UNIVERSITY OF
NEWCASTLE UPON TYNE

HEALTHACTION
TYNE & WEAR

Child Health Information Development

Developing child health information for Tyne and Wear Service Providers

Report on Exemplar Issue: **Quality Protects December 2001**

Executive Summary

'Looked after children' is a term that was introduced by the Children's Act 1989 to describe children who are in public care. In 1998, the 'Quality Protects' programme was introduced to set mandatory national objectives for services for children and young people in the looked after sector. Amongst these objectives was Objective 4 'To ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care' and this included a sub-Objective 4.2 'To ensure that children looked after enjoy a standard of health and development as good as all children of the same age living in the same area'.

It is clear from a number of earlier research studies that children who are looked after away from home have greater levels of health need than their peers, yet are less likely to receive adequate health care. Indeed the House of Commons Health Select Committee in 1998 concluded that *'the failure of local authorities to secure good health outcomes for the children and young people they look after is a failure of corporate parenting'.*

A number of types of routine data are now published about the implementation of quality protects.

Using these data, it is clear that, in the Authorities covered by the Tyne & Wear HAZ, the proportions of children in the looked after sector are about 30% higher than the rest of the country. There is some small variation amongst the local authorities within Tyne & Wear, but all of them have relatively high rates, with just under 1% of all people under the age of 18 being looked after at any one time. This includes a large number of children on agreed short-term placements, but also includes about 25% of the children who have been looked after continuously by the Local Authority for more than four years. Thus, there are something approaching 2,000 children in Tyne & Wear who are looked after at any one time, and of these, about 450 have been looked after continuously for more than four years.

Children in the looked after sector move around between placements frequently, with about 20% having three or more placements per year (the government target for this is less than 16%). Mostly, they are placed with foster parents (about 65%) and a further 10-20% in community homes. The reason that many of these children are in care is to do with abuse or neglect, and there are increasing numbers, as children get older, with the largest numbers now being 10-15 year olds.

Insofar as they are known, the outcomes for these children are relatively poor. For instance, 70% leave full time education with no GCSE or GNVQ equivalents as compared to less than 10% of the general population of young people aged more than 16 years.

With respect to the health outcomes, very little is known, and only four routine indicators are required by central government, ie the percentages of those with complete primary immunisation, those who have had routine dental checks, those who have had an annual health assessment, and those who have had a comprehensive health assessment when they entered the looked after sector.

On these criteria, Authorities in Tyne & Wear show some variation, with between 60 and 90% of children looked after fulfilling the first three of these criteria. This compares to about 95% of children who are in the non-looked after sector, who will have had complete primary immunisation and dental checks.

What is most striking about these data is, first, their sparsity - this is all that is known routinely about the health of this group of children. Second, feedback from a consultation session with a number of local professionals suggests that it is very difficult to generate reliable information about the health of children in the looked after sector for a number of reasons.

- There is not always clear transfer of information from Social Services to Health Authorities concerning the identity of children in the looked after sector to allow their health to be monitored.
- Although we have considerable information about resident children who attend hospital or who have been offered immunisation and health screening through Community Child Health services, it is rarely known which of these children are in the looked after sector.
- The records, which are held about all children as they make contact with health services, do not have a unique identifier. Thus linkage to a separate confidential database of looked after children cannot be made.
- The situation is complicated by the fact that this vulnerable group of children is transient and highly mobile; with many children entering, leaving and changing care each year.

To deal with this, most local Health and Social Service departments have set up collaborative arrangements to ensure that there are regular health assessments for these children. Information systems are being developed, based on these individual personal records. Compiling more comprehensive records by linkage to other useful data systems is theoretically possible but unlikely until logistic and ethical issues are clarified.

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Introduction

Looked after children

'Looked after children' is a term that was introduced by the Children Act 1989 to describe children who are in public care. This may be a voluntary agreement with parents (accommodated) or as the result of a legal order (in care). Children who are looked after by the local authority may live with foster carers, in residential care, with relatives or may remain at home with their parents on a care order. Children with disabilities who are offered respite care (often a series of short-term breaks) are also deemed to be "Looked After".

Research has shown that children and young people who are or have been in public care are amongst the most socially excluded groups in England (Broad 1999). A number of reports and research findings have established the lack of safeguards that these children and young people were afforded by the systems commissioned to protect them (Department of Health 1997, North Wales Judicial Inquiry 1998, De Cates et al. 1995, Department of Health 2000).

The Department of Health has identified that children who are looked after have a unique set of disadvantages. There may be an initial failure on the part of parents to safeguard these children. A system, which incorporates recurrent changes of placement and consequently school and/or general practitioner then compounds this problem, frequently resulting in a lack of available and up to date information about the child that can prevent access to services through ordinary routes. It is also clear from the research that children who are looked after away from home have greater levels of health needs than their peers, yet are less likely to receive adequate health care, including mental health and monitoring Dimigen et al (1999), Payne & Butler (1998). Despite the fact that health monitoring is required by regulation, children who are looked after receive poor supervision.

Adolescents have particular difficulties, and on leaving the care system are frequently over represented in high risk groups amongst the population (Broad 1999). High levels of early parenthood, mental ill-health and stress, loneliness and potentially damaging behaviour amongst the population of young people leaving care have been indicators of the failure of the systems which were in place.

The House of Commons Health Select Committee (1998 para 265) concluded that:

"*The failure of local authorities to secure good health outcomes for the children and young people they look after is a failure of corporate parenting*."

Quality Protects

The government launched the Quality Protects programme in 1998. This is a key part of the government's wider strategy for tackling social exclusion. It focuses on working with children who are looked after by councils, children in the child protection system and other children in need requiring active support from social services. The Quality Protects

programme aims to ensure that children are protected against abuse, that standards in children's homes are raised, that children in care are provided with better opportunities in education and improved health care and that they are prepared to establish a successful adult life.

The programme is mandatory across local government and agencies and sets national objectives for services for children, young people and families. Each local authority must submit an annual Quality Protects Management Action Plan, which sets local targets and monitors developments.

There is an overall aim to improve the quality and management of children's services and this requires partnership working between those providing day-to-day care, birth parents, education, health and social services departments. There is an emphasis on corporate responsibility with an expectation that all departments will work together effectively. This supports the belief that the Quality Protects programme will make a "demonstrable difference to the lives of children".

There are 11 Government Objectives for Children Social Services. The main objective providing consideration for the health of looked after children is objective 4, sub-objective 4.2. All the objectives are listed in Annexe 3

Objective 4: To ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care.

Sub-objective 4.2: To ensure that children looked after enjoy a standard of health and development as good as all children of the same age living in the same area.

The aim of this report is to draw a HAZ wide profile, by collating data on the way children are being looked after in Tyne and Wear, on their health status and educational achievements.

Children Looked After: Trends over time

Number of Children Looked After

Figure 1 shows the children who started to be looked after from 1997 to 2000, expressed in rates of children starting to be looked after by 10,000 children aged under 18 in the general population at that time. Only the first occasion on which a child started to be looked after in the year has been counted, and figures for children looked after in this graph exclude agreed series of short-term placements (see annexe 1 for more information).

The number of children starting to be looked after decreased in most local authorities in Tyne and Wear over the past four years, which contributed to the national decline. However, there is a discrepancy between local authorities, with 22 children per 10,000 under 18 starting to be looked after in Gateshead, versus 38 children per 10,000 in Newcastle.

Figure 1: Children who started to be looked after, during the years ending 31 March 1997 to 2000

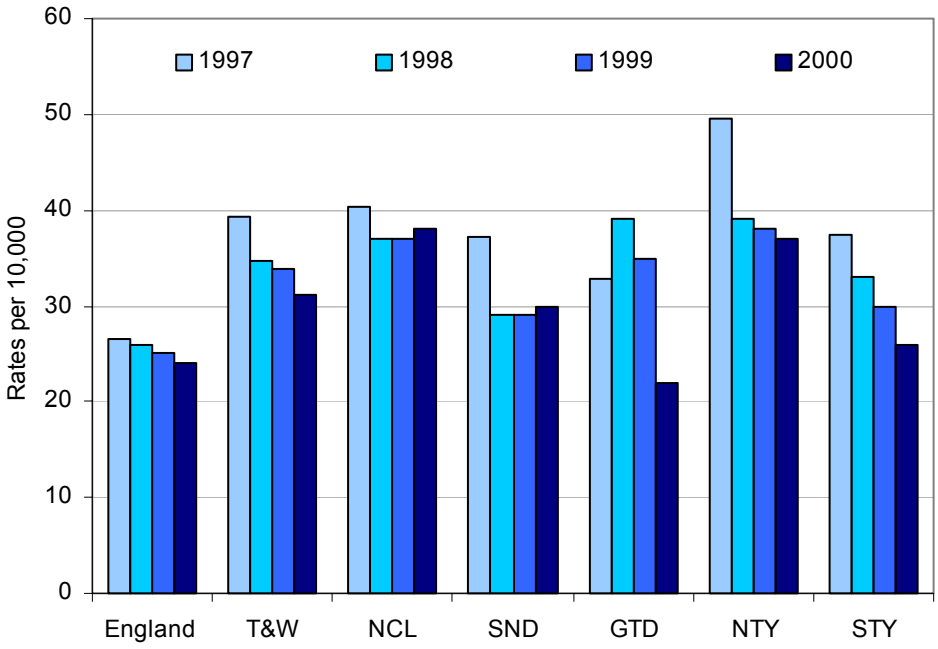


Figure 2 shows the rates for children ceasing to be looked after over the same period of time in Tyne and Wear local authorities. Only the latest occasion on which a child ceased to be looked after in the year has been counted in this graph.

Nationally, the number of children who ceased to be looked after decreased over the past four years, to reach a rate of 23 children per 10,000 under 18s in the year ending on the 31st March 2000. This rate in generally higher across Tyne and Wear (30 children per 10,000), ranging from 23 in Sunderland to 41 in North Tyneside.

Figure 2: Children who ceased to be looked after, during the years ending 31 March 1997 to 2000

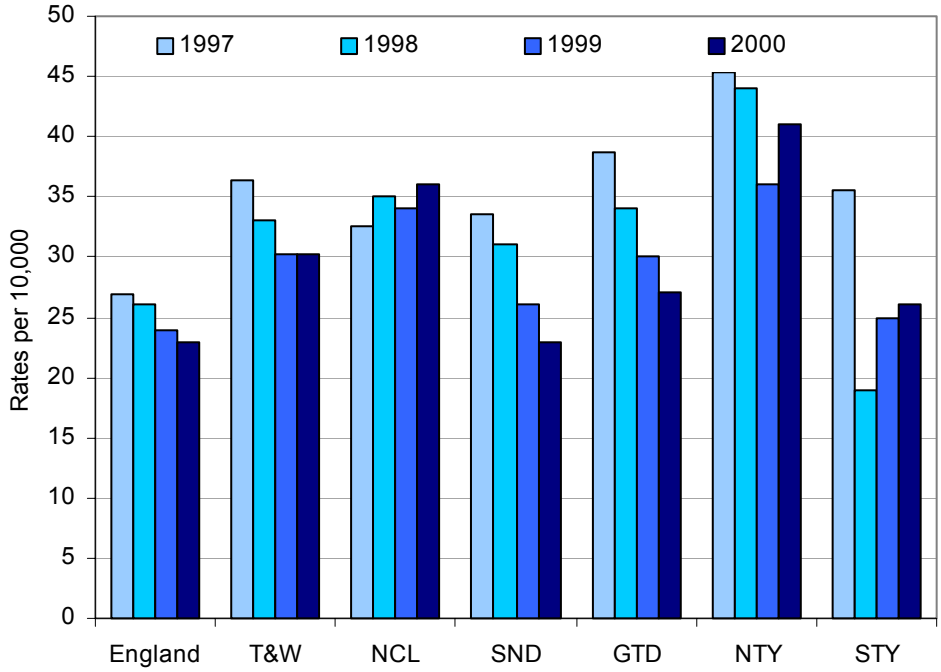
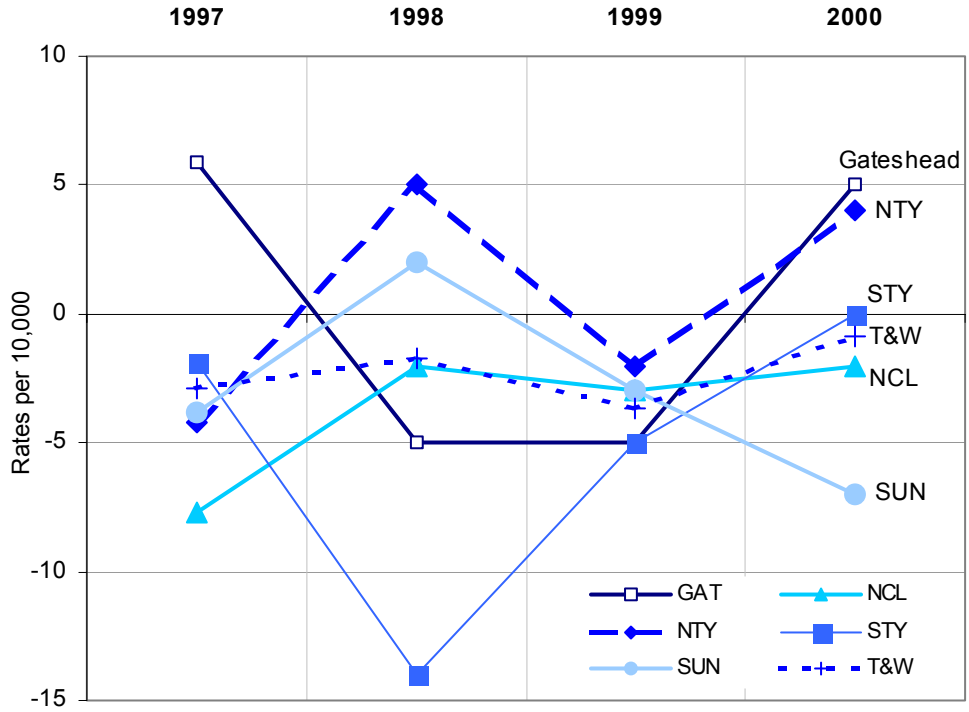


Figure 3 shows the turnover amongst the population of looked after children; It has been calculated by subtracting the number of children who started to be looked after to the number of children who ceased to be looked after, and is expressed per 10,000 children aged under 18 in the general population.

Figure 3 Turnover in the population of looked after children.

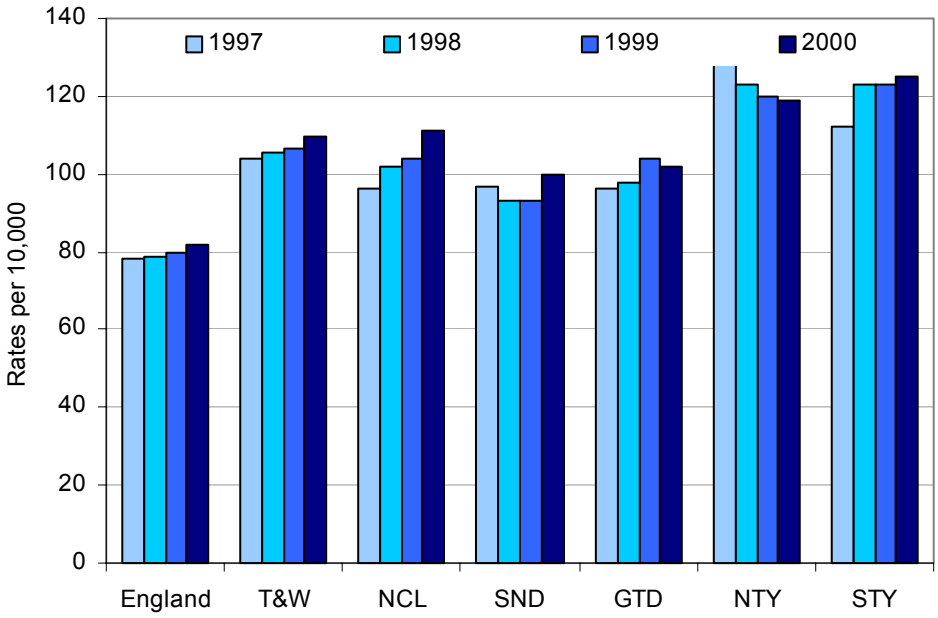


The population of children looked after decreased slightly nationally, but that hides big discrepancies amongst local authorities. Generally in Tyne and Wear, the number of children looked after increased over the past 3 years, due to an increase in the number of children looked after North Tyneside, South Tyneside and Newcastle and in spite of the decrease in Sunderland and Gateshead.

In the whole of Tyne and Wear, the number of children who started to be looked after during the year ending on the 31st March 2000 was 770. The number of children who ceased to be looked after during the same period of time was 739.

Figure 4 shows the total number of children looked after, expressed per 10,000 children under 18 in the general population.

Figure 4: All children looked after during the year, including children under series of short-term placements



These figures are estimated from the SSDA 903 "one-third" sample and are therefore subject to sampling error. The number of children looked after increased over the past few years in England to reach an estimated 82 children per 10,000 under 18 in 2000. It increased also in most local authorities in Tyne and Wear, except North Tyneside where although it has been decreasing, the number stays as high as 119 children per 10,000 under 18s.

Type, duration and number of placements

Some looked after children are accommodated under an agreed series of short-term placements as provided for in '*Regulation 13 of the Arrangement for Placement of Children (General) Regulations, 1991'*. Figure 5 shows the percentage of children looked after under an agreed series of short-term placements. These children often present with a disability, and the short-term placement system is organised as a temporary relief for their natural parents.

Figure 5: Children looked after at any time during the years ending 31 March 1997 to 2000, under an agreed series of short-term placements

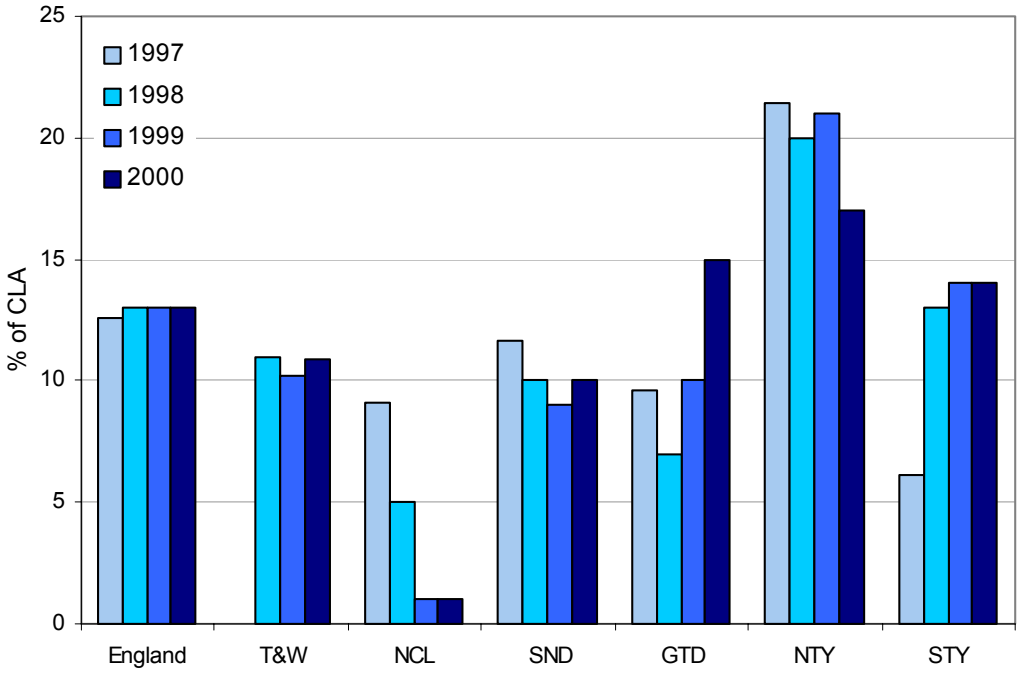
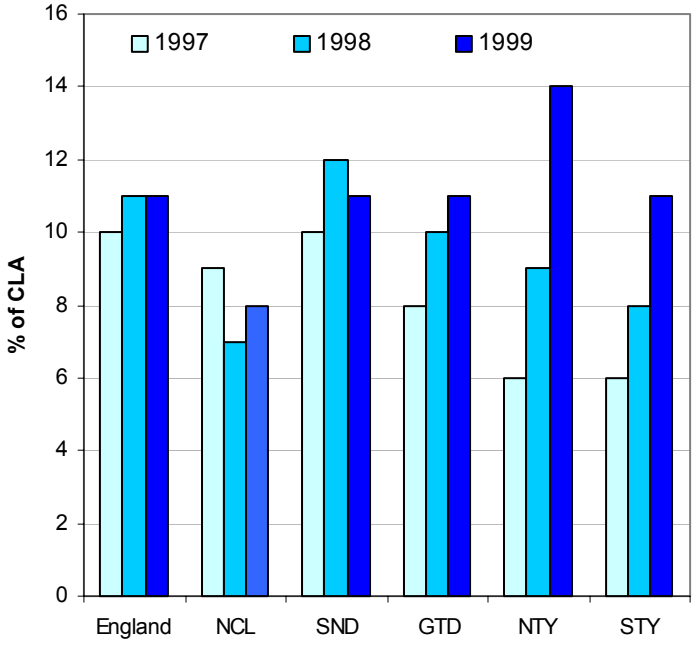


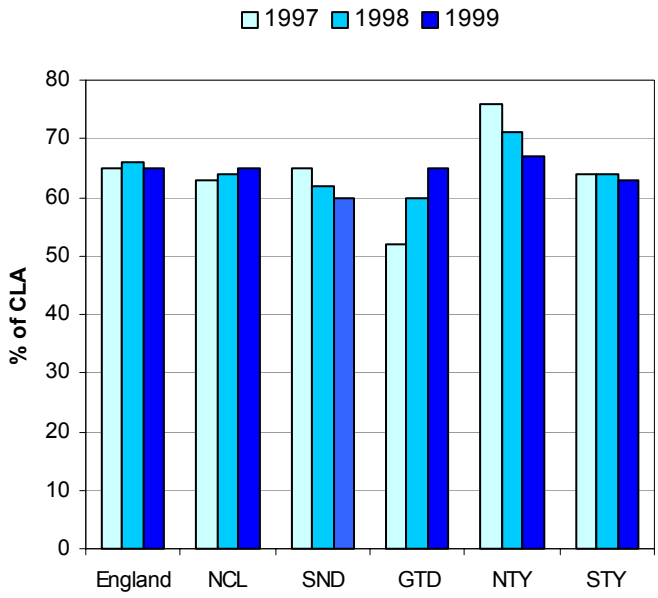
Figure 6, 7, and 8 show the percentage of all children placed with their parents, in foster placements, or in children's homes, over the total number of children looked after at the 31st March 1997 to 1999 (excluding children looked after under an agreed series of short term placements).

Figure 6: Placement with parents



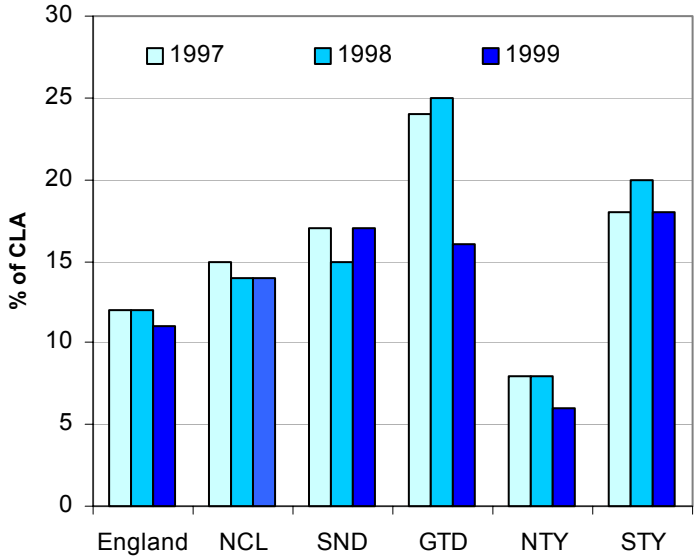
Placements with parents are generally increasing but with variations between districts.

Figure 7: Foster placements



Foster placements are by far the most commonly used, with 65% of children looked after nationally being fostered in 1999. Although the national proportion did not change dramatically over the past few years, it has increased noticeably in Gateshead and decreased in North Tyneside.

Figure 8: Children's homes



Community homes, voluntary homes, hostels, and private registered children's homes are all included in children's homes in this graph.

Information available from the Department of Health website at www.doh.gov.uk/public/sb0109i.pdf identifies that:

6% of the children looked after in North Tyneside were placed in 4 community homes in 1999. 3 were Controlled Community Homes (provided by a voluntary organisation, but predominantly managed by a local authority), and one was an Assisted Community Home (provided by a voluntary organisation with assistance and some funding from a local authority).

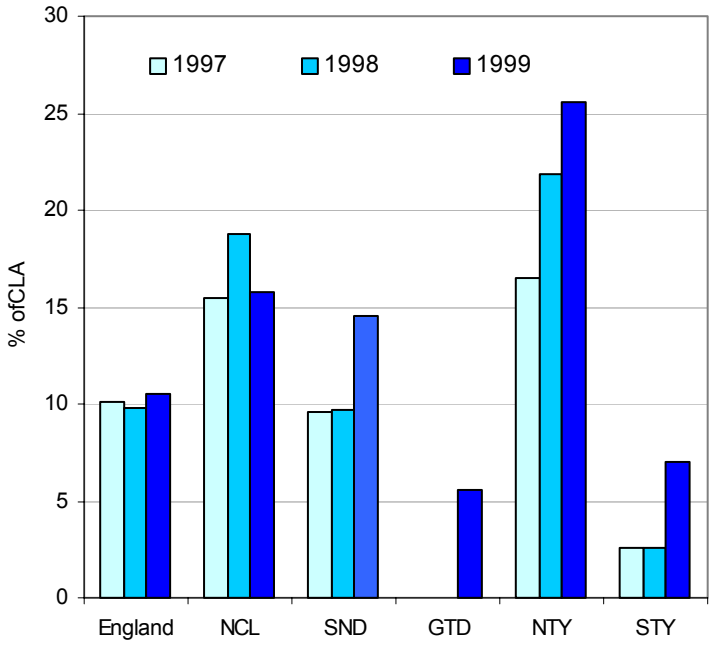
14% of the children looked after in Newcastle were placed in 9 community homes. 6 were Maintained Community Homes (fully funded, maintained and directly managed by a local authority), 1 was an Assisted Community Home, 1 was a private registered children's home (run by private individuals, companies or organisations for profit and which are registered with social services) and the last one was a Registered Residential Care Home (registered under the Residential Homes Act 1984; the service they provide will normally include an element of personal care or nursing care and is therefore appropriate for children in need of health care).

16% of the children looked after in Gateshead were placed in 7 Maintained Community Homes.

17% of the children looked after in Sunderland were placed in 13 Maintained Community Homes.

18% of the children looked after in South Tyneside were placed in 5 Maintained Community Homes.

Figure 9: Percentage of children under 10 years placed for adoption at 31.03.97



Placements for adoption have been used in very different ways between local authorities, with only 6% of the children looked after in Gateshead being placed for adoption in 1999, versus 26% in North Tyneside. This proportion has increased dramatically between 1997 and 1999 in North Tyneside.

Figure 10 shows the number of children who have been looked after continuously during the past four years in Tyne and Wear local authorities. This number has not changed evenly across local authorities, with Newcastle decreasing from 99 in 1997 to 85 in 2000, and Gateshead increasing from 54 to 78 children over the same period of time. Nationally, the total number of children who have been looked after for at least four years went from 14,600 in 1997 to 16,600 in 2000. This same number went from 398 to 439 over the same period of time in Tyne and Wear.

Figure 10: Number of children who had been looked after continuously for at least four years, at 31 March 1997 to 2000

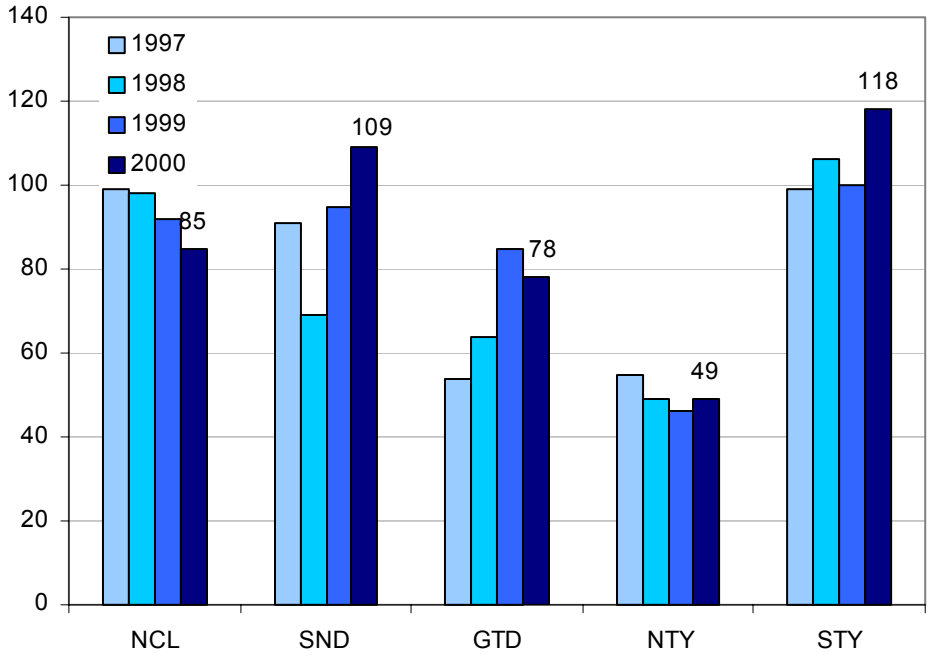
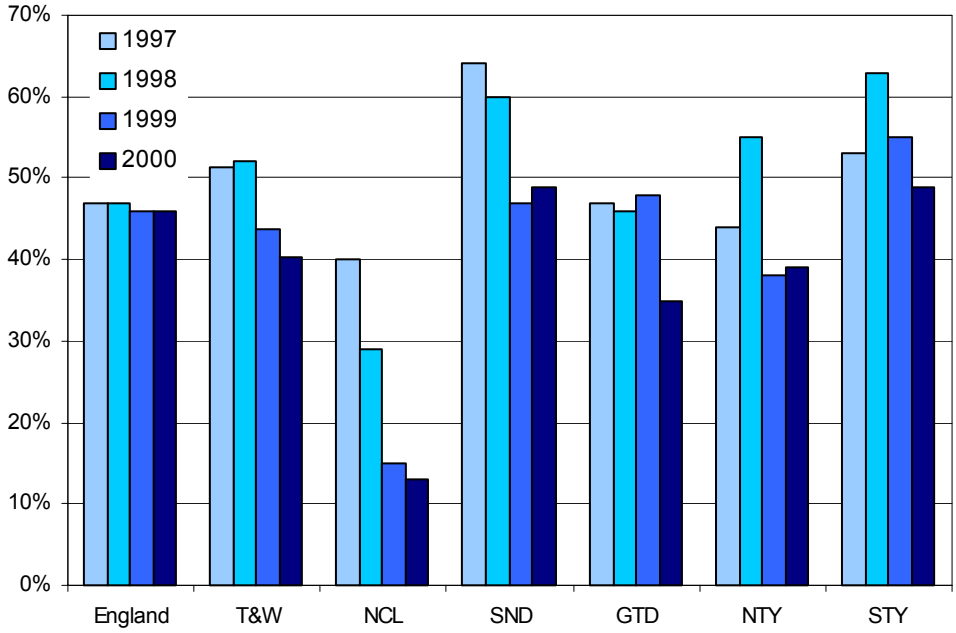


Figure 11: Among the children who had been looked after continuously for at least four years, percentage of those who had been in their foster placement for at least two years.



The percentage of children who had been in their foster placement for at least two years changed very little in England (46% in 2000), but this hides great disparity between local authorities. Newcastle decreased this percentage from 40% to 13% between 1997 and 2000, whereas Sunderland decreased from 64% in 1997 to 49% in 2000.

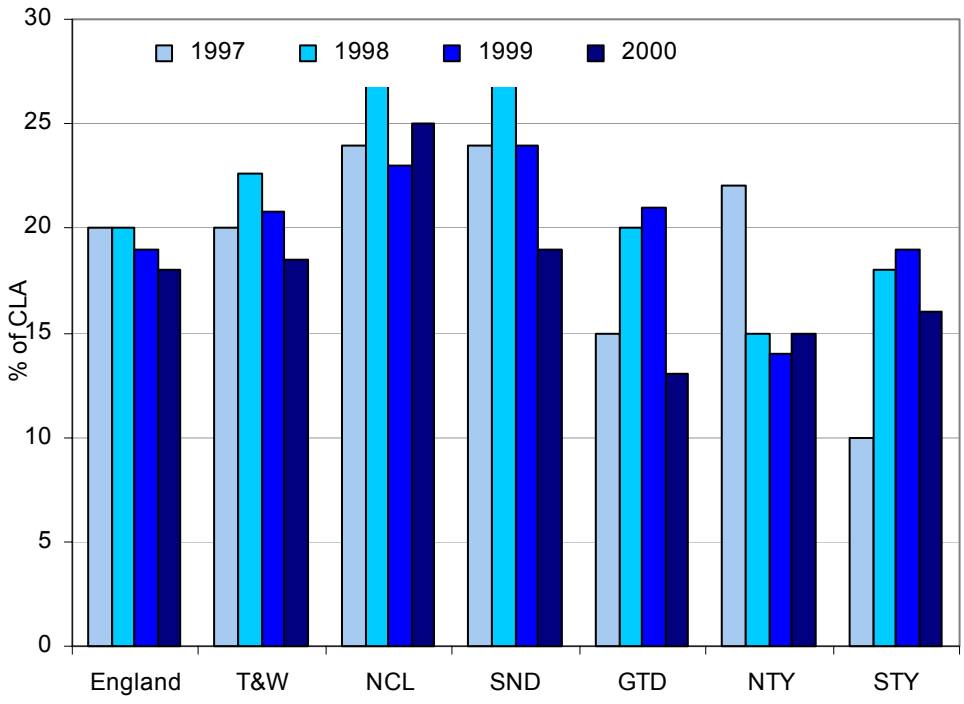
Movement within the care system is a major factor in children and young people failing to access appropriate primary and specialist health services, and the Department of Health is concerned about the frequent changes in placement that some looked after children experience. To tackle a national target for social services has been established under the National Priority Guidance as follows:

Reduce to no more than 16% in all Authorities, by 2001, the number of children looked after who have three or more placements during the year.

A count of the number of different placements a child has had over a given period of time provides a rough measure of the stability of care that that child has experienced. The proportion of children looked after at 31st March who have had 3 or more placements during the year has been established as a performance indicator in the Performance Assessment Framework (PAF) of Social Services; it is also a Best Value performance indicator.

Figure 12 shows the percentage of children looked after at 31 March 1997 to 2000, with three or more placements during the year. The denominator is the total number of children who were looked after at 31 March. Children who were looked after on that date under an agreed series of short-term placements were excluded from the count.

Figure 12: Percentage of children looked after at 31st March 1997 to 2000 with three or more placements during the year.

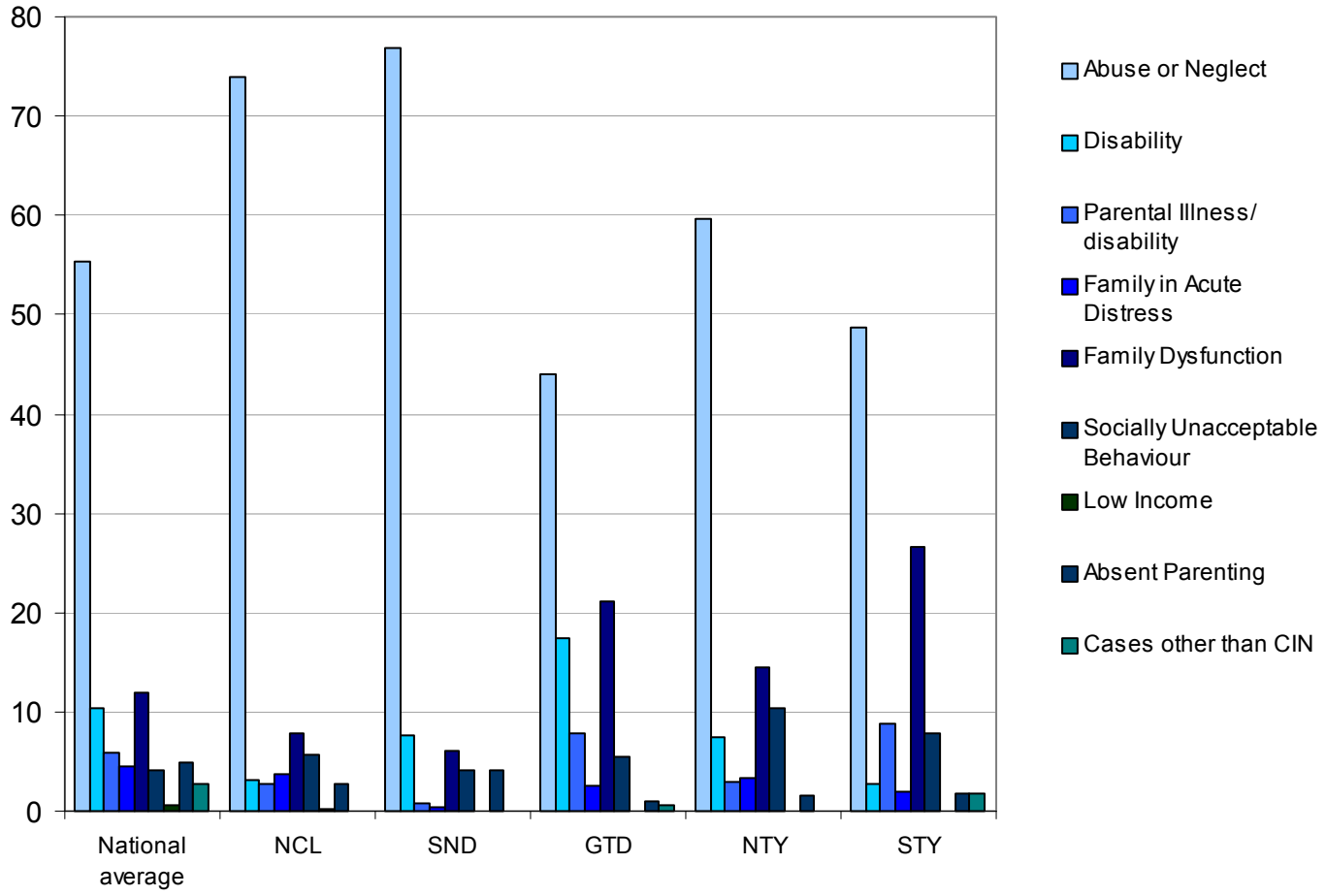


Gateshead, North Tyneside and South Tyneside have reached the national target of 16% or less by 2001, but with Sunderland (although they have noticeably reduced over the past few years) and Newcastle being well above it. Tyne and Wear as a whole still present with 18%, which remains above the national average.

Children Looked after at 31 March 2000

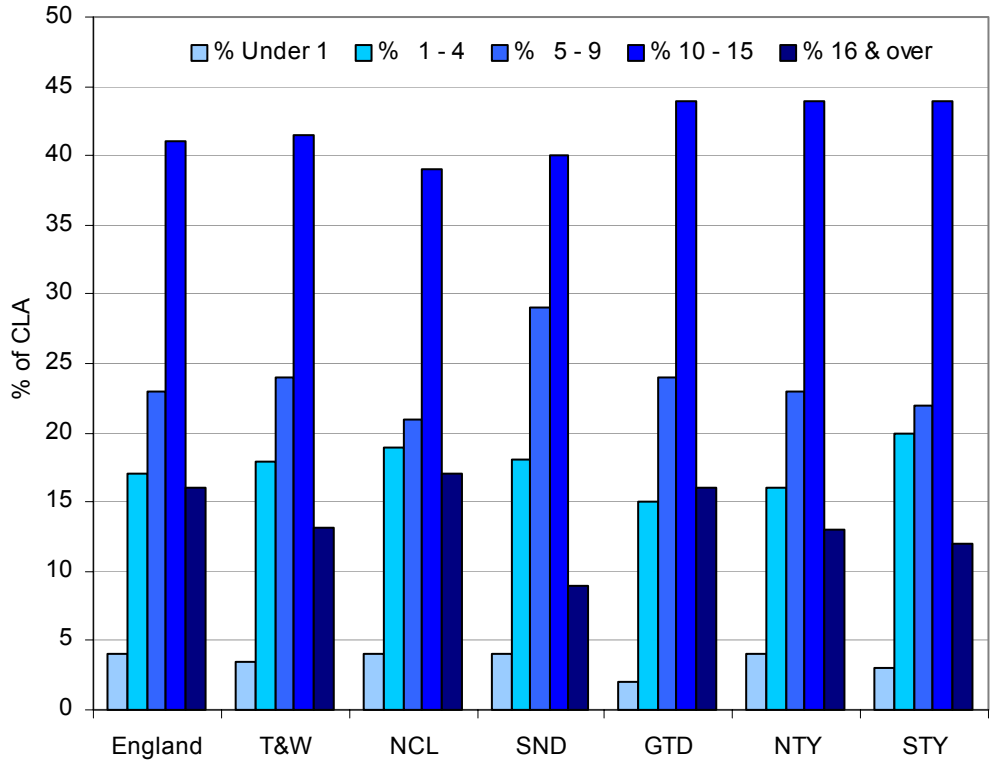
Children Looked After in 2000: who are they?

Figure 13: Children looked after by reason for needing services, expressed as a percentage of the total number of children looked after.



The proportion of children looked after on account of abuse or neglect is above the national average in North Tyneside, Newcastle and Sunderland. Gateshead looks after the greatest proportion of children with disability amongst Tyne and Wear local authorities. Parental illness and family in acute distress are the cause for children to be looked after in less than 10% of the cases, but family dysfunction accounts for 27% of the causes for children to be looked after in South Tyneside. Socially unacceptable behaviour is the cause for 10% of the children to be looked after in North Tyneside.

Figure 14: Children looked after at 31 March 2000, by age.

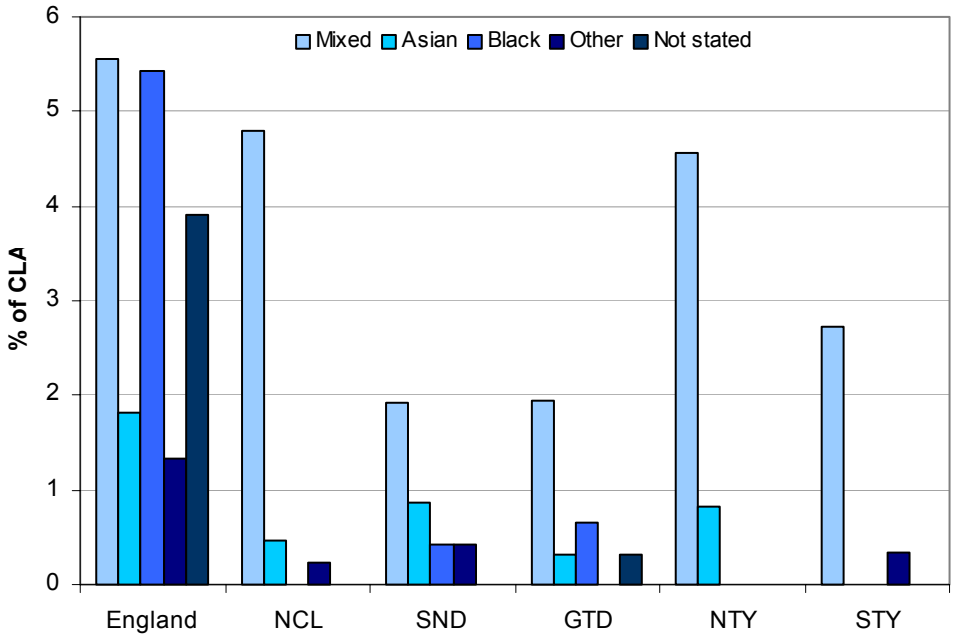


A large majority of the Children Looked After are aged between 10 and 15 years. The snapshot in 2000 shows that there are more boys looked after (55%) in England than girls. In Tyne and Wear the situation is the same, with proportions of boys going from 52% in Newcastle to 60% in North Tyneside.

The highest proportion of children looked after is amongst the 10 to 15 year age group in all authorities.

Figure 15 shows the ethnic origin of children looked after in a "typical week" in February 2000. This data is a result of a survey of activity and expenditure by local authorities in England, based on a census week in February 2000 (a "typical week" as chosen by each local authority).

Figure 15: Percent Breakdown of Ethnicity of Children Looked After in a typical Week

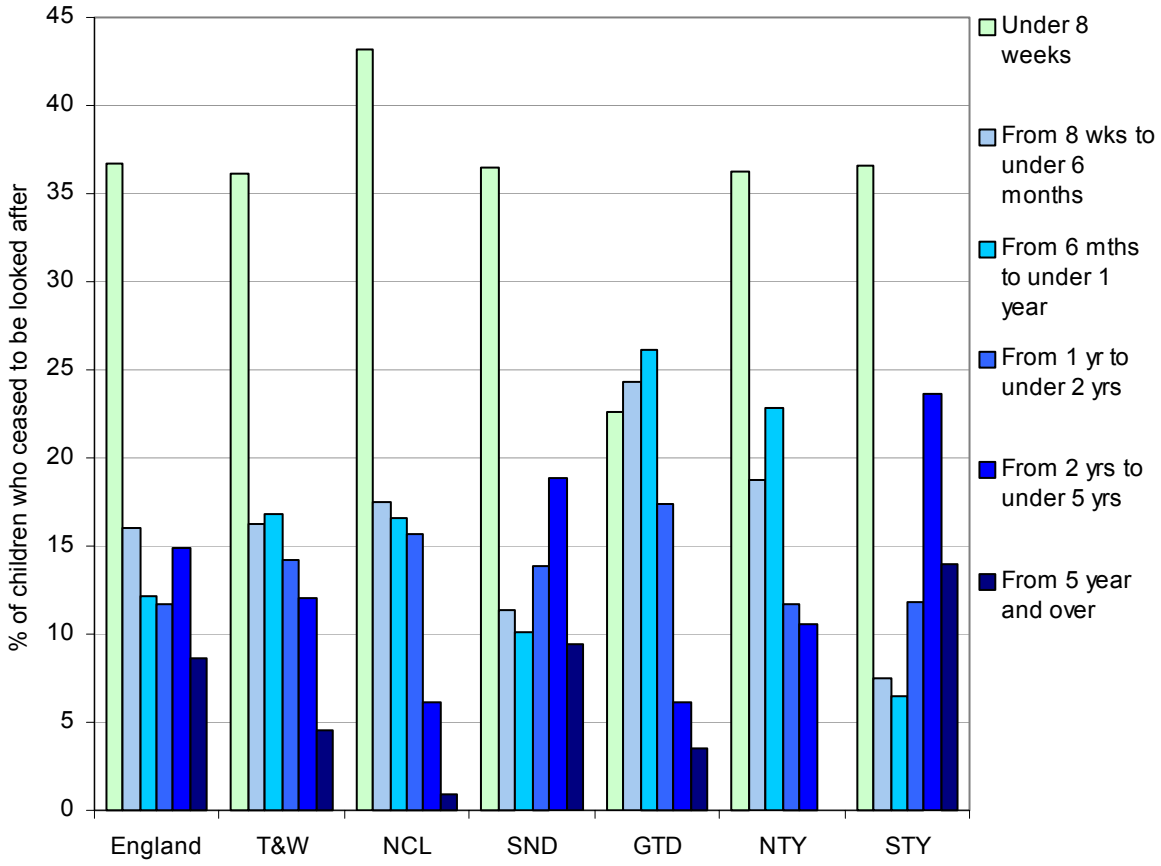


Nationally, 82% of the children looked after are of white ethnicity. This proportion is higher in Tyne and Wear, and ranges from 95% in Newcastle to 97% in South Tyneside.

The intention of the Children Act 1989 was to promote the use of accommodation as a family support service and, when a child has to live away from home, to make voluntary arrangements with the parents whenever possible. In Tyne and Wear at 31 March 2000, there were 545 children looked after by voluntary arrangement under section 20 of the Act (ie excluding children under agreed series of short term placements), representing 31% of all children looked after in Tyne and Wear.

Children Looked After in 2000: Stability in care

Figure 16: Children who ceased to be looked after at 31 March 2000, by duration of the last period of care.

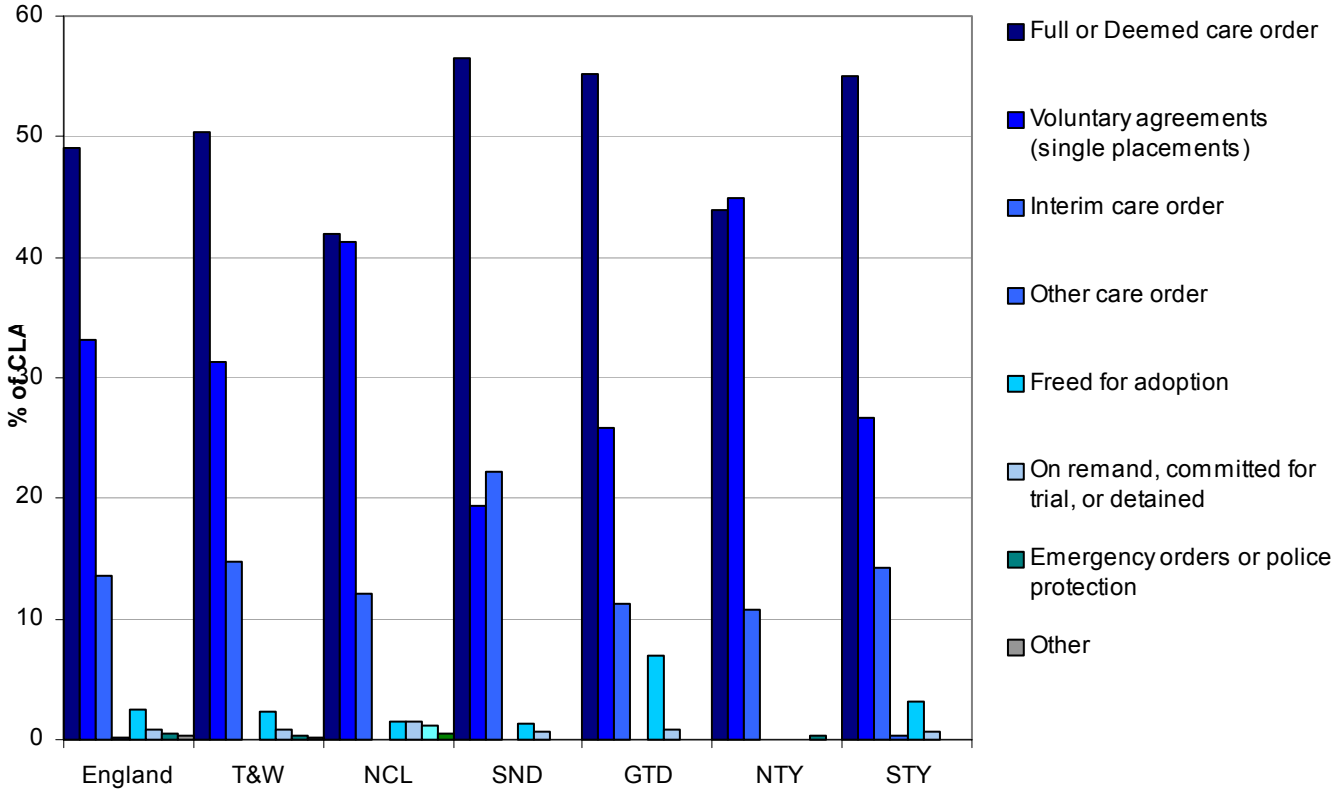


Sunderland and South Tyneside have noticeably high proportions of children looked after for 2 to 5 years, whereas this proportion is much lower in North Tyneside, Newcastle and Gateshead.

Children Looked After in 2000: Services provided

Figure 17 shows the legal basis for children to be looked after in Tyne and Wear; this excludes children looked after under an agreed series of short term placements and is based on the best estimate for England, including estimates for missing data.

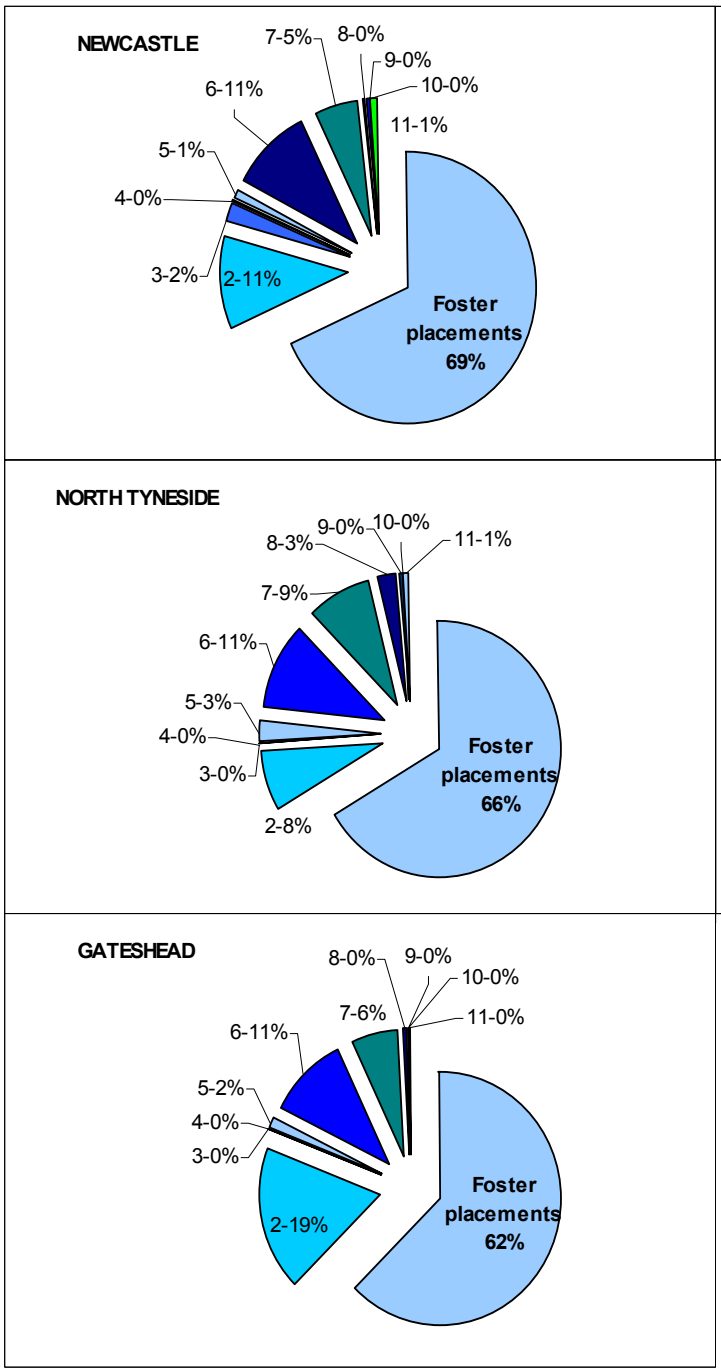
Figure 17: Children looked after by 31 March 2000 by legal status.



Care orders are more commonly used in South Tyneside, Gateshead and Sunderland than in Tyne and Wear as a whole or than in England. Newcastle and North Tyneside seem more prone to use voluntary agreements.

Figure 18 shows the types of placements preferentially used by each of the local authorities in Tyne and Wear. It is expressed in percentage of children sent to a particular type of placement, over the total number of children looked after in the local authority at the 31st March 2000 (excluding series of agreed short term placements).

Figure 18 Children looked after by placement and by local authority in Tyne and Wear March 2000

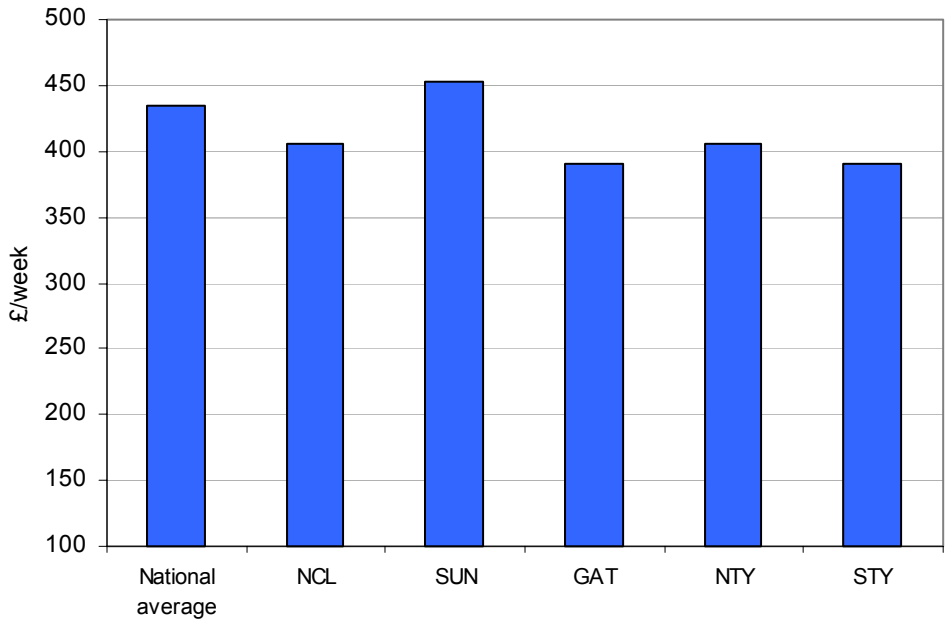


The key to placements is as follow:

1. Foster placements
2. Community home
3. Voluntary homes or hostels
4. Private registered homes
5. Schools, associative homes and hostels
6. Placement with parents
7. Placed for adoption
8. In lodging, living independently
9. Young offenders institution or prison
10. Absent from agreed placement
11. Other

Figure 19 shows the estimated cost of each child looked after per week, and figure 21 the estimated number of hours of staff or centre time received by children looked after, in a "typical" week in February 2000. These data were extracted from the report: "*Children in Need in England: Results of a survey of activity and expenditure by local authority in England*" by the Department of Health. The Results were based on a survey of Children in Need and the activity and expenditure reported by social services.

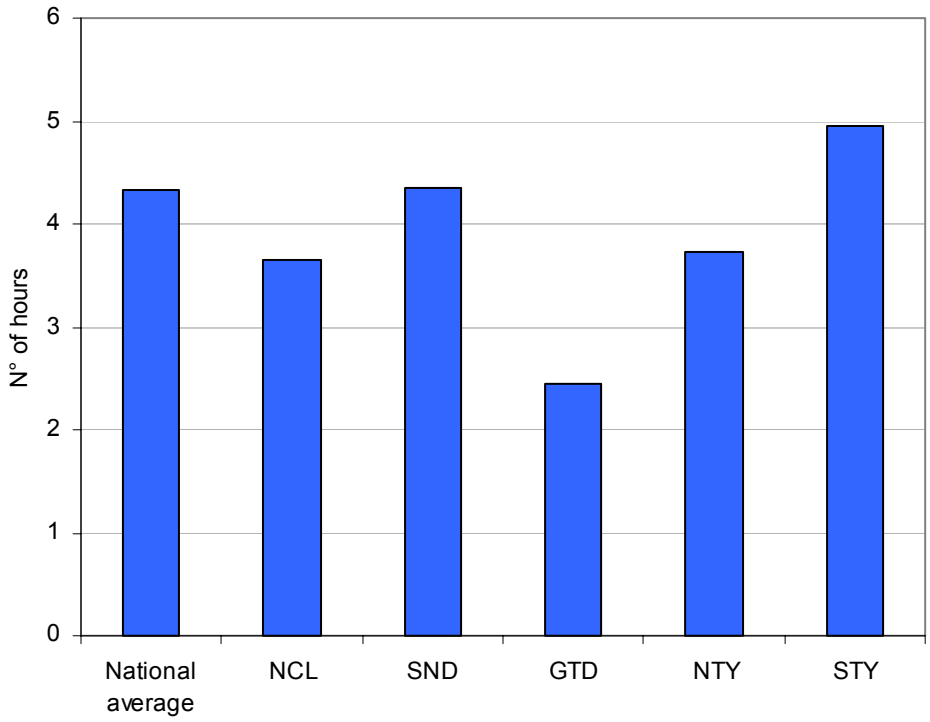
Figure 19: Expenditure per Child Looked After receiving a service from local authorities social services, in a sample week in February 2000



All authorities' estimated weekly expenditure on each child they are looking after falls below the national average, except for Sunderland. The estimated costs range from £390 a week per child in South Tyneside to £452 in Sunderland.

The weekly expenditure per child in Sunderland of £17 more than the national average might be accounted for by a bigger number of residential homes in Sunderland (13, compared to 9 in Newcastle, 7 in Gateshead, 5 in South Tyneside and 4 in North Tyneside), which provide 24 hours care for children, and are therefore particularly expensive to run. In addition, a new training programme for foster carers has been initiated last year in Sunderland, contributing to the cost.

Figure 20: Number of hours of staff or centre time received by Children Looked After in a sample week in February 2000



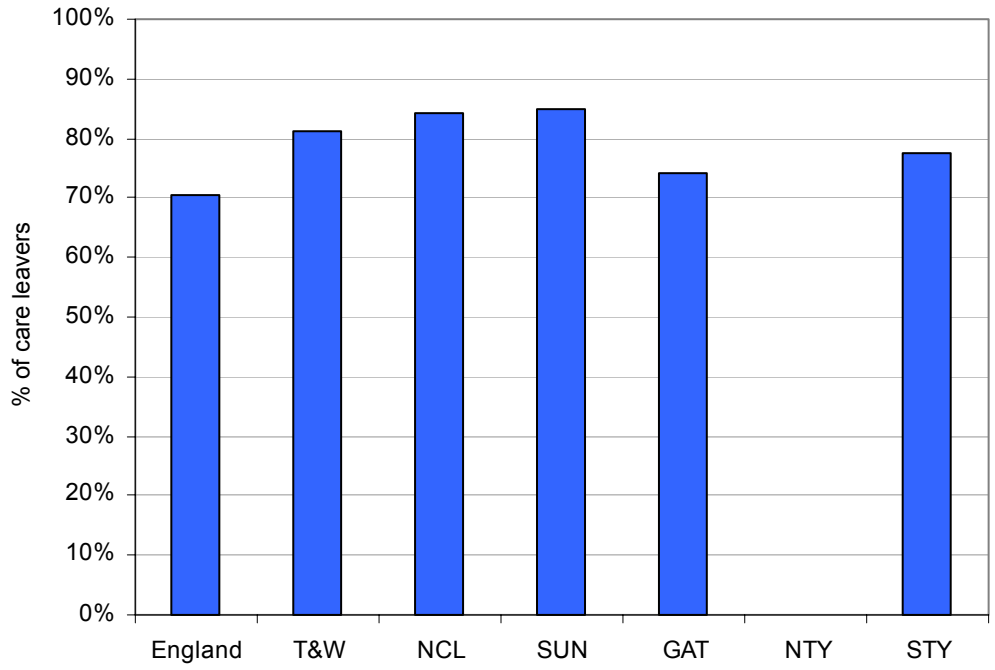
The estimated time spent with each child looked after varies greatly between authorities; children looked after in Gateshead benefit on average from 2.4 hours per week each whilst it is estimated that they are seen on average 5 hours in South Tyneside.

It has to be noted that these data include time spent and expenditure by social services, and may or may not include information on the time children have spent under medical attention. As a result, these data may not be the best reflection of all resources used and needed for the benefit of the children. These data should be put in balance with the health status, and the social and psychological well-being of the children looked after in each local authority.

Access to good education has a direct impact on a child's health and well-being. It can enable integration within a social network and encourage a sense of being a valued member of the local community, as well as helping to establish positive peer relationship. Many looked after children experience disruption to their schooling through placement moves and they make up a disproportionate number of children either temporarily or permanently excluded from school. This not only affects their academic achievement, but contributes towards them becoming socially excluded and places them at greater risk of engaging in activities which may be detrimental to their health.

The Government has set the target to "improve the educational attainment of children looked after by local authorities, by increasing to at least 50% by 2001 the proportion of children leaving care at 16+ with at least one GCSE or GNVQ equivalent; to 75% by 2003". Figure 21 shows the proportion of children who left care at 31 March 2000 without GCSE or GNVQ qualifications.

Figure 21: Children who ceased to be looked after during the year ending 31 March 2000, aged 16 or over, without GCSE or GNVQ qualifications.



The DFE website quotes the national average for all children aged 16 or over who do not have a qualification as 5.6%, this displays a wide variation to the children who have been looked after with a national average of 70%. In Tyne and Wear the figures are:

South Tyneside	5.4%	Newcastle	11.0%
North Tyneside	5.6%	Gateshead	8.4%
Sunderland	4.8%		

The proportion of care leavers with a qualification is much higher in England as a whole than in Tyne and Wear. Amongst local authorities, this proportion varies from 15% in Sunderland to 26% in Gateshead (no data available for North Tyneside).

A national initiative (Neighbourhood Renewal) is trying to re-dress this balance by targeting the most deprived wards in the country and providing extra educational help for the children who are not achieving the results, which they would be expected to achieve. Many of these children are those who are looked after, and the initiative is expected to be specific to individuals by providing such things as classroom assistants. This funding will last for between 7 and 10 years

The health of children looked after

There is clear research and practice evidence that children and young people who are looked after away from home have greater levels of health needs than their peers and yet are less likely to receive adequate health care. Much of this may be due to their environments and experiences before they started to be looked after. But it also reflects a lack of effective parenting within the care system combined with a lack of thorough partnership work across agencies to ensure fully joined up service between birth parents, carers, children and the health services.

A study conducted in 2000 found that children in residential care within Leicestershire and Rutland (Patel et al, 2000) have unmet health needs and a higher incidence of mild to moderate learning difficulties, emotional and behavioural problems. The figures indicate higher rates of growth failure, obesity, epilepsy, teenage pregnancy, psychological disturbance, habitual smoking, alcohol drinking and use of illicit drugs. These unmet health needs of children looked after in Leicestershire and Rutland are likely to have long term consequences in these young people's lives, and to be widespread within the UK regions.

There is evidence that the current take up of health assessments and examinations for looked after children is poor nationally. While in some authorities well co-ordinated and child centred arrangements ensure a high take up, in many other authorities figures are as low as 25%. Evidence about the health of looked after children, as a population is hard to gather, as current recording practice on health questions in local authorities is not consistent.

Tyne and Wear have implemented a number of initiatives to improve the health outcomes of children who are looked after, including local action plans, the appointment of specialised professionals and of a Health Action Zone co-ordinator.

The Tyne and Wear healthcare standards aim to ensure that children who are looked after will receive healthcare that is appropriate and responsive to their age and needs. Each district has a different practice base for healthcare which ranges from a medical model of health assessment undertaken by a paediatrician to a more social based nurse led arrangement by school nurses or health visitors. Sunderland have combined both approaches offering the skilled medical expertise of a paediatrician with the social holistic aspects of health promotion by a specialised nurse in a "children's centre". Sunderland have been able to collate more comprehensive data on the children in their authority as each child who has been looked after has had a new initial health assessment during the year 2000 / 2001, irrespective of their previous health status. This review of the health process has found that 65% of the children who were assessed for the first time had health needs which required referral to other services, whilst 35% of children who had already been assessed under the previous system continued to have outstanding health needs requiring referral. These needs included ENT, orthodontic or dental treatment and child and family mental health referrals.

Health assessment of children looked after by local authority, in Tyne and Wear

Gateshead:

Approximately 309 children looked after.

There has been a pilot scheme from January 01 to July 2001; health assessments are now undertaken by school nurses (for 11 year olds or older) or by the health visitor (for under 11s), whereas previously they were all seen by a Community Medical Officer (CMO) or GP. During the initial assessment, an individual health plan is prepared. A database had been set up separate from social services, prior to the pilot. A school nurse in a short-term seconded post is in charge of the co-ordination of services around Looked After Children.

The pilot process for arranging and recording health assessments for children entering care is organised by the Administrative Co-ordinator upon receipt of request from Social Services. An appointment is arranged by the professional undertaking the health assessment who tries to ensure that this is completed and the health care plan prepared for the child's 28 day Review.

The department accesses the National Child Health System, which records health information for children from birth to 16 (or children with special needs to the age of 19). This provides background information concerning their developmental checks, screening and immunisation status. An Excel system has operated throughout the pilot to record basic information, a brief outcome, referrals and follow-ups. Once the initial assessment is completed, information is fed back to the Local Authority database.

Health promotional work has been initiated this year with residential staff and foster carers, with the view to later identify some peer educators amongst young people.

An assessment of the health needs of children looked after in Gateshead was undertaken in January 2000 by Gateshead Children's Services. Data available to school nurses and health visitors were assessed through an audit of Child Health Records for school children, and Health Visitor records for pre-school children.

In school health records, the Boarding-out medical was recorded in 54.5% of the records, but there was no content of the consultation and no evidence of a health plan or of intended intervention. 50% of the Looked After Children were not known to their school nurse.

The health visitors knew all pre-school children and although 100% had up to date developmental checks, immunisation and care plans, dental details were not recorded. 40% of birth details and parent held records were missing, giving an incomplete history at a very young age. The Boarding-out medical was only recorded as having taken place in 20% of the records and the health visitors were unaware of who had carried out the medical, the content or the outcome of the consultation.

Questionnaires distributed to carers showed that 50% of the carers in Gateshead felt that children coming into care did not have a comprehensive health / medical record and did have unresolved medical or health problems. Only 53.6% had a clear idea of the health needs of children in their care.

Newcastle:

Approximately 440 children looked after

Paediatricians complete all reviews and assessments, and a specialist nurse is currently being appointed. The database is separated from social services. An Education Achievement Team has been set up, and ensures that expertise in health, education and social services is available to Looked After Children in residential units.

North Tyneside:

Approximately 240 children looked after.

Paediatricians and GPs complete the initial and review assessments for younger children. School nurses are completing reviews for young people aged 13 and over.

The database is separated from social services, but there are difficulties in accessing accurate and relevant information.

South Tyneside:

Approximately 290 children looked after.

GPs undertake initial and review assessments for all children apart from those in residential care who are seen by the paediatrician. The appointment of a specialist nurse is currently being considered. The database is still in the early stages, and includes a list of new children coming into the system and the date of their initial health assessment.

Sunderland:

Approximately 470 children looked after.

Until January 2000 all children who entered the Looked After System were seen by their own or their carers GP's for their initial and annual medical examinations. Any comprehensive health assessments commissioned were conducted separately and were not recorded as such in any database.

From January 2000 a completely new system was introduced, involving all children entering the Looked After System being seen by the Consultant Community Paediatrician at the central clinic, for a comprehensive health assessment, which includes access to existing health records and consideration of the child's social history.

Unmet health needs (for example, incomplete immunisation programmes, missed specialist appointments as well as newly diagnosed conditions) are identified for each child, and immediate referrals made to the appropriate service. The service sets a target to provide health information and a health-care plan for the child in time for the first looked after review held within 28 days of the child becoming Looked After. The Community Consultant Paediatrician schedules the annual review.

During the first two years of implementation all annual health reviews are being conducted as full comprehensive assessments in order to ensure that a complete health database is established for all Looked After Children.

A new database has been established within the central clinic. This is separate from the social services database, and extensive collaboration between the two services, and periodic validation, allows the system to be kept rigorously up to date. All health information is held on this database, minimising the potential loss of information that occurs when children change placement, GP or school. The team is able to optimise follow-up where this is required.

In Sunderland all the following data are systematically recorded, and kept up to date:

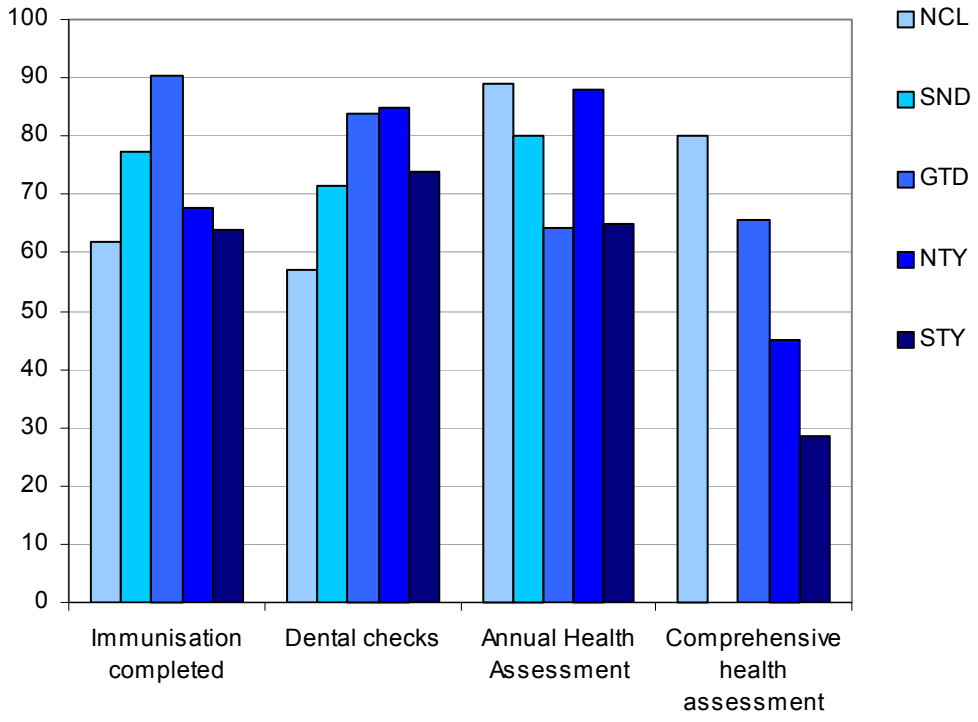
Demographic information	Christian name, Surname;
	Sex, Date of Birth;
	Current address;
	Family address;
	NHS N°; Social services N°
Professional (1st)	Address of referring person;
	Registered GP;
	Health visitor;
	School
Professional (2nd)	Name, address, specialty, status and reason for referral
Project	Relation with carer;
	Name of natural parents, Name of carers
	Health authority;
	Dated placed, date of notification received, date of assessment completed, date of information received from GP, date sent to social services;
	Out of area
Family members	Relationships (mother / father…), Name, Date of Birth;
	Relevant health issues;
Birth / Development	Gestation;
	Place of birth;
	Delivery, birth weight;
	Special Care Baby Unit;
	Gross motor, Fine motor, Speech & Language;
	Cognitive development
Immunisations	Date, status, comments
Medical problems	Professional address
	Specialty;
	Status
Medication	Drugs, Dosage;
	Allergies (effect);
Register	Registration date; end date; status
	Adoption;
	Child With Disability;
	Looked after child;
	Remand

Other details	Foster / adoption, placement
	Accommodation, legal status
	Parental response
	Special education need, Stage code of practice
	Reference to a psychologist
	Language, Ethnicity
Medical details	Height, Weight (date)
	Vision (date)
	Hearing (date)
	Dental checks (date)
Childhood illnesses	Date for: Measles, Mumps, Chicken pox, TB, TB (family),
	Whooping cough, German measles, Disability
Reference to	Professional, date, status, comments
Surveillance	Surveillance, date, status, done, comments
Discharge	Where, why, action, date

The health status of children looked after in Tyne and Wear

Figure 22 shows the Quality Protects base line information for Tyne and Wear for 1999. Each local authority is now required to collate this information annually and present it within their Quality Protects Management Action Plans. Prior to the launch of Quality Protects this information was not recorded. The information remains inaccurate and incomplete although this is improving. The graph indicates the number of children looked after in Tyne and Wear presenting with a completed course of immunisation, those who have had regular dental checks, children who have had an annual review health assessment and those who had a comprehensive health assessment when they became looked after.

Figure 22: Health indicators for children looked after in Tyne and Wear 1999.



Within the general population about 95% of all children had been immunised against diphtheria, tetanus and polio by their second birthday. The national target for complete immunisation status remains at 95%. Statistical data available at: http://www.doh.gov.uk/public/sb0126.htm

The information provided within figure 22 gives an incomplete picture of the services operating across the Tyne and Wear Health Action Zone. A variety of factors compromise the data. These include:

- Variations between individual authorities' data collection methods
- Variations in interpretation of standards
- Lack of common or consistent definitions of a 'comprehensive health assessment' and the danger of equating an 'initial medical' with a comprehensive assessment.
- The impact of changes to immunisation programmes over the past 18 years

- (including recent changes in some authorities due to prioritisation of the meningitis vaccination programme)
- The lack of management systems to collect appropriate data in the initial stages.
- The lack of previous base line information.

At present there is no clear definition of what a comprehensive health assessment consists of. As a result, the outcomes may not always be comparable. The regulations in force at the time only provided for a 'medical examination'. The Department of Health has issued recommendations on data sets for comprehensive health assessments within their consultation document (see annexe 2). This may standardise the format of health assessments to some extent. However at present each district has developed its own system, and health and social services agencies are waiting for the Department of Health guidance, which might clarify how, when, by whom and to what standards a comprehensive health assessment should be conducted.

The data in figure 22 shows that in Newcastle, children looked after were the least likely to be fully immunised (62%) or to have had a dental check (57%), but 89% of them had had an annual health assessment, and 80% had had a comprehensive health assessment on admission into the system.

In South Tyneside, less than a third of the children (29%) had a comprehensive health assessment when they first started to be looked after, and just over 60% had had an annual health assessment and had their immunisation completed; 74% of them had had a dental check.

In North Tyneside, 45% of the children had had a comprehensive health assessment when they first started to be looked after, and 88% had had an annual health assessment. North Tyneside was the area where children were the most likely to have had a dental check (85%), but only 68% of the children were fully immunised.

In Gateshead, only 64% of the children had had an annual health assessment, and no data were available at the end of 1999 on the proportion of children who had been admitted in the system with a comprehensive health assessment. However, 84% of the children had had dental checks, and 90% of the children were fully immunised (the highest percentage in all authorities).

At this time, no data was provided on the initial comprehensive health assessment from Sunderland. 80% of the children had had an annual health assessment, just over 70% had had dental checks and 77% of the children were fully immunised.

Whilst these are the official returns for Tyne and Wear to the DoH as at 30.9.1999 they do not provide an accurate account of the health status of looked after children at that time due to the factors identified above which adversely affect the reliability of this data. In particular, Sunderland did not provide the data for the initial comprehensive health

assessment as they took the view that the 'initial medical examination', which was the standard prior to January 2000, could not be regarded as a comprehensive health assessment. Since January 2000 Sunderland's revised arrangements provide for a fully comprehensive health assessment, and in the first 9 months of the operation of this service 93% of children entering the system have been so assessed. It has also been possible to identify those children who missed the assessment due to leaving the system very quickly, and to ensure they are appropriately notified to other health services. This system also ensures that information about looked after children is accurate and up to date.

Gateshead have, also had a pilot scheme operating from January 2001 providing a nurse led health assessment for looked after children. The secondment of a school nurse to oversee this development provided accountability and gave the scheme its direction.

The authorities, which have been able to provide specialised professionals, have been able to make the most progress and Sunderland has demonstrated the effectiveness of having a specialised team to consider the needs of Looked After Children.

Conclusion

Natural parents care for their children in a holistic manner, they know their history and will be able to monitor changes in a child's well-being and act upon it. When children are looked after by local authorities, their care is shared between social services, health and education authorities. As a result, information concerning these children is scattered amongst professionals sometimes without continuity between different agencies and different care episodes.

The government requires social services to record all relevant information on children being looked after, and there is an expectation of corporate responsibility between all agencies. Holistic health has had a low priority, the focus being rather on crisis intervention and illness. The baseline information required by the Department of Health (immunisation, attendance at health assessments and dental checks) is very limited, a wider overview which, links to children's education plans and social services reviews may provide a greater measure of health outcomes for children who are looked after.

Until recently, data collection on the health of children looked after has been very poor, and this has made it difficult to monitor children's health progress. Even the baseline information required by the Department of Health has not always been available and remains inaccurate. The difficulties around the collection of this information have been related to:

- a lack of communication between agencies
- a lack of compatibility between databases, even where they exist
- different priorities between agencies
- confidentiality issues and policies
- division of responsibilities between agencies
- lack of awareness amongst professionals about the need for preventative and educational health
- lack of consensus on the content of health assessments and on which professional group should undertake them
- the nature of the children's experiences has lead to research identifying additional health needs, which are not always recognised amongst the range of professionals involved with them
- professionals being employed on short term contracts, which prevents them from having any long term impact on the management of children's health
- health monitoring being an additional responsibility for already stretched resources

Many of these issues will require a long-term co-operative approach to develop health-monitoring systems for children who are looked after. It is now widely recognised that health outcomes for these children are poor and that the systems in place do not work well for children who have frequent moves and a lack of parental advocacy.

Additionally vast quantities of epidemiological data may not provide an improvement in the qualitative nature of their healthcare. Payne et al (2001) recommends a minimum epidemiological data set of:

- Immunisation status
- Child health surveillance uptake
- Registration with dentist
- Presence of health care plan
- Implementation of health care plan
- Waiting times for therapy
- School attendance

This level of data collection would provide a measure of access to services, healthcare and outcomes, which are universal. Alongside this, is the need for individual monitoring of each child via their health assessment, the presence of the healthcare plan and it's implementation. The individual healthcare plan will assess the 'healthiness' of individual children, which due to the wide variations in their profiles is impossible to compare.

These two measures: the epidemiological data and the individual monitoring indicate access to healthcare in a universal sense of general expectations throughout the population. Normally healthcare planning and implementation is co-ordinated by parents advocating on behalf of their children. Where this is not possible, systems need to be put into place to produce the same outcomes. These measures can be benchmarked to illustrate the efficiency of the professionals and systems involved.

The minimum data set needs to be supported by a qualitative measure of the health assessments in order to ensure these are meeting the needs of the children/young people Payne et al (2001). Local authorities need to devise the means to provide indicators of the qualitative standard of the healthcare of the children in their care. This will require a range of indicators to be established by authorities to ensure their outcomes.

There have been a number of strategies implemented by Tyne and Wear to improve the health outcomes of children who are looked after, including local action plans, the appointment of specialised professionals and of a Health Action Zone co-ordinator. There are pockets of initiatives and good practice within all the authorities, but these are often related to particularly committed individuals, rather than a co-ordinated strategic overview. The areas which have appointed specialised health professional for looked after children have been more proactive in responding to the inherent problems of collaborating with other agencies, collecting appropriate information and monitoring children's health.

To ensure that children who are looked after acquire and maintain positive health outcomes both qualitative and quantitative assessment of their needs should take place. It is imperative that the right issues are considered and monitored.

Children who are not in the care of their natural parents and enter a system that necessitates frequent and often unplanned moves require services to fit their situation. Within this system no one person retains the totality of knowledge or ability to deal independently with these children. There is therefore an overriding need for multi-agency co-operation and communication.

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Consultation Process

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A consultation process took place with reference to the report with members of the HAZ Task Group for Looked After Children who represented Health and Social Services professionals from the Tyne and Wear region.

The process followed the same format that had been used with the other exemplar issues of Cerebral Palsy, Low Birth weight and Serious Injury. The first part of the exercise focused on a wish list that individuals held on working practices and then concentrated on which actions could take place to improve the development of information systems for Looked After Children (LAC)

It was felt that Quality Protects was substantially different to the other exemplar issues, Quality Protects was generic in nature and all the other five issues could impinge on Looked After Children.

Wish List

1. To resolve which numbers we use for identifying children

If there were a common identifier for children it would be easier to track their development. Sunderland have now resolved this within their area as health will now use NHS numbers for all children and all documentation (including letters) will have this common identifier. This could be more effective if it was used regionally/nationally. There is however another issue about how we can then use this information – there is a difference between having the ability to know who the children are and then using this knowledge.

2. Databases between Health and Social Services are linked.

Information is available on a generic level about children's health but it is not possible to know who is going to be Looked After (or sometimes even who is currently being Looked After). There are indicators of concerns for children's health, and if databases were linked it would be possible to be more fully informed of the indicators and then to act on them.

It would also allow comparisons for example if smoking was an issue in one area it would be possible to check how that affected LAC. Also to check the level of unmet health needs and to measure which are elective issues eg orthodontic treatment.

3. Being able to monitor Failure to Attend

Many of the children have health appointments but fail to attend – protected addresses and movements make tracking these children very difficult. If health were able to deal with failure to attend by knowing where children were it would save massive amounts of money and improve health issues for this group of children. An example of this was that at an initial referral in Sunderland the child didn't attend however the mother arrived with another child in the family and they were able to pick up on the first child, if this had been left solely to Social Services to deal with the child would probably have been lost.

If a child has a genetic disorder and a family who do not attend appointments how do you pick it up again? For families who do not attend children are frequently missing important follow-ups.

A system, which monitored and supported this problem, would be very useful for this group of children who have high rates of failure to attend appointments.

4. A link between the people using the information and what is being collected

At the present time people just want the systems that are in operation to work and don't worry about how it is or what is collected. A link is needed between the information that is collected and the people who are using it so that the correct information is collected.

There are questions about what should be collected: How do we want to ask questions and get the answers that we need. For example getting census information to provide the answers we need – to make available the information that people want.

At the present time there is no health information aggregated into a useable format, there is a lot of individual information but these need to have a way of linking together. It is also possible to get snap-shots at certain points but there is no way of being able to monitor on an on-going basis.

Aggregating the data would also be able to help service providers. Many assumptions are made about issues such as smoking or other health conditions being more prevalent amongst LAC. Aggregating the data would enable targeted interventions.

5. Information shared across the region

If systems were set up across the region instead of in each locality children could be tracked when they move around or are placed out of area.

6. One information system for Health

One information system that addressed the complete age span for children, as health cannot even provide information for themselves under the present system.

General Discussion Points

Comments were made about the Quality Protects PAF Indicators as this focused Social Services attention to these areas whilst health had a much broader remit. Targets however make this more difficult as they need to be measured and mean that people concentrate on these pointers. Additionally the targets were not age specific so dental checks were required for babies and would then become a negative factor. Also for children in short-breaks where parents have declined immunisations this is recorded as a 'no'.

The PAF indicators were felt to be too broad and we now needed to collect more refined information. Also that it was necessary to check out information that was given by word of mouth eg being able to check that children are registered with a dentist. Also need measure of outcomes for LAC – perhaps this needs to be part of their pathway plans.

In Newcastle the dates of immunisations are also given, this allows cross checking with placements and ensuring that people have undertaken their responsibilities.

Lessons have been learnt by trying to track down the very basic information that was required for QP. This proved to be a difficult exercise and in the initial stages impossible – how is it then going to be possible to track more difficult information? For example if we wanted to know the number of referrals that had been made to drug and alcohol teams.

Discussion took place about IT systems and the need to ensure that agencies knew what they could and couldn't provide and the impact they would have on other service providers. There was also felt to be a need for clear guidance about data protection as many of the children are on legal orders with shared parental responsibility.

It was also felt that frameworks were developed without agreements between agencies about the processes or viability of collecting some information for example the request on LAC documents for the child's NHS number. There is no agreement about how this number will be obtained or consent to request it. This needed government guidance about the way it was to be collected and how it was to be used before being included in the documents. There is no point in collecting data for the sake of it – there needs to be clarity about what it is being collected for and what it will be used for.

One centre should be responsible for ensuring that all information is correct – all names addresses etc. This depends on the quality of the person inputting the information. A central point for inputting information eg a school or hospital was considered a way forward. However the more changes there are the more errors and the percentage of error could affect the children in this group. If the accuracy in Sunderland were 99.9% this would still mean that 400 children had inaccurate records and these would generally be the vulnerable children who Social Services are most interested in – how can you then validate the information?

Social Services were considered to be the key agency for collecting information as they have prime responsibility and health does not collect all information.

The graphs contained in the report were felt to be extremely useful and have had an impact on local services. If the graphs could be produced in this format on an annual basis this would be helpful to all the agencies.

For the data to be useful it needs to be linked to other information that is representative.

There needs to be a mechanism in place to make representations, and local authorities need to have a means by which user satisfaction can be measured.

There was additionally a lack of Internet access for many of the agencies which was felt to be a major local government issue as DOH is using the web for many of it's documents.

The HAZ task group has enabled communication throughout Tyne and Wear with regard to the health of LAC. As HAZ funding is due to expire in March it was considered that there needs to be a continuing mandate for agencies across the region to meet regularly to share and develop information. Otherwise, "main streaming" of these important initiatives will not occur.

Child Health Information Development Project

Terms of Reference

To collate information across sectors concerning the health and health outcomes of local children and assess its fitness for the purposes of users

To develop and map a set of exemplar indicators of child health and health outcomes from public services for children across Tyne and Wear

To pilot and evaluate option(s) for improved creation and dissemination of inter-sectoral child health information.

Programme of Work

A series of representative indicators of children's health across the HAZ will be explored in some depth, in particular, for their social differentiation and relationships to indicators of social exclusion.

The exemplar issues chosen are:

1 Teenage Pregnancy

2 Low Birthweight

3 Smoking Prevalence

4 Incidence of Serious Injury

5 Prevalence and Severity of Handicap in Children with Cerebral Palsy

6 Quality Protects

A consultation exercise with a sample of users will examine the fitness-for-purpose and priorities for development across the full range of actual and potential indicators of child health outcomes. An option appraisal exercise will be conducted on potential methods of access to and enhancement of such information sources within and without the Authorities and bearing in mind the requirements of the NHS Information Strategy. Following this exercise the recommended options will be piloted and evaluated using quality indicators, pre-specified by users.

The work is led by Dr Philip Lowe, a senior research associate employed by the University of Newcastle and supervised by Professor Jarvis and Dr Cresswell, former Director of Public Health, Newcastle and North Tyneside. Close links will be developed with the Health Authorities, Local Authorities and Community Paediatricians.

Timetable

Stage 1: Collation of data: in-depth studies of 6 exemplar issues with reports.

Stage 2: Sample survey of users: Option development, appraisal and reports.

Stage 3: Option pilot(s) and evaluation. Reports and recommendations.

For further information please contact Dr Philip Lowe, Tel: 0191 477 6000, Fax: 0191 477 0370 or e-mail: p.j.lowe@ncl.ac.uk

Quality Protects Data Issues

Source(s) of Data

The various data were downloaded from www.doh.gov.uk/public/stats3.htm.

Detailed information is available for the year ending 31 March 1999. An analysis of these data has been completed by the Department of Health and published as “Children Looked After by Local Authorities, Year Ending 31 March 1999 England. Ref A/F 99/12”. Only provisional data are available for the year ending 31 March 2000.

Health authorities were contacted and data on the health status of looked after children were obtained directly from the people collecting them.

Data Problems

Data concerning social services are collected nationally and are relatively easy to get hold of. This is not the case with medical data, which are only sparsely collected, at the sole initiative of local groups.

Annexe 1

Technical Notes

The statistics presented in this report are based on two returns by local authorities:

- Form CLA100, on which authorities provide some aggregate figures;
- Form SSDA903, on which they provided detailed data on a “one third” sample of their looked after children, covering children born on a day of the month divisible by 3. This sampling approach was introduced from 1 April 1997.

Figures from the CLA100 collection were summarised in a Department of Health Statistical Bulletin in October 1999. Since then additional information has been received and as a result some figures have been revised in this publication.

Figures presented for years before 1997/1998 are based entirely on the detailed SSDA903, which for those years covered all looked after children. For 1997/1998 onwards, data from the two collections have been combined to provide the best estimates available for the figures at a national level and at a local authority level. The methodology in the main has been to use a range of multiplying factors, which are calculated by comparing CLA100 totals with counts of valid SSDA903 records.

The 1997/1998 and 1998/1999 figures in some tables are based entirely on the aggregate data from the CLA100 return.

All other tables present breakdowns derived from the SSDA903 return grossed up using figures for the whole population from CLA100. In some tables the figures for ‘all children’ are CLA100 figures whereas the detailed breakdowns are obtained from the SSDA903 sample. The act of sampling reduces the reliability of some of the breakdowns presented. This should be borne in mind when interpreting figures for individual authorities that are derived from the SSDA903, particularly where the figures for individual categories are relatively small.

Figures from the two sources are presented on a consistent basis wherever possible, so that the sum of figures from the sample equals the total the total figure from CLA100. However in some cases this was not possible, and footnotes explain the inconsistency.

Rates per 10,000 population have been calculated using the appropriate mid-year estimates of the number of children in England aged under 18years, supplied by the office of National Statistics. A small number of children aged 18years and over are included in the figures, but this is not thought to seriously distort the rate. The mid year population estimates for 1996 to 1998 have been used to derive estimates of rates for the years 1996/1997 to 1998/1999 respectively.

Annexe 2

Data for Comprehensive Health Assessment

The Department of Health suggests a minimum data set for children who have been looked after for more than 12 weeks.

- Full registration with general practitioner
- Registration with a dentist
- Uptake of age appropriate immunisation
- Uptake of age appropriate child health surveillance
- Referral to specialist hospital services
  - Waiting time referral to appointments
  - DNA (Did Not Attend) at appointments
- Referral to CAMHS (Child and Adolescent Mental Health Service)
  - Waiting time referral to appointments
  - DNA (Did Not Attend) at appointments
- Referral to child development team
  - Waiting time referral to appointments
  - DNA (Did Not Attend) at appointments
- Referral to speech therapy
  - Waiting time referral to appointments
  - DNA (Did Not Attend) at appointments
- Referral to Drug Advisory Service
- Requests for input to Statement of Educational Needs
- Attendance at A&E
  - Injury
  - Other
- Hospital admissions
  - Emergency
  - Other
- Deaths

- Pregnancies
- Births

BAAF (British Agency of Adoption and Fostering) have developed a format for initial health assessment record (which can be purchased), their intention is that this should accompany the child throughout any change of address.

Some authorities have developed their own record form, which encompasses information, which they feel, is relevant. This is a step forward, as it entails the need to collect information from appropriate sources and sets up a standard for health checks.

Annexe 3

Quality Protects - Objectives

Objective 1: To ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood.

Objective 2: To ensure that children are protected from emotional, physical, and sexual abuse and neglect (significant harm).

Objective 3: To ensure that children in need gain maximum life chance benefits from educational opportunities, health care and social care.

Objective 4: To ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care.

Objective 5: To ensure that young people leaving care, as they enter adulthood, are not isolated and participate socially and economically as citizens.

Objective 6: To ensure that children with specific social needs arising out of a disability or health condition are living on families or other appropriate settings on the community where their assessed needs are adequately met and reviewed.

Objective 7: To ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response.

Objective 8: To actively involve users and carers in planning services in planning services and in tailoring individual packages of care; and to ensure effective mechanisms are in place to handle complains.

Objective 9: To ensure through regulatory powers and duties that children in regulated services are protected from harm and poor care standards.

Objective 10: To ensure that social care workers are appropriately skilled, trained and qualified, and to promote the uptake of training at all levels.

Objective 11: To maximise the benefit to service users from the resources available, and to demonstrate the effectiveness and value for money of the care and support provided, and allow for choice and different responses for different needs and circumstances

This report has been prepared by:

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