looked after children's health and wellbeing:

- Our children have the best start in life and are ready to succeed
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens
- We have improved the life chances for children, young people and families at risk
- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society

The Scottish Government's vision for children and young people is clear: we want Scotland to be the best place in the world for them to grow up; a place where rights are respected and where children can access all the opportunities and support they need; and a place where children have the best start in life, are ready to succeed and live longer, healthier lives.

The Scottish Government is also striving to improve the life chances for children, young people and families at risk. Looked after children have some of the poorest life outcomes of the child populations. The factors associated with the child becoming looked after are often associated with a range of health needs and higher vulnerability. An additional factor in poor health outcomes is disjointed and disrupted health care as a result of multiple placement moves.

Our aim is that the health outcomes of children and young people who are, or have been, looked after will be as good as those of their peers who have not.

'[Getting it right for every child](#)' (GIRFEC) is Scotland's overarching approach to improve outcomes for all children and young people. It is being threaded through all existing and new policy, practice, strategy and legislation affecting children, young people and their families. GIRFEC therefore provides the framework for all work with looked after children and young people including health assessments and planning.

The [Children and Young People \(Scotland\) Act 2014](#) will require through regulation that the looked after child's plan is fully integrated with the holistic Child's Plan described in the Act and GIRFEC policy. NHS Scotland policy supported by legislation provides the framework for health boards, services and practitioners to assess, plan and deliver health services for all children

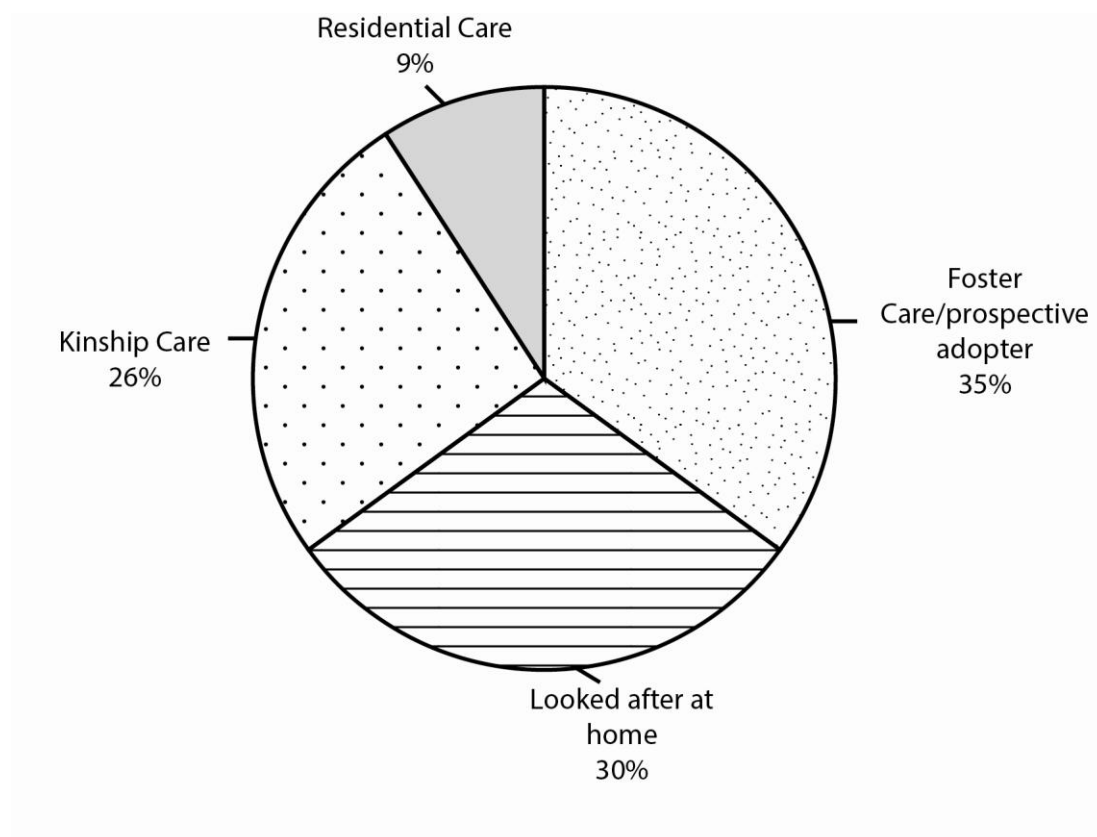
and young people taking a GIRFEC approach. Health assessments and planning for Looked After Children should be carried out within the Values and Principles of the Getting it right approach and applying the core components of the approach.

### **Looked After Children in Scotland**

In 2012/13 16,041 children were looked after by local authorities in Scotland.

The vast majority of looked after children have become looked after for care and protection reasons. Some will have experienced neglect or mental, physical or emotional abuse. Some parents are unable to look after their children because of their own health problems, substance misuse or poor parenting skills.

Children who are looked after can either be looked after at home (eg supervised by the local authority but living at home) or looked after away from home (eg living in residential accommodation or with family and friends in kinship placements). In 2012/13 this was broken down as follows:





Scottish Government [Children's Social Work Statistics Scotland 2012/13](#) show that the majority of looked after children will have more than 3 placement moves during their time in care. These moves uproot the child or young person from their known support systems, their family, local community and – from a health service perspective - from their local school, GP, health visitor and/or school nurse.

Professionals working with looked after children should be aware of the negative impact on long-term outcomes of such disruption of children's attachments.

Looked after children often face a range of difficulties arising from their home circumstances, health or learning needs. The GIRFEC approach provides the framework to address these wellbeing needs. The approach requires different agencies to work together with children, young people and families to holistically assess and consider the wellbeing needs of the child in the context of their wider circumstances. Services and practitioners can then prioritise and plan action to address the identified needs.

### **Policy Context**

In 2007, [We Can and Must Do Better](#) set out an action plan to improve the life outcomes of Looked After children and young people. Action 15 stated that:

*'Each NHS Board will assess the physical, mental and emotional health needs of all Looked After children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to Looked After and accommodated children and young people, and to those in the transition from care to independence.'*

Recommendations designed to address this action were issued to health boards on 28 April 2009 in Chief Executives Letter ([CEL 16 \(2009\)](#)) – see para 59. CEL 16 instructs NHS Boards to implement the 7 recommendations applying to all looked after children and young people.

[The Looked After Children \(Scotland\) Regulations 2009](#) reflect a child's journey through the looked after system. These Regulations set out the statutory requirements for every looked after child to have their needs assessed and a child's plan created setting out the child's immediate and long term needs and how they will be met.

Part II of the Regulations establishes the care planning process, including gathering information on the child; assessment of that information and the formation of the child's plan. Section 3(b) states that the local authority must obtain a written assessment of the child's health and their need for health care by a registered medical practitioner or a registered nurse. This requirement may not apply if a health assessment has been carried out in the 3 months before the child began to be looked after.

The [Healthcare Quality Strategy for NHSScotland](#) (May 2010) sets out 3 clearly articulated and widely accepted ambitions based on what people said they wanted from their NHS – care which is person-centred, safe and effective.

The strategic narrative [Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision](#) (September 2011) provides the context for taking forward the required actions to improve efficiency and achieve financial sustainability to meet the significant challenges that Scotland's health services face. This will involve planning sufficient universal health service to meet the needs of looked after children.

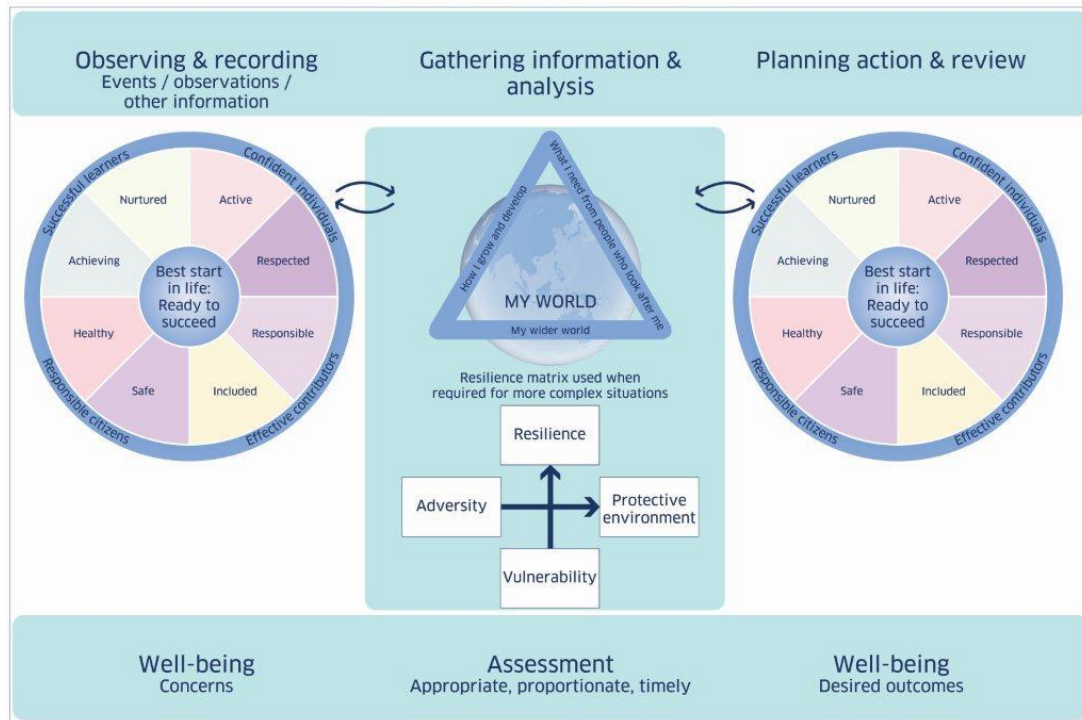
Service providers should ensure that services for young people reflect the Quality ambitions and the 2020 vision.

### **Child Centred Approach to Care Planning**

[Getting it right for every child \(GIRFEC\)](#) is the national approach to supporting and working with all children and young people in Scotland. It affects all services for children and adult services where children are involved. It is designed to ensure all parents, carers and professionals work effectively together to give children and young people the best start we can and improve their life opportunities. The looked after child's assessment and plan is administered in this context.

It is Scottish Government and NHS Scotland policy that children and young people should benefit from a single planning process when they require assessment, planning and action to promote, support or safeguard their wellbeing. In many situations, as for children and young people who are looked after, [the Child's Plan](#) will include contributions from different services and agencies including needs identified through specialist assessments such as the Health Assessment and the actions to address these needs. To ensure that a consistent approach is taken by services and agencies the GIRFEC National Practice Model, should be utilised as the framework for any assessment and planning.

## National practice model



The GIRFEC National Practice Model provides a framework for practitioners and agencies to structure and analyse information consistently to understand a child or young person's holistic needs and consider what support they might require. It is a dynamic and evolving process of assessment, analysis, action and review, and a way to identify outcomes and solutions for individual children or young people. It is not intended or designed to replace existing methodologies but should be used as a 'common tool' alongside and in conjunction with other processes and assessment tools. It is a way for all agencies and workers who support children, young people and their families to begin to develop a common language within a single framework, enabling more effective inter- and intra-agency working.

[The Early Years Collaborative \(EYC\)](#) is a good example of joint working between government, local authorities and health boards. It is an outcomes focussed, multi-agency, quality improvement programme, which aims to deliver nationally on the vision and priorities of the Early Years Taskforce and build on the Early Years Framework. It covers children pre-birth to 8 years old.

The EYC breaks traditional approaches, enabling professionals from all disciplines and agencies, including third sector, as well as children and families to test ideas for improvement that will lead to transformational change. Driven by those receiving or closest to the service delivery, changes are rigorously tested using rapid small scale tests of change before implementing and spreading across local and national areas.

## **Corporate Parenting**

The Children and Young People (Scotland) Act includes provision that requires every corporate parent to:

- be alert to matters which, or which might, adversely affect the wellbeing of looked after children, young people and care leavers under the age of 26;
- assess the needs of those children and young people for the support and services it provides; places a duty on corporate parents to collaborate with each other when exercising their responsibilities in relation to looked after children and young people;
- promote the interests of those children and young people;
- seek to provide those children and young people with opportunities to participate in activities designed to advance their wellbeing;
- take action it considers appropriate to help those children and young people to access opportunities and support and make use of the services it provides; and
- take any other action as it considers appropriate for the purposes of improving the way in which it exercises its functions in relation to those children and young people.

There will also be a requirement for corporate parents to collaborate with each other when exercising their corporate parenting responsibilities. They will be required to prepare, consult on and publish a corporate parenting plan and keep this under review. They will also be required to report on how they are exercising their corporate parenting duties to Scottish Ministers.

Community Planning helps public agencies work with the community to deliver better services. Community Planning Partnerships (CPPs) have been established to drive children's integrated service plans to achieve better outcomes. As well as local authorities and health boards, CPPs comprise a diverse range of public, private, voluntary and community organisations within their membership – some of who will also have corporate parenting responsibilities.

## **SECTION 2: HEALTH OUTCOMES IN LOOKED AFTER CHILDREN**

Evidence from research and practice<sup>1</sup> shows that looked after children and care leavers are more likely to experience health problems than young people in the general population.

A number of studies have identified that the mental health problems for looked after children and young people are markedly greater than that of their peers in the community. The prevalence of speech and language problems is above average, as are issues with co-ordination, eyes and sight. Oral and foot health can be poor, and across all age groups the number of looked after children identifying themselves as regular smokers and consumers of alcohol is significantly higher than the average.

It is estimated that a quarter of young women leaving care are pregnant or have a child and that the numbers of young women who give birth increases within 18-24 months of leaving care.

Looked after children experience a greater number of moves than children in the general population. Moving between different homes or units can mean that health problems get overlooked. Moves may involve changing health board areas, resulting in appointments being changed, missed, delayed or cancelled. Changes in placements can also result in changes in schools and this, together with higher truancy rates, can mean looked after children miss out on universal school health services and health promotion initiatives within school.

The disruption of children's attachments caused by multiple placements can have a negative impact on long-term outcomes.

Research informs us that a child's first attachments are vitally important. Children whose needs have been met in a sensitive, loving and timely way by their primary carer have a sense of trust and confidence in themselves. Securely attached children do better at school and these early attachments help them to form close relationships later in life. They grow up knowing that when they need something, someone will help them. Children whose early experiences of attachment have been less optimal can have insecure or disorganised attachments. These children will potentially be more vulnerable with respect to coping with future relationships and life events.

Secure, organised attachments are associated with the development of effective physiological regulatory systems and better physical and mental health outcomes across the life cycle. Children with disorganised attachments are more likely to have a developmental trajectory associated with anti-social behaviour and violence. They are more likely to require disproportionate levels of health care themselves and in some cases their behaviour to others may result in physical or emotional injury.

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<sup>1</sup> [Evidence Summary: Looked After Children \(NHS Scotland 2012\)](#)  
[Looked After Children in Glasgow and Scotland: A Health Needs Assessment \(ScotPHN 2013\)](#)

## **Fetal Alcohol Spectrum Disorder**

Because many looked after children will have come into care because of parental drug and alcohol use, it is important that family history is well documented, and a clear understanding of the effects of alcohol on the developing foetus and the child is appreciated by all health and care workers.

Fetal Alcohol Spectrum Disorder (FASD) is the leading known preventable cause of permanent learning disability worldwide and is caused by maternal use of alcohol during pregnancy. Affected children can have a wide range of physical, growth and neurobehavioural problems which impact on their everyday lives and limit their independence.

Fetal alcohol spectrum disorders are permanent lifelong developmental disabilities caused by maternal use of alcohol during pregnancy. Alcohol consumption in Scotland is high, but recognition of children affected by fetal alcohol harm in the UK is poor, much lower than in other parts of the world.

Young women in care should also be made aware of the dangers of drinking in pregnancy. Pre-conception and pregnancy are arguably the earliest stages at which services can work effectively together to offer guidance and support to families at risk from substance misuse issues. Women do not need to be alcohol dependent to have a child with FASD, although it is much more common in children of dependent women, and alcohol use is often a co-occurrent substance use with drug problems. Since the brain of the foetus develops throughout the duration of pregnancy, it can be damaged at any time during pregnancy.

## **Health for All Children 4 (Hall 4)**

Where a child is Looked After, they should receive the full core/universal programme of screening, surveillance and health promotion as set out by Hall 4 in addition to any specialist health assessment required.

Hall 4 is the programme of screening, surveillance and health promotion contacts which **every** child in Scotland should receive.

[The Hall 4 guidance](#) introduced a tiered programme of support and intervention for those children who are vulnerable or are considered to be at risk, empowering health visitors and school nurses to assess the level of support and intervention required according to assessed need. The guidance expects health professionals to work closely with other agencies and services, in particular childcare and early education to build on existing contacts with children and families. Looked after children should have access to the full range of health services, including General Practitioner (GP), health visiting/school nurse, child and adolescent mental health, speech and language therapy, audiology, vision, health promotion, oral health, specialist, and sexual health services. All Hall 4 contacts will result in data being recorded about a child's looked after status on the National Child Health Surveillance Programme.

[A New Look at Hall 4](#), launched by the Scottish Government in January 2011, set out the way forward for the successful delivery of Hall 4 in the Early Years. It supplements the 2005 guidance and addresses key issues identified as requiring further clarification. In line with GIRFEC, it recommends the Health Visitor should be the Named Person for the 0-5 age group or until the child enters school, to act as the first point of contact for children and families.

From April 2013, a new review at age 27-30 months has been introduced to the universal core programme of contacts. This review covers issues such as child development (including social, emotional and behavioural, speech and language, and gross and fine motor skills), nutrition and growth, physical health, home learning environment, early learning and childcare as well as parental health (all those in a parenting role, including foster parents and other carers).

## **Dental Health**

Childsmile is a national programme designed to improve the oral health of children in Scotland and reduce inequalities both in dental health and access to dental services. The programme combines targeted and universal approaches to tackling children's oral health improvement. This combination provides a comprehensive pathway of care that is tailored to the needs of individual children.

At a population level, every child will have access to:

- A tailored programme of care within Primary Care Dental Services.
- Free daily supervised toothbrushing in nursery.
- Free dental packs to support toothbrushing at home.

Directed support targeting children and families in greatest need through:

- Additional home support and community interventions.
- An enhanced programme of care within Primary Care Dental Services.
- Clinical preventive programmes in priority nursery and primary schools and facilitation into dental services as appropriate.
- Daily supervised toothbrushing in P1 to P2 of priority schools.

## **Health Promotion**

Health promotion is the process of enabling people to increase control over and improve their health through evidence-informed action within health education, protection and prevention. Health professionals play a lead role in health promotion through a range of action such as screening, immunisation, health education, signposting, behaviour change, and promoting healthy lifestyles. Health promotion acknowledges the wide range of factors which influence health and wellbeing. It extends beyond the individual to include the wider social and physical environments which influence health and wellbeing.

Adopting a multi-agency approach encourages health professionals to liaise with a wide range of partners such as education, social care and the Third Sector. These partners are in a strong position to support behaviour change, reinforce health promotion messages and influence the social, emotional, physical and organisational environments within which people live their life. As such, they have a supporting role to play in responding to health promotion activity identified as part of a comprehensive health needs assessment for looked after children.

## Mental & Emotional Health

There are a number of factors which may impact on a looked after child's mental health including: the child's experience in terms of poor parenting, trauma, bereavement or serious illness, mental health difficulties in one or both parents, and the impact on the child of the environment such as poor neighbourhoods, deprivation, social exclusion and poverty.

Additional factors can include stability and quality of care, and the child's links to family, friends and peers.



Source: Centers for Disease Control and Prevention

The [Mental Health of Young People Looked After by Local Authorities in Scotland \(2004\)](#) found that among young people (n=242), aged 5-17 years, looked after by local authorities, following assessment:

- 45% were diagnosed with a mental disorder
- 38% had clinically significant conduct disorders
- 16% were assessed as having emotional disorders – anxiety and depression
- 10% were rates as hyperactive

It is recommended that looked after children are screened for emotional and mental health difficulties using [Goodman's Strengths and Difficulties Questionnaire](#) (SDQ). This can be easily used by the professional carrying out the health assessment and can be scored using online programmes. The



form can be discussed as part of the assessment or completed by the young person as they wait for their appointment.

While it is important to pick up any formal 'mental disorder' amongst these children, arguably a more important task is to respond appropriately to the emotional distress that they experience. Understanding that distress in the contents of attachment processes is quite a challenge, but one that health professionals should try to respond to.

The SDQ is weighted towards externalising difficulties like ADHD and behavioural problems and tends to be less useful for picking up internalising problems such as anxiety, depression or attachment difficulties. To address this, additional questions should be added to capture more information about internalising difficulties.

Where the tool is being used for younger children, questions about attachment should be included.

If further specialist services are required, consultation should be provided by CAMHS for any concerns raised during the health assessment and mental health screening, or if there is uncertainty around results. Where children are thought to have significant emotional and/or mental health difficulties, they should always be referred to a specialist service for full assessment.

It is worth remembering that CAMHS services are specialist children's services and that access to clinical psychology, educational psychology, primary care mental health workers and voluntary agencies may be more useful to support looked after children.

### SECTION 3 - HEALTH SERVICE RESPONSIBILITIES FOR LOOKED AFTER CHILDREN (HEALTH ASSESSMENT)

In 2009, a letter was issued to NHS Board Chief Executives ([CEL 16 \(2009\)](#)) making the following recommendations:

- Each Territorial Health Board should nominate a Board Director who will take a corporate responsibility for looked after children and young people and care leavers by 30 June 2009.
- The Director will be responsible for ensuring that Health Boards fulfil their statutory duties under the Looked After Children Regulations (1996)\*. This will enable the Board, on the basis of information from local authority partners, to identify all looked after children and young people and care leavers in their areas by 31 July 2009, including those who are looked after at home and those placed from outwith their Health Board areas.
- The Director will also be responsible for the implementation of Next Step (a) under Action 15 of *We Can and Must Do Better*.

*Joint assessment and planning which takes into account the views of the young person and includes details of their particular health needs, including registration with a GP, dentist, regular health and dental checks, advice on sexual health, mental health and emotional wellbeing and access to any mental health services required.*

- The Director will ensure that the Board offers every currently looked after child and young person in their area a health assessment by April 2010. Any new child or young person coming into the system from March 2010 should have a health assessment within 4 weeks of notification to the Health Board.
- The Director will ensure that the Board offers a mental health assessment to every looked after children and young person. This recommendation should be phased in line with the implementation of “Mental Health of Children and Young People Framework for Promotion Prevention and Care” (FPPC) by 2015.
- The Director will ensure that every looked after child or young person who has general and mental health needs identified as part of their health assessment, the person undertaking that health assessment takes responsibility for ensuring their care plan is delivered/coordinated as appropriate.
- The Director will ensure, using existing systems, that the performance of the Board in carrying out general and mental health assessments for looked after children and young people, and the health outcomes of those assessments, is reported annually to the Scottish Government.

\*(now replaced by the Looked After Children (Scotland) Regulations 2009).

## **HEALTH BOARD DIRECTOR WITH RESPONSIBILITY FOR LOOKED AFTER CHILDREN (LAC DIRECTOR)**

CEL 16 (2009) recommended that each Territorial Health Board should nominate a Board Director to take a corporate responsibility for looked after children and young people and care leavers. In 2012 the Looked After Children Strategic Implementation Group (LACSIG), in consultation with LAC Directors, described what was expected from LAC Directors, clarifying the role and responsibilities.

The LAC Director should ensure that the Health Board works with placing authorities in its area to ensure:

- the Board is able to identify all looked after children and young people in its area, making sure there are clear procedures in place, detailing who should be informed and how.
- structures are in place so health professionals are involved in the decision-making process regarding care placements where there are specific health needs.
- there are processes and resources in place to support health professionals with the complex issue of health consent and confidentiality.
- arrangements are in place for a registered medical practitioner or a registered nurse to offer a written assessment of the child's health and their need for health care within 4 weeks of notification.
- that looked after children's nurses, school nurses, health visitors and paediatricians have the capacity to:
  - receive referrals;
  - identify health records and request them from the NHS Board in whose care they are held;
  - provide a comprehensive health assessment;
  - make sure that the looked after children and young people are engaged with primary care, secondary care and specialist care as required;
  - facilitate transfers where looked after children and young people move to another health board area, including information sharing and continuity of service delivery and care planning.
- information and data from the health assessment is fed back into the Child's Plan.
- a Lead Professional is identified to ensure the child's health needs are addressed. Where the lead professional is not from the Health Board, a key worker should be identified to liaise over delivery of healthcare.
- arrangements are made for looked after children and young people to be provided with healthcare services, including medical and dental treatment.
- the connection between the child protection processes and wider structural processes to support and plan services for vulnerable people.
- procedures are in place so the Health Board is able to offer a mental health screen to every looked after child or young person by 2015.

### **At Health Board level, the Director should**

- engage Board members in the Corporate Parenting agenda.
- ensure s/he is able to access specialist health advisors.
- ensure mechanisms are in place for multi-agency partnership working
- support Board members to ensure that the needs of looked after children and young people are articulated within the Community Plan, associated action plans, Integrated Services Plan and Single Outcome Agreement.
- actively seek to promote the needs of looked after children and young people within service design and improving patient care.
- ensure that arrangements are in place for the transition of looked after children and young people from child health to adult health services.
- advocate on issues around consent, confidentiality and implications of data protection, relevant to looked after children and young people.

### **CHILD HEALTH COMMISSIONERS**

There is a Child Health Commissioner appointed in every Health Board in Scotland. Whilst there is some variance across Scotland, the broad role of the Child Health Commissioner should include the following –

- Lead on local child health strategy
- Board and CHP reports with a children's element
- Regional planning
- Involving children and young people in service planning and provision
- Child health contribution to local delivery plans and Single Outcome Agreements
- Communication across local systems on new policy
- Providing advice to NHS Board on policy matters
- Champion partnership working with local authority and other key local partners
- Involvement in performance reviews of child health services
- Participation in the National Child Health Commissioners Group.

This role was set out more fully in [CEL 19 \(2011\)](#).

In addition, many of the Child Health Commissioners are leading on the looked after children health strategy in their Board wide area.

## **OUT OF AREA PLACEMENTS (cross boundary and cross border placements)**

[CEL 06 \(2013\)](#) sets out the procedures for establishing the Responsible Commissioner for an individual's care within the NHS. Paras 75-80 outline arrangements for looked after children where they are placed in a setting out with their home Board area:

### **ESTABLISHING THE RESPONSIBLE COMMISSIONER: GUIDANCE AND DIRECTIONS FOR HEALTH BOARDS, MARCH 2013**

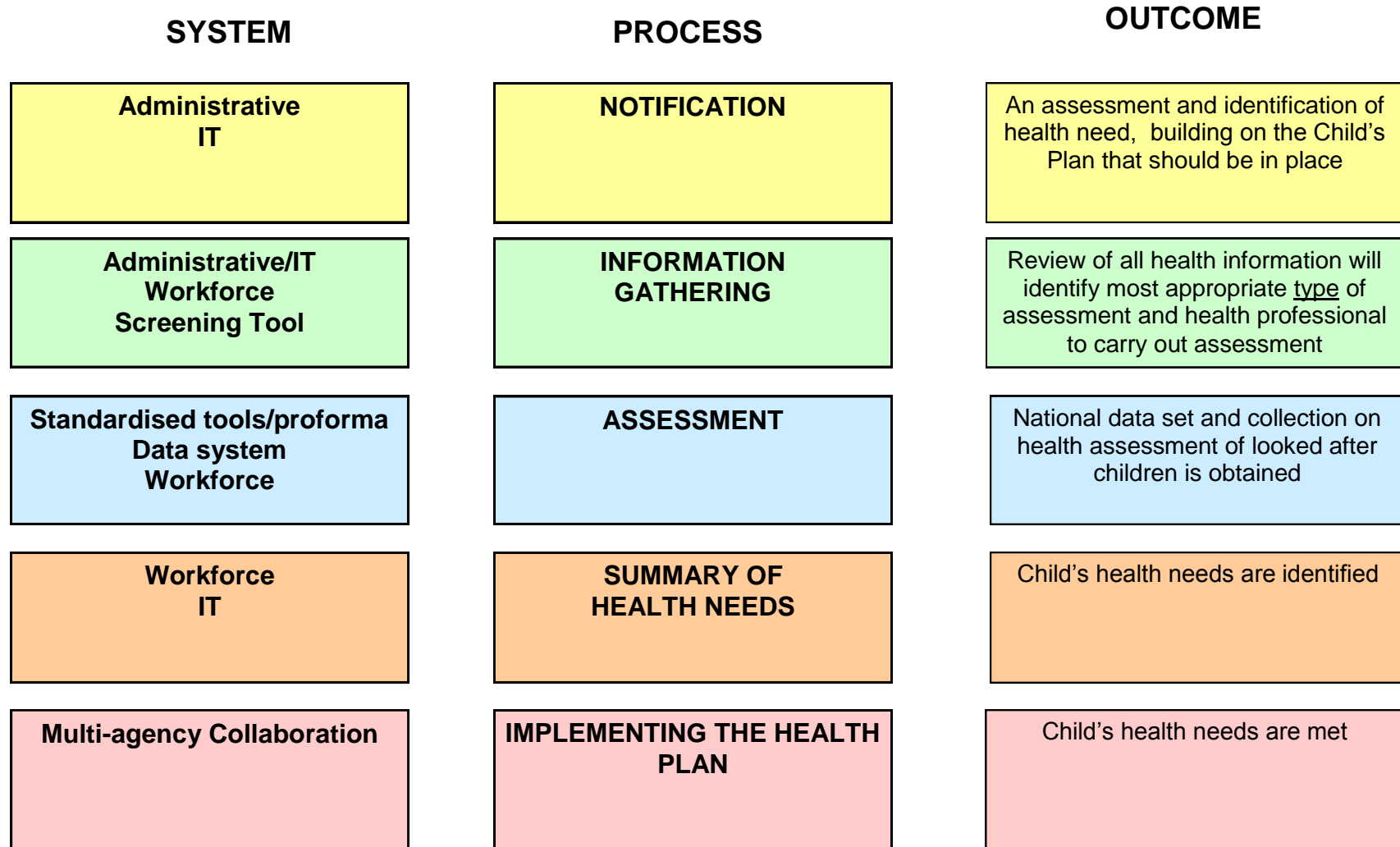
- Children who are looked after by local authorities can remain at home or be provided with accommodation away from their normal place of residence (i.e., kinship/foster/residential placement, respite care). The responsible Health Board should be established by the usual means identified in paragraph 6 et seq (i.e. the address where the child is ordinarily resident).
- The Looked After Children (Scotland) Regulations 2009 place a duty on local authorities to notify Health Boards when they place children in a kinship/foster/residential setting. There may also be cases where a child who is looked after at home moves to a new area. The duty to notify applies regardless of whether or not the child moves out of the original local authority area. This applies in respect of placements with foster carers and kinship carers as well as placement in a residential establishment and must be carried out as soon as reasonably practicable. Where placements are arranged urgently the notification should be done as soon as reasonably practicable.
- Under regulation 3(3)(b) of The Looked After Children (Scotland) Regulations 2009, when a child becomes (or is about to become) looked after, the local authority must obtain a written health assessment by a registered medical practitioner or a registered nurse. CEL 16 (2009) recommended that this is offered within four weeks of notification to the Health Board. A new assessment may not be necessary where one has been carried out within three months of the child becoming looked after.
- If a looked after child moves to a new area, the receiving Health Board should honour the current health care plan until this is changed following a new assessment. Arrangements should be made, in discussion between those currently providing the health care and with the new Health Board and relevant specialist services, to ensure continuity of health care. Continuity in some circumstances may involve continued care from the original provider until a handover can be arranged. Any changes in the health care commissioning responsibilities must not be allowed to disrupt the ultimate objective of providing high quality, timely care for the individual child or young person. It is important to ensure a smooth handover of clinical care where that is the agreed best plan for the child.
- For all looked after children, the local authority and receiving Health Board should identify a lead professional to ensure the child's health needs are addressed.
- When a child who is looked after reaches the age of 18, the test to determine their ordinary residence does not change: the ordinary residence of the child on his or her eighteenth birthday will identify the responsible Health Board, unless the child is attending a special school when the rule set out in paragraph 73 will apply.

## **SECTION 4: HOW TO DELIVER A HEALTH ASSESSMENT**

The following charts show the systems and processes required to deliver comprehensive health assessments for children and young people who become looked after.

There may not be a requirement to have repeated comprehensive health assessments every time the child moves into and out of care.

**LOOKED AFTER CHILDREN AND YOUNG PEOPLE HEALTH ASSESSMENT PATHWAY**



**LOOKED AFTER CHILDREN AND YOUNG PEOPLE HEALTH  
ASSESSMENT PATHWAY**

	<b>Task</b>	<b>Requirement</b>
<b>Notification</b>	Local Authority to inform Health Board re status of child	Every Health Board to have a central administration co-ordinator for looked after children
	Health Board to ensure consent to carry out assessment from person with parental rights and responsibilities is confirmed via Lead Professional	IT system
	Central admin to identify the key health partner to the plan	Local Authorities should have a standard list of essential information to be provided at time of notification
<b>Information Gathering</b>	Generate a profile which includes: <ul style="list-style-type: none"> <li>• a copy of the Child's Plan</li> <li>• name of Lead Professional</li> <li>• names of all health partners to the plan</li> <li>• hospital out patient history</li> <li>• details of outstanding appointments</li> <li>• name of GP</li> <li>• immunisation record</li> </ul>	Identify appropriate admin system and support to complete profile  An IT system which connects primary care/universal services to secondary care and includes dental services, eg NHS SIRS, CHI and ISOFT/Education and Social Work systems
	Review of profile by clinical staff	
	Identify most appropriate health professional to undertake a health assessment	A clinician with appropriate knowledge and skills should make this decision
	Inform appropriate person of their role/task	Health visitors, school nurses and paediatricians should know they have specific roles and tasks in this assessment and should be provided with adequate training and resources



**LOOKED AFTER CHILDREN AND YOUNG PEOPLE HEALTH ASSESSMENT PATHWAY**

	Has an assessment of emotional wellbeing /mental health been made?	A suitable screening tool has been used, eg WEMWS, SDQ, BAAF emotional and behavioural wellbeing profile
<b>Assessment</b>	Carry out age appropriate health assessment as per agreed national guidance	Provide supporting documentation: <ul style="list-style-type: none"> <li>• General health profile</li> <li>• Child's Plan</li> <li>• Others?</li> </ul>
	Complete appropriate proforma	Health Board to provide a standard proforma based on national minimum data set
		A national system should be developed to collate the agreed dataset
<b>Summary of Health Needs</b>	Summarise identified health needs	Electronic communication
	Complete child's health plan	
	Communicate with key health partner to Plan	
	Integrate health needs within inter-agency Child's Plan	Child's Plan
<b>Implementing Health Plan</b>	Identify who will address health needs	Meeting required with Lead Professional to discuss how health needs will be addressed

## **PART 1 - NOTIFICATION**

### **Referral Process To Health**

The local authority must inform the health board nominated administrator for looked after children within 5 working days of any child or young person who becomes looked after. A health assessment should be carried out within 4 weeks of this notification to the Health Board. The Health Board should ensure there is a clear process to carry out a health assessment.

### **Consent**

Local authorities should have guidance in relation to consent to the medical examination and treatment of children/young people who are looked after. They should make this known to the child/young person, health services, the parents, carers and staff. The arrangements for medical consent should be set out in each care plan where a child/young person is looked after. These will vary according to the legal status of the child/young person (Section 17(6) of The Children (Scotland) Act 1995), the age and understanding of the child/young person and whether a local authority does or does not have parental responsibilities for the child.

In Scotland, the starting point for who is entitled to consent to medical treatment for an individual child/young person is section 2(4) of [The Age of Legal Capacity \(Scotland\) Act 1991](#). This states that:

*A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capacity of understanding the nature and possible consequences of the procedure or treatment.*

## **PART 2 – INFORMATION GATHERING**

Before the health assessment, it is essential to gather as much relevant health and social information as possible.

This will include information from the following sources:

- local authority's information on the child, including child's plan incorporating social work report, child protection report and any available parental health information;
- child health surveillance information, including child health screening and immunisations;
- GP-held information;
- community health services;
- Health Visitors/School Nurses/AHPs;
- NHS system (eg TRAKCARE), access to note, attendance at Accident and Emergency and other paediatric departments, or out of hours GP services;

- referrals or contact with hospital services;
- referrals or contact with child and adolescent mental health services;
- referrals or attendance at primary care dental services (Public Dental Service or General Dental Practice).

Local authorities and NHS Boards should have in place protocols, which establish the framework for information sharing. The issues to consider would include:

- who has access to what information and how data security is ensured;
- arrangements for seeking consent to information sharing;
- how children, parents and other third parties are informed of, and allowed to challenge, information that is kept on them;
- how carers contribute to and receive information;
- mechanisms for sharing information between local authorities and health boards.

Guidance from the Information Commissioner's Office on information sharing between services in respect of children and young people is attached at Annex C.

### **PART 3 – COMPREHENSIVE HEALTH ASSESSMENT**

#### **Objectives of health assessment**

The objectives of the health assessment are to:

- Provide an opportunity to collate and to analyse the child/young person's health history including antenatal, birth, neonatal, past medical and family history.
- To identify unrecognised/unmet health needs, ascertain if the child/young person has missed or has any outstanding appointments, and to plan appropriate action.
- To comprehensively assess the child/young person's current physical, developmental and emotional health needs.

All assessments and planning by each Agency involved in a child's plan should be constructed around the 8 wellbeing indicators; safe, healthy, achieving, nurtured, active, respected, responsible and included. The Child's Plan should contain a holistic overview of all information gathered and assessments carried out and structured around the wellbeing indicators; a summary of how this information was considered in terms of the child's circumstances identifying strengths and pressures; how specific actions/priorities were identified; and detail of a clear action plan. This must include the health assessment and action plan.

The comprehensive health assessment will lead to a single agency health plan that can be shared and integrated to develop the multiagency Child's Plan. The initial health assessment should be submitted to the multi-agency

plan in My World Assessment format – ie strengths and pressures around SHANARRI.

This comprehensive assessment is best achieved using a proforma to prompt clinicians to seek relevant details and the recommended content for the different stages of childhood are outlined on pages 24-25. Local arrangements may vary, but standardised assessment tools have been developed which may assist NHS Boards (eg [BAAF health assessment tool](#)).

Information relating to the child's attendance, behaviour and achievement at school should also be taken into account as these factors can be related to unmet health needs and low self-esteem.

The clinician carrying out the assessment has a duty of clinical care to the child which includes making any necessary referrals for investigation and possible treatment of any health needs identified at the assessment. The clinician should follow up any concerns sharing appropriate, and proportionate information with the Named Person.

It should be ascertained at the time of this assessment whether the child/young person is already receiving or awaiting health treatment. Every effort should be made to ensure that being looked after does not disrupt existing arrangements or cause them to lose a place on a waiting list. Health professionals must be informed of placement changes in a timely manner.

The content of the assessment should be age sensitive and developmentally appropriate. The recommended content for the different stages of childhood are outlined on the following pages.

## **Age-appropriate recommended content of the comprehensive health assessment for looked after children and young people**

### **UNDER 5s**

For children under five years or pre-school, the focus will be on:

- Assessing child development, in particular the development of speech and language, gross and fine motor function, vision and hearing, play and pre-literacy skills, social and self-help skills and progress in nursery. Standardised assessment tools such as Schedule of Growing Skills may be useful.
- Assessing physical health and identification of health conditions.
- Assessing and interpreting growth.
- Ensuring childhood immunisations are complete for age.
- Dental health and registration with a dentist.
- Consideration of antenatal exposure to drugs and alcohol and exposure to blood borne viruses, either from birth or exposure in the home.
- Emotional wellbeing including consideration of attachment issues.

### **AGES 5-10**

For primary school age children the focus will be on:

- Assessing child development, in particular the development of speech and language, gross and fine motor function, vision and hearing, play, social and self-help skills, and progress at school.
- Assessing physical health and identification of possible health conditions.
- Assessing and interpreting growth.
- Level of physical activity, dietary intake and understanding of a healthy lifestyle.
- Dental health and registration with a dentist.
- Emotional wellbeing including consideration of attachment issues
- Assessing level of self-care skills; eg personal hygiene, tying shoe laces, telling the time.
- Awareness of basic safety issues, including road safety and social media.
- Where appropriate, to recognise and cope with the physical and emotional changes associated with puberty.
- Ensuring childhood immunisations are complete for age.

## **ADOLESCENCE AND LEAVING CARE 11-18**

For secondary school age children and young people and care leavers the focus will be on:

- Assessing physical health and identification of health conditions.
- Ability to take age appropriate responsibility for their own health, including responsibility for specific health conditions eg asthma, diabetes.
- Assessing and interpreting growth.
- Level of physical activity, dietary intake and understanding of a healthy lifestyle.
- Dental health and registration with a dentist.
- Vision and hearing – last eyesight test.
- Progress/attendance at school and whether any additional supports required.
- Ensuring childhood immunisations are complete for age.
- Communication and interpersonal skills, including ability to make and sustain friendships.
- Emotional health and wellbeing including consideration of mental health issues.
- Where appropriate, to recognise and cope with the physical and emotional changes associated with puberty.
- Assessing young person's understanding of relationships, sexual health and the particular risks of early sexual activity.
- Assessing young person's understanding of involvement with health risk taking behaviour eg smoking, misusing alcohol and drugs, inappropriate access to social media.
- Assisting the young person to access appropriate sources of information and advice about a range of health issues.
- Ensuring care leavers have an understanding of their own health history and knowledge on how they can access their health records so they are able to make informed choices relating to their health.

### **Specialist assessments**

If the Comprehensive Health Assessment identifies the need for any further specialist assessment that the child or young person may require, the assessing clinician should discuss this need and make the appropriate referrals. Such specialist assessment may include:

- Specialist LAC assessment
- Child and Adolescent Mental Health Assessment
- Education Psychology Assessment
- Speech and Language/Physiotherapy/Occupational Therapy assessment
- Specialist Paediatric/Surgical Paediatric assessment
- Ophthalmology/Audiology

#### **PART 4 – SUMMARY OF HEALTH NEEDS**

After the assessment the clinician should compile a health care plan specifying any timescales for actions to be completed and when the health care plan will be reviewed. As outlined in CEL 16 (2009), the clinician undertaking the health assessment takes responsibilities for ensuring the care plan is delivered/co-ordinated as appropriate.

#### **PART 5 – IMPLEMENTING THE HEALTH PLAN**

Where two or more agencies need to work together to help a child or young person, there will be a lead professional to co-ordinate that help. It is the responsibility of the Lead Professional to ensure that relevant assessment information, outcomes and actions are integrated into the Child's Plan and that what is recorded is agreed by the contributing parties.

Clear explanations should be given to the child/young person about any further consultations, treatment or care. Referral to local services should be made where appropriate.

If the child/young person ceases to be looked after the social worker needs to inform the LAC Administration team. On-going implementation of the child's health care plan will then be the responsibility of primary care.

## **IMPLEMENTING HEALTH SERVICES FOR LOOKED AFTER CHILDREN**

### **NURSING WORKFORCE**

The Children's (Scotland) Act (1995) emphasises that looked after children are entitled to the same health services as any other child. In response most Health Boards have established LAC Health Teams based on local needs and requirements. Currently therefore, roles, titles, responsibilities, delivery models and managerial arrangements differ across Scotland. Initially aims of LAC Teams were to improve outcomes through assuring appropriate health assessment and intervention. In support NHS Education Scotland and the RCN developed [A Capability Framework for Nurses who Care for Children and Young People who are Looked After Away from Home](#) (2009).

#### **Universal services**

Universal services, Midwives, Health Visitors and School Nurses play a vital role in reviewing and improving the health of looked after children. For all pre-school children Hall 4 sets out a number of child health reviews from 0-5 years of age. For the majority of school age children, currently universal school health reviews are provided only once at Primary One although many school age looked after children are more likely to have poor attendance at school, be excluded, have more complex needs, and in addition many experience a number of placements making continuity of care and intervention difficult. For children of school leaving age to 18 years, no universal health services are identified to undertake the child's health assessment.

#### **Specialist Looked After Children (LAC) Health Services**

Over the past 12 years, the introduction of LAC Health Services, Lead Nurses and LAC Health Teams; paediatricians and LAC nurses, have made significant improvements in improving the health needs of looked after children. The principle aim is to improve outcomes through assuring delivery on statutory and CEL16 (2009) requirements and by providing continuity of health assessments from age 0-19. LAC Teams have evolved to include a variety of roles and complexities ranging from staff nurse to those at advanced practitioner level. These encompass engaging with vulnerable children, assessing and analysing health information and providing comprehensive reports detailing implications of the information for the child's current, future health and wellbeing. Prior to the development of specialist services for looked after children identified challenges included: inconsistent, delayed or repeated health assessments of variable quality, use of a variety of assessment tools, lack of consistent health care together with the need for additional consideration to be given to such issues as blood borne virus testing, sexual exploitation, abuse in care which universal services may not have previously considered.

CEL16 (2009) is currently the only performance measure against which all NHS Boards report in respect of looked after children.



## **Current Nursing Workforce**

In June 2013 a review of current nursing provision for looked after children was undertaken by the Scottish Government's Directorate for Chief Nursing Officer, Patients, Public and Health Professions (CNOPPP) to identify existing nursing roles and resources. Findings indicate that the majority of current service provision is directed to looked after and accommodated children and young people. Some Board areas have expanded this to include all looked after children, as per CEL 16 (2009) requirements. Two models of service provision were identified.

### **Model 1 - Designated Specialist LAC Health Teams**

Specialist designated nurses and LAC Health Teams offer health assessments for looked after and accommodated children. Usually these specialists are Band 6 or 7 nurses who may be led by a Band 8 nurse. These teams are responsible for undertaking statutory health assessments for looked after children, developing health care plans, coordinating health care and supporting staff and carers. They ensure information is gathered on admission to care, is regularly reviewed and provide reports for children undergoing permanency and adoption processes. Some teams are multi-disciplinary including paediatricians ensuring appropriate health action plans are in place based on health needs. Standardised comprehensive health assessment tools such as the BAAF are used. All approaches to medical consent and information sharing, complies with The Children (Scotland) Act 1995, Age of Legal Capacity Act and conditions of orders from children's hearings. The LAC nurse co-ordinates children's health care irrespective of the number of care placement moves, ensuring coordinated continuity of health care and avoiding repeated assessments.

These designated nursing services are in addition to universal services such as health visiting and school nursing and encompass leadership and management responsibilities. Teams serve as a HUB and central point of contact for health information, the local authority and care placements irrespective of where a child is placed. Roles are highly developed, understanding the impact of neglect and abuse on children and child development, attachment difficulties and high level health risk taking behavior. Children have a named LAC nurse who follows the child irrespective of placement and children who are excluded from education or have left school are offered a consistent service up to 18 years.

### **Model 2 - Lead Nurse for Looked After Children**

NHS Boards have a Lead Nurse for looked after children (**Band 7 or 8**) who provides professional leadership within the NHS Board structure for staff caring for looked after children. The role of the Lead Nurse centres on ensuring improvement of outcomes and delivery of legal and CEL 16 (2009) requirements within universal services. The role manages a system wide process which ensures health professionals (across all disciplines associated with the child), are active, accountable and responsible for delivery of care as

the child moves across placement. The role also includes up skilling, training and support of staff in universal services, clinical supervision and governance of staff with looked after children on their case load, Quality Assurance of health assessments, input to the multi-agency plan, working at a leadership level within the NHS Board, with systems in place to support staff in universal services support looked after children. In terms of competencies of the workforce, the Lead Nurse needs specialist skills, however the role is principally professional lead with the driver to improve the skills in the universal workforce in respect of looked after children.

### **Future Models**

There are advantages and disadvantages associated with both current models described but currently both lack a robust evaluation or research base. Although future team compositions are likely to continue to vary across Health Boards due to differing levels of need, it is essential nursing staff are able to evidence competency and job descriptions should state the range of duties related to the role. Examples of current role descriptions are attached at Annex B.

### **Implications for Nursing Resource**

As set out in CEL 16 (2009) the health needs of all looked after children should be assessed within 4 weeks of notification by the local authority or evidence exists that a health assessment has taken place within the previous three months.

The review by CNOPPP recommended that, despite the need for locality responsive models, it is **essential** that a consistent approach is taken nationally to roles, support and supervision of nursing resource, and expected levels of service provision. The following good practice is required:

- Universal services should be provided to all looked after children 0-19 years as set out in Hall 4 and according to additional HV/SN guidance (currently under development).
- Assessments should be undertaken regularly by HV/SN in line with GIRFEC and HPIs allocated accordingly, based on individual needs.
- Each Health Board should have a named designated lead nurse for LAC and or ANP with appropriate knowledge and skills to ensure appropriate leadership and governance and to assist nominated Board Directors fulfil responsibilities in accordance with CEL 16 (2009).
- Looked after children aged 5-19 should be frequently assessed by SNs and or LAC Health Care Teams according to local needs, models and requirements.
- Looked after children may require additional specialist assessments. These may be carried out by LAC Specialist Nurses, LAC Teams and or universal services (supervised by LAC specialist nurses) depending

on local delivery models.

- LAC Teams and Specialist Nurses should provide specialist and additional support, assessment and intervention as required. They should provide a key leadership role for universal services which includes training, education, supervision and quality monitoring.
- National nursing guidance for looked after children should be re-assessed and/or developed which standardises roles, appropriate knowledge, skills and competencies required.
- LAC Nurses job titles should be standardised and job descriptions should be precise and transparent.
- In areas where numbers of looked after children are high, Boards may benefit from specialist LAC nursing teams.
- LAC Teams and Specialist Nurses should ensure practice, professional and/or managerial links with universal services, nursing and child protection services and structures and/or LAC nursing services should be supported and line managed through a nursing structure within children/community services
- On-going professional clinical supervision, support and professional development are essential for the LAC Nurse, when providing a service to this highly vulnerable child population.
- Consideration at Board level needs to be given to expected levels of input from universal services for looked after children if this is in addition to the core programmes. It is well recognised that Health Visitors due to more structured contact with families often have a more established relationship with parents, children and or foster carers. For school age children, this is more challenging due to children from the same placement attending different schools, SN caseload size and a possible lack of relationship with the child or placement. It may be that for children of school age, health needs are co-ordinated by a specialist nursing team, due to care placement complexity and levels of vulnerability of the child.

## **MEDICAL WORKFORCE**

The Medical Workforce delivering clinical assessments of looked after children has historically been based in Community Child Health (CCH) services, with little uniformity across Scotland in sizes of medical teams, and no matching of medical resource against population need. In addition, demands for statutory provisions of medical advisers to adoption and fostering panels has far outweighed supply of a new generation of doctors. There is a national shortage of paediatricians training in CCH, and even fewer applying for consultant posts, leaving Consultant Paediatricians being appointed with competing demands between acute paediatric services and community based services including looked after children.

In 2013 there were 45 doctors working within looked after children's services across 14 Health Boards and liaising with 32 Local Authorities. The extent of

each doctor's involvement with looked after children, those moving towards permanence, adults wishing to care for all these children varies on an individual basis. The Adoption Act (2007) states a legal requirement to have a Medical Adviser appointed to each adoption, permanence or fostering panel. Although it is not a requirement for them to attend fostering panels there is a considerable workload in evaluating the health assessment of looked after children so that all the relevant medical information is available for the other panel members in a timeous fashion.

### **Medical Workforce resource**

Whilst developing this guidance, an informal audit of the present medical workforce roles and responsibilities was carried out. It is apparent that the vast majority of medical staff, if not all, were unable to fit their current workload into agreed job plans. Nearly all require to read the detailed, extensive paperwork for panels at home, in their own time in order to complete this before panels take place. As local authorities have increased the number of LAC permanence panels, the workforce is struggling to meet the demand for medical reports.

<b><u>LAC stats</u></b>	<b>Consultant</b>	<b>Assoc. Spec.</b>	<b>Specialty Dr</b>	<b>GP/GPS</b>
<b>Total number</b>	9	21	10	5
<b>Total PAs (WTE)</b>	11 (1.1)	24 (2.4 )	9 ( 0.9)	4.5 (0.45)

Total PA's for clinical assessments = 48.5 ( WTE 4.85)  
 Total PA's for Panel work = 46.5 ( WTE 4.65 )

Several of these paediatricians are due to retire leaving significant gaps in service. The specialist nature of these jobs necessitates specific training and experience to fulfil these positions. Although some roles could be filled by GPs with a special interest, they require training and supervision to deliver their responsibilities adequately.

The fourth edition of Health for All Children estimated that a Health Board covering a population of 100,000 would provide about 50 comprehensive assessments and 100 health reviews per year. It suggests that a comprehensive assessment report takes on average 6 hours. For workforce calcuations, they suggest:

- 2 notional half-days per week of medical time for comprehensive assessments
- One FTE designated nurse (H Grade) to undertake and coordinate health reviews
- One session per week for the designated doctor
- Administrative and data management support

However, medical skill mix has been used creatively with specialty doctors, consultants and GPs with special interests participating on provision of services.

In addition most Health Boards have appointed a Lead Paediatrician for LAC, mainly Associate Specialists with a few Consultants but in some areas, the strategic lead is providing direct clinical care to looked after children.

### **Implication For Medical Resource**

- New Consultant job descriptions need to be explicit about the tasks that require specific competencies, to deliver medical assessments of looked after children. BAAF and RCPCH (should) have detailed job descriptions of these roles.
- LAC health teams should consider skill mix across specialist medical and nursing CCH teams, to deliver the tasks that require specialist competencies.
- LAC Executive Director at Board level should engage with local authorities at the earliest opportunity, through the Integrated Service's Plans, and Single Outcome Agreement, to detail the investments in medical and nursing resource needed to increase capacity to deliver timeous reports for the Permanence and Adoption Panels.
- Board Workforce Planners should participate in a workforce exercise across health and social care, to deliver robust medical and nursing resource to meet the CEL16 requirements.

## **SECTION 5: CORE DATASET TO BE RECORDED ON ALL COMPLETED ASSESSMENTS**

In general there is value in recording the findings of looked after children health assessments in a consistent way across Scotland. A consistent approach to capturing the rich information required to

- understand and plan to meet children's needs
- allow clear communication of children's needs between professionals and agencies responsible for their care; and
- facilitate transfer of information between areas when children move.

In addition, ensuring that a core subset of this detailed information is captured (according to agreed definitions and standards) will enable local monitoring and governance of looked after children's health assessments and the health needs of this group. Such a subset would also provide the essential first step towards developing a national data return that would allow comparative reporting and benchmarking between areas.

Data should be consistently captured and be compatible with existing systems across social work and health.

A required core subset of data to be captured electronically on all LAC health reviews along with supporting definitions and standards is provided in Annex A. This dataset focuses on the personal identifier information that should be captured on children undergoing a LAC health assessment and key health areas that are known to be particularly poor for looked after children. The personal identifier information is required to enable subsequent data linkage (e.g. linkage of LAC health assessment data to children's subsequent hospital admission records) which is an important way of monitoring outcomes for this group of children.

## SUBSET OF DATA TO BE CAPTURED ON ALL LOOKED AFTER CHILDREN AND YOUNG PEOPLE'S HEALTH ASSESSMENTS

The following core subset of information should be captured electronically on all completed assessments using the definitions specified.

VARIABLE	DEFINITIONS	COMMENT
<b>Child's personal identifiers and demographics</b>		
First name		
Surname / family name		
Gender	Male/female	
DOB	DD/MM/YYYY	
Ethnicity	See code list at end	
Family home postcode	Full postcode e.g. EH12 9EB	
Current residence postcode	Full postcode e.g. EH12 9EB	
CHI number	Unique identifier of patients within Scottish health service	
LA child social work identifier	Unique identifier of children within LA management information systems	If known
Scottish Candidate Number	Unique identifier of pupils within the Scottish education system	If known
<b>Looked after history</b>		
Looked after status	See code list at end	
Date this episode of being looked after started	DD/MM/YYYY	
First episode of being looked after?	Yes/no	
<b>Assessment provision</b>		
Date of health assessment	DD/MM/YYYY	Indicate date on which assessment was completed if undertaken over more than one appointment
Professional conducting assessment	Health Visitor School Nurse LAC specialist nurse General practitioner Community paediatrician Other	Tick all that apply if more than one professional involved
<b>Health Assessment</b>		
<b>Growth</b>		
Weight	Weight in kg to one decimal place	Weight and height centiles, BMI, and BMI centile can be calculated from this, date of birth, date of review, and gender
Height	Height in cm to one decimal place	
Gestation	Gestation at delivery in completed weeks	For infants aged <1 year only to indicate if gestational correction needed when calculating growth centiles

<b>Development</b>		
Developmental concern	No concern, concern newly suspected (i.e. as a result of the health assessment), concern/disorder previously identified	Concern about a child's development in any domain (e.g. motor, language, cognitive, social) identified after history, observation, and any formal assessments such as SOGs or ASQ For children aged 0-9 years only to fit with BAAF form? If so, note this doesn't quite fit with the age appropriate assessment content suggested in this guidance
<b>Immunisation</b>		
Child fully immunised for age	Yes/no	Based on current Scottish vaccination schedule, child's vaccination history, and child's age
<b>Dental Health</b>		
Currently registered with a dentist	Yes/no	
Attended dentist within last 12 months?	Yes/no	Lower age limit eg $\geq 1$ year?
<b>Mental Health</b>		
SDQ result	Score for each of the SDQ subscales ie Emotional symptoms Conduct problems Hyperactivity Peer problems Prosocial	
Type of SDQ used	Parent completed 4-16 years Teacher completed 4-16 years Parent completed 3-4 years Educator completed 3-4 years Self completed 11-17 years	This may be needed to understand the scores recorded above
<b>Substance use</b>		
Current smoker	Does the child smoke at least one cigarette a week (SALSUS and Scottish Health Survey definition for children)	Note this is not clearly recorded in the BAAF form but I would have thought this was pretty straightforward to collect. Children age $\geq 11$ years only
<b>Disability</b>		
Has a disability	Binary yes/no. If yes, longer list of types of disability to select from (e.g. list of longstanding illnesses from Scottish Health Survey).	



## Ethnicity code list

Please note that this code list is the one developed for the 2011 census and is used as standard across the NHS. Alternative code lists should not be used.

Code 99 indicates that the individual was not asked to give their ethnicity. If they are asked but decline to answer, code 98 should be used.

### Group A - White

- 1A Scottish
- 1B Other British
- 1C Irish
- 1K Gypsy/ Traveller
- 1L Polish
- 1Z Other white ethnic group

### Group B - Mixed or multiple ethnic groups

- 2A Any mixed or multiple ethnic groups

### Group C - Asian, Asian Scottish or Asian British

- 3F Pakistani, Pakistani Scottish or Pakistani British
- 3G Indian, Indian Scottish or Indian British
- 3H Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- 3J Chinese, Chinese Scottish or Chinese British
- 3Z Other Asian, Asian Scottish or Asian British

### Group D - African

- 4D African, African Scottish or African British
- 4Y Other African

### Group E - Caribbean or Black

- 5C Caribbean, Caribbean Scottish or Caribbean British
- 5D Black, Black Scottish or Black British
- 5Y Other Caribbean or Black

### Group F - Other ethnic group

- 6A Arab, Arab Scottish or Arab British
- 6Z Other ethnic group

### Group G - Refused/Not provided by patient

- 98 Refused/Not provided by patient

### Group H - Not Known

- 99 Not Known

## Looked after status code list

Please note that this code list is that used by the Scottish Government for national LAC returns. Alternative code lists should not be used.

- 01 At home with parents (or 'relevant persons' as defined in Sec. 93(2)(b) of the Children's (Scotland) Act 1995)
- 02 With friends/relatives (who are not approved foster carers)
- 03 With foster carers provided by local authority
- 04 With foster carers purchased by local authority
- 05 With prospective adopters
- 06 In other community placement (e.g. supported accommodation)
- 07 In Local Authority home
- 08 In voluntary home
- 09 In residential school (LA, voluntary, private or independent)
- 10 In secure accommodation
- 11 Crisis care (e.g. women's refuge, hostel for offenders, hostel for drug/alcohol abusers)
- 12 Other residential setting

## NURSING WORKFORCE - CURRENT ROLE DESCRIPTIONS

<b><i>Designated nurse role for looked after children</i></b>	<p>Assists NHS Boards in fulfilling their responsibilities in accordance with CEL 16 (2009) including;</p> <ul style="list-style-type: none"> <li>• Providing expert clinical advice on looked after children to all healthcare staff.</li> <li>• Working jointly with the Lead Paediatricians in order to undertake evaluations and ensure quality assurance and service</li> <li>• Providing supervision for those nurses with a role in looked after children including operational responsibility and line management of the dedicated posts.</li> <li>• Ensuring specialist advice and support is accessible to all staff</li> </ul>
<b><i>Specialist LAC Nurse / LAC Nurse role</i></b>	<ul style="list-style-type: none"> <li>• Caseload responsibility for looked after children;</li> <li>• Ability to include holistic analysis of health chronologies, providing written comprehensive reports detailing implications of information for the child's current and future health and wellbeing.</li> <li>• Participating in interagency meetings where appropriate (e.g. child protection case conferences, permanency planning meetings)</li> </ul>
<b><i>LAC Staff Nurse</i></b>	<ul style="list-style-type: none"> <li>• Delegated workload;</li> <li>• Ability to undertake and review health assessments for looked after children, in stable care placements</li> <li>• Ability to deliver missed childhood immunisations to looked after children</li> <li>• Delivery of health education to children who have missed school based health education, taking cognisance of the child's history, including experiencing abuse and neglect</li> </ul>
<b><i>Health Care support worker</i></b>	<ul style="list-style-type: none"> <li>• Supports clinics, immunisations, provides simple health education (e.g. hygiene)</li> </ul>

Further details of roles are outlined in [RCN/ RCPCH Looked after Children: Knowledge, Skills and Competences of Health Care Staff Intercollegiate Document \(2012\)](#)



Upholding information rights

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28 March 2013

## **Information Sharing Between Services in Respect of Children and Young People**

The Information Commissioner's Office (ICO) is contacted regularly by practitioners seeking advice and guidance on whether they can share professional concerns about their clients/patients and, if so, what level of information may be shared. Often, the Data Protection Act 1998 (the Act) is viewed as preventing such sharing and it can be fear of non-compliance that becomes a barrier, even though there may be a concern about a child's or young person's wellbeing. While it is acknowledged that practitioners need to be sure their actions comply with all legal and professional obligations, fear that sharing genuine concerns about a child's or young person's wellbeing will breach the Act is misplaced. Rather, the Act promotes lawful and proportionate information sharing, while also protecting the right of the individual to have their personal information fairly processed.

Most practitioners are confident about appropriate and necessary sharing where there is a child protection risk. The problem can be where the circumstances do not yet reach the child protection trigger yet professional concerns exist, albeit at a lower level. Getting It Right For Every Child (GIRFEC) introduced eight indicators of wellbeing: safe, healthy, achieving, nurtured, active, respected, responsible and included (SHANARRI). In many cases, a risk to wellbeing can be a strong indication that the child or young person could be at risk of harm if the immediate matter is not addressed. As GIRFEC is about early intervention and prevention it is very likely that information may need to be shared before a situation reaches crisis. In the GIRFEC approach, a child's Named Person may have concerns about the child's wellbeing, or other individuals or agencies may have concerns that they wish to share with the Named Person. While it is important to protect the rights of individuals, it is equally important to ensure that children are protected from risk of harm.

**Where a practitioner believes, in their professional opinion, that there is risk to a child or young person that may lead to harm, proportionate sharing of information is unlikely to constitute a breach of the Act in such circumstances.**

The Act requires that an individual's data be processed fairly and lawfully and that specific conditions/justifications for processing are met. The Act provides

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several conditions/justifications for processing, only the first of which rely on consent and, where required, it should be fully informed and freely given. However, the issue of obtaining consent can be difficult and it should only be sought when the individual has real choice over the matter. Where circumstances exist such that consent may not be appropriate, for example where an assessment under the SHANARRI principles raises concerns, the Act provides conditions to allow sharing of this information, such as 'for the exercise of any other functions of a public nature exercised in the public interest by any person' or 'in the legitimate interests of the data controller or the third party to whom the data are disclosed so long as it is not prejudicial to the child', and procedures should be clear about those circumstances which may necessitate processing without consent.

It is vital that data controllers put appropriate and relevant protocols in place and that they are conveyed to practitioners to provide them with a support mechanism for the decision making process. It is also vital that a recording process is included in the protocol so that the decision – including the rationale behind making it – is formally recorded. Such protocols will assist in providing confidence to practitioners in the event the decision is challenged.

**It is very important that the practitioner uses all available information before they decide whether or not to share. Experience, professional instinct and other available information will all help with the decision making process as will anonymised discussions with colleagues about the case. If there is any doubt about the wellbeing of the child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing.**

**Dr Ken Macdonald  
Assistant Commissioner Scotland & Northern Ireland  
Information Commissioner's Office**

## Links to Further Information

CEL 16 (2009): Implementation of Action 15 of the Looked After Children and Young People: We Can and Must Do Better Report

[www.sehd.scot.nhs.uk/mels/CEL2009\\_16.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf)

Supporting Young People's Health & Wellbeing – A Summary of Scottish Government Policy

[www.scotland.gov.uk/Publications/2013/04/4112](http://www.scotland.gov.uk/Publications/2013/04/4112)

We Can and Must Do Better

[www.scotland.gov.uk/Publications/2007/01/15084446/0](http://www.scotland.gov.uk/Publications/2007/01/15084446/0)

Health for All Children 4: Guidance on Implementation in Scotland

[www.scotland.gov.uk/Publications/2005/04/15161325/13269](http://www.scotland.gov.uk/Publications/2005/04/15161325/13269)

A New Look at HALL 4

[www.scotland.gov.uk/Publications/2011/01/11133654/11](http://www.scotland.gov.uk/Publications/2011/01/11133654/11)

The Scottish Child Health Programme: Guidance on the 27-30 month child health review

[www.scotland.gov.uk/Publications/2012/12/1478](http://www.scotland.gov.uk/Publications/2012/12/1478)

Equally Well

[www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf](http://www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf)

Better Health, Better Care

[www.scotland.gov.uk/Publications/2007/12/11103453/9](http://www.scotland.gov.uk/Publications/2007/12/11103453/9)

A Pathway of Care for Vulnerable Families (0-3)

[www.scotland.gov.uk/Publications/2011/03/22145900/8](http://www.scotland.gov.uk/Publications/2011/03/22145900/8)

A Guide to Implementing Getting it right for every child: Messages from pathfinders and learning partners <http://www.scotland.gov.uk/Publications/2010/07/19145422/0>

A Capability Framework for Nurses who Care for Children and Young People who are Looked After Away from Home

[www.mnic.nes.scot.nhs.uk/media/17530/lac\\_framework\\_finalfinal.pdf](http://www.mnic.nes.scot.nhs.uk/media/17530/lac_framework_finalfinal.pdf)

Looked After Children: Knowledge, skills and competences of health care staff – Intercollegiate Role Framework

<http://www.rcpch.ac.uk/sites/default/files/RCN%20&%20RCPCH%20LAC%20competences%202012%20v1.0%20WEB%20Final.pdf>

Looked After Children (Scotland) Regulations 2009

[www.legislation.gov.uk/ssi/2009/210/contents/made](http://www.legislation.gov.uk/ssi/2009/210/contents/made)

Guidance on the Looked After Children (Scotland) Regulations 2009

[www.scotland.gov.uk/Publications/2010/06/01094202/28](http://www.scotland.gov.uk/Publications/2010/06/01094202/28)

These Are Our Bairns: A guide for community planning partnerships on being a good corporate parent

[www.scotland.gov.uk/Publications/2008/08/29115839/24](http://www.scotland.gov.uk/Publications/2008/08/29115839/24)

Looked After Children in Glasgow and Scotland: A Health Needs Assessment

[www.scotphn.net/pdf/2013\\_05\\_13\\_Health\\_Needs\\_Assessment\\_Looked\\_After\\_Children\\_in\\_Glasgow\\_and\\_Scotland\\_Final\\_Draft\\_for\\_Web\\_Publication.pdf](http://www.scotphn.net/pdf/2013_05_13_Health_Needs_Assessment_Looked_After_Children_in_Glasgow_and_Scotland_Final_Draft_for_Web_Publication.pdf)

Attachment Matters for All – An Attachment Mapping Exercise for Children's Services in Scotland

<http://www.celcis.org/media/resources/publications/Attachment-Matters-For-All.pdf>

**Consent**

- [The Age of Legal Capacity \(Scotland\) Act 1991](#)
- [A Good Practice Guide on Consent for Health Professionals in NHSScotland](#) NHS HDL (2006) 34
- [NHS Code of Practice on Protecting Patient Confidentiality](#) SEHD 2003



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