DEVELOPING SYSTEMS AND PROCESSES TO IMPROVE HEALTH AND WELLBEING IN SCOTLAND: **CHILDREN LOOKED AFTER AT HOME**

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"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."
Looked After Children & Young People: We Can & Must Do Better (Scottish Government, 2007)

INTRODUCTION

This paper provides a brief overview of a study commissioned by NHS Health Scotland, which was designed to support partners in their efforts to progress national and local policy agendas relating to the health and wellbeing of children looked after 'at home' or living in kinship care in Scotland. It focuses on the systems, processes and protocols currently in place across Scotland by which these children are identified to NHS Boards; the mechanisms by which their needs are assessed, recorded and communicated; and the inter-agency links set up to help 'act on' and improve their health and wellbeing.

The study employed a three-stage research methodology:

- An online survey, sent to local authority corporate parenting leads and health board directors.
- In-depth interviews with 14 local authorities and their corresponding health board areas.
- Brief good practice case studies developed from material gathered during the in-depth interviews.

The research was undertaken between November 2009 and February 2010

BACKGROUND

Looked-after children represent one of the most excluded and vulnerable groups in Scotland with poorer levels of mental health and wellbeing and fewer educational qualifications than peers not in care (Social Work Inspection Agency, 2006). The Social Work Inspection Agency (SWIA) report shows higher levels of substance misuse, teenage pregnancy and sexually transmitted infections for looked-after children than peers not in care.

Children and young people can face adverse life circumstances prior to becoming 'looked after', such as neglect as well as mental, physical and emotional abuse. Evidence suggests that children looked after at home experience even poorer health outcomes than those looked after away from home (Scottish Government, 2009).

Given their experiences and the fact that numbers of looked-after children are on the increase, their health status, along with existing health inequalities, is seen as a priority.

Improving aspects of children's services for children who are looked after at home or in kinship care is particularly challenging since children in these placements can be less readily recognisable and accessible to health improvement teams than, for example, children placed in residential care homes.

It was therefore deemed timely to explore the mechanisms currently in place to help ensure health outcomes for children looked after at home or in kinship care are addressed in tandem with peers in different placement settings.

Holistic approaches to improving health outcomes (Getting it Right for Every Child, Scottish Executive, 2006) call for a more integrated and effective collaboration between agencies to improve outcomes for all children and young people. This study has explored the extent to which partner agencies work together in developing strategic systems, inter-agency partnership working and appropriate services to improve the health and wellbeing of looked-after children.

NHS Health Scotland

AIMS & OBJECTIVES

The main aim of the study was to profile the current systems and processes designed to identify, assess and act on the health and wellbeing needs of children looked after at home or living in kinship care in Scotland.

In particular, the study would:

- Establish the process by which children looked after at home or in kinship care are identified to NHS Boards.
- Determine the mechanisms by which the health and wellbeing needs of these children are assessed, recorded and communicated between partners.
- Analyse local strategic, cross-sectoral planning mechanisms designed to improve the health and wellbeing of children looked after at home or in kinship care.
- Analyse inter-agency mechanisms and processes that enable local organisations, services and professionals to 'act' on the needs of these children to improve their health and wellbeing.

METHODOLOGY

The study adopted a three-stage process using quantitative and qualitative research methods.

An online questionnaire was distributed to all corporate parenting leads in every local authority across Scotland and to every health board director with corporate responsibility for looked-after children.

To encourage a high-response rate, the survey was designed to be completed within fifteen minutes. In addition, telephone interviews using the survey questions were undertaken, and respondents were assured that their responses would be anonymous.

In-depth, semi-structured interviews were then undertaken, either one-to-one or in small groups, in seven NHS Board areas with relevant health professionals and their colleagues in local authorities.

Detailed notes of each interview were grouped thematically then analysed. Case studies highlighting good practice were developed from the 1:1 interview material in order to illustrate key partnership links, referral pathways and effective responses in addressing health and wellbeing issues.

The study confined itself to an overview of children's planning and assessment systems, rather than a detailed review of complex care pathways between health and social care services.

MAIN FINDINGS

Strategic Planning

In general, local authorities and their partner organisations reported having joint strategic planning processes in place for looked-after children. However, this was further developed for children looked after 'away from home' than for children looked after 'at home' due to planning partners exercising a perceived need to 'prioritise' some groups over others. Some local authorities and NHS Boards adopted a stepped approach which, in relation to strategic planning, served to identify as a priority those children looked after at home who are on the child protection register or living in kinship care.

As a result, joint planning for children living at home with their own families and not listed on the child protection register appear less well developed than those defined as looked after 'at home'.

Identifying looked-after children

Most areas reported having systems in place to inform local health services whenever a child became looked after at home, while just over half routinely informed health boards of further changes in the child's circumstances.

However, there was little evidence of clear, consistent processes that routinely informed NHS Boards of 'all' looked-after children in their area, although the in-depth interviews did indicate that steps to develop such systems were underway in several areas.

Information relating to children looked after at home or in kinship care tended to be reported to health services ad hoc, rather than on a routine/systematic basis – most often when social work was actively involved with a family and only when a health assessment was deemed necessary.

Sharing such information relied on having sufficient capacity and suitable systems in place so that social work departments could routinely alert health services and that health services in turn could then receive and process this information.

During the in-depth interviews, one NHS Board reported being routinely informed about looked-after children living in kinship care in their area only because these children were defined by local authorities as looked after 'away from home'.

Another NHS Board reported receiving paper notification of children looked after away from home but no information on children looked after at home or in kinship care.

Barriers which served to discourage the practice of notifying health services with regards to children looked after at home in their area included:

- High mobility of children and their carers.
- Perceived lack of capacity in looked-after children health teams that prevents them from offering the same level of assessment and services to the children looked after at home as they do to children looked after away from home.
- Inadequacy/absence of consistent, compatible processes and shared IT data.

Assessing health & wellbeing

The data strongly suggested that routinely undertaking comprehensive health needs assessments for children looked after at home or in kinship care is rare across Scotland, with the majority of areas reporting no system or protocol being in place to routinely undertake this task.

Only three of the areas routinely assessed the health of these children, with a further two doing so for looked-after children in kinship care only.

Some NHS Boards and social work services did not regard 'all' children looked after at home or in kinship care as being 'at risk of poor health'.

Therefore, in some of these areas, children looked after at home or in kinship care received a comprehensive health assessment by health services 'on request', if deemed necessary by social work, which was often considered on a case-by-case basis.

NHS Boards and Community Health Partnerships had developed their own approaches to assessing the health of children looked after at home, dependent upon the systems they had available.

The lack of a consistent format/template for carrying out comprehensive health assessment did not appear to support the exchange and recording of information.

Training for public health nursing staff and other professionals involved in delivering assessments was not comprehensively delivered across all areas, and in some rural communities experience in the process was limited due to the low number of children looked after at home or in kinship care living in the area.

The British Association of Adoption and Fostering (BAAF) form used in assessing the health of children looked after away from home was not generally used in assessing the health of children looked after at home or in kinship care, even in the areas where they were managed in the same way.

Acting on identified health needs

In terms of 'acting' on health needs, the majority of areas reported that they did not deliver health improvement initiatives solely for children looked after at home or in kinship care. Instead, the need to make universal/mainstream health services and initiatives suitable and accessible to children looked after at home or in kinship care was highlighted.

A minority of areas had developed healthcare pathways specifically for children looked after at home, or had a system for coordinating and monitoring referrals. However, less than half of the areas had rapid access to appropriate health services for children looked after at home.

Examples of good practice in enabling children looked after at home to access wider, relevant services that addressed their health needs were found to some extent in the form of youth-specific sexual health and counselling services. Very few voluntary sector services appropriate to children looked after at home were identified.

The involvement of healthcare professionals and services was not made clear once information from the comprehensive needs assessments was incorporated into a child's care plan.

A degree of confusion was reported relating to the delineation of children looked after away from home and those in kinship care, which hindered co-ordination and understanding of the needs of the study's target group.

SUMMARY

Rather than develop separate services, the data highlighted a clear desire to make universal/ mainstream health services and initiatives accessible and suitable for children looked after at home or in kinship care. To facilitate this outcome, a number of factors may require further development. As reported, this includes having sufficient capacity, systems and protocols in place so that social work departments can alert health services of all looked-after children in their area and that health services are in a position to receive, process and act on this information. This in turn may require mutually compatible, user-friendly IT data systems and protocols, along with the capacity and commitment to use them.

In addition, a consistent template to undertake comprehensive health needs assessments may be needed to support the process. Further clarity may also be required with regards to the involvement of healthcare professionals and voluntary organisations once information from the comprehensive needs assessments has been incorporated into a child's care plan. It is clear from the data that progress is being made with regards to this agenda. It is therefore hoped that findings from this brief study will help share learning between partners so that further progress can be made to improve health and wellbeing needs for *all* looked-after children in Scotland.

The full report: 'Profiling Current Health Improvement Processes which Identify and Act on the Health and Wellbeing Needs of Children Looked After at Home in Scotland' is now available from NHS Health Scotland's website: http://www.healthscotland.com/documents/4269.aspx

Developing Systems and Processes to Improve Health and Wellbeing in Scotland (Children Looked After At Home). Pauline Cameron & Associates/June 2010. For further information please contact: John Brown, Senior Health Improvement Programme Officer, NHS Health Scotland: john.brown8@nhs.net