Looked after children:
Best practice guide for primary care

NHS Kent and Medway CCG Looked after Children's team

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Contents

Glossary:

CCG	Clinical Commissioning Group
Coram BAAF	Coram British Association of Adoption and Fostering
CYPMHS	Children and Young People Mental Health Service
DfE	Department for Education
DoH	Department of Health
FGM	Female Genital Mutilation
GP	General Practitioner
IHA	Initial Health Assessment
LA	Local Authority
RHA	Review Health Assessment
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
PR	Parental Responsibility
SCIE	Social Care Institute for Excellence
UASC	Unaccompanied Asylum-Seeking Children
CYP	Children / Young People

1. Executive Summary

Primary care play a vital role in ensuring the healthy outcomes for all children and young people, especially those who are vulnerable, such as looked after children. Looked after children have often experienced significant neglect and / or some form of trauma. Neglect of health needs is a common factor and as a result looked after children are at risk of poorer health outcomes than their peers[i]. It is therefore vital that this group of vulnerable children receive continuity of health care, careful management of health records, access to routine surveillance, immunisation and prioritisation of referrals to secondary and tertiary care when required.

This policy is for all staff within primary care and has been developed to support Kent and Medway CCG and primary care colleagues to strive for continuous improvement in providing equitable, effective, safe, timely, efficient and child centred health care for all looked after children.

Context

As of the 31st March 2019, the numbers of looked after children by local authorities in England increased, by 4% to 78,150 from 75,420 in 2018 and there have been continued increases in recent years. This is equivalent to a rate of 65 per 10,000 children in 2019, which is up from 64 per 10,000 in 2018 and 62 per 10,000 in 2017[ii].The number of children starting to be looked after fell slightly at end of 2019, by 2%. 31,680 children started to be looked after in the year ending 31st March 2019, down from 32,050 in 2018[iii]. The number of children ceasing to be looked after has fallen again by 2% to 29,460, from a high of 31,850 in 2016. Statistics for the numbers of looked after children are published in September for the previous financial year; therefore the most up to date national data is from March 2019.

Local data demonstrates that at the 31st March 2019 there were 1358 looked after children by Kent County Council and 424 by Medway Council; both overall numbers have been relatively stable from the previous year. Many children are placed into Kent and Medway from other local authorities and at the 31st March 2019 there were 1363 looked after children placed into Kent and 477 placed into Medway. The data is not always reliable due the dependence on other local authorities informing the CCG of their placement; therefore it is possible that a greater number of children are in fact placed here.

Legal framework

In UK law a child is ‘looked after’ if they are in the care of the local authority for more than 24 hours[iv].

Legally this could be when they are:-

- living in accommodation provided by the local authority with parental agreement (Section 20)
- the subject of an interim or full care order (Section 31)
- the subject of an emergency protection order to remove them from immediate danger

- detained in a secure children's home, secure training centre or young offender institution
- an unaccompanied asylum-seeking minor

For the purposes of this document, as described in the Children Acts 1989[v] and 2004[vi], a child or young person is anyone who has not reached their 18th birthday. A child ceases to be 'looked after' when they are either adopted, returned home, placed on a Special Guardianship Order (SGO) or reach 18 years of age.

Consent

It is important to enquire under what legal basis a looked after child is accommodated in order to ensure valid consent is obtained from the correct person. Young people aged 16 or 17 are regarded as adults for the purposes of consent and therefore entitled to the same duty of confidence as adults. The principles of the Gillick competencies also apply to looked after children as they would with any child[vii].

Below is a summary of the consent requirements:

- **Section 20 of the Children Act 1989** - Voluntary care: If a child is accommodated by a local authority for a continuous period of more than 24 hours, but not subject to a care or placement order, they are likely to be subject to Section 20 of the Children Act 1989. The child is still deemed to be a looked after child but the parent(s) retain full parental authority. Consent for medical treatment should be obtained from the child's parent. The child's social worker will be able to support the obtaining of consent from the parent with parental responsibility.
- **Section 31 of the Children Act 1989** - Care order: Consent for medical treatment of a looked after child who is subject to a care order or placement order could be obtained from the child's birth parent(s) as well as the local authority (i.e. all those with parental responsibility). However, section 33 of the Children Act 1989, deems that, for children subject to a care order, the local authority determines the level at which a parent can exercise their parental responsibility - in essence the local authority has the final say and as such will act in the best interest of the child.

Foster carers, residential care workers or prospective adopters (prior to the adoption being completed) never have parental responsibility for a child in their care and therefore can only make decisions that the local authority have 'delegated' to them[viii].

When referring a looked after child for any further treatment, it should be made clear that they are 'looked after' and the name of the social worker/ team manager (if known) at the local authority also included with the referral; they are the 'corporate parent' of the child.

The child's voice and the importance of seeing young people alone

No child is too young to have a voice and it is important that their wishes and feelings are heard and documented appropriately. Children and young people should be at the centre of any decision making, which not only promotes their self-esteem but supports them in developing their own story about their lives.

Promoting engagement with health appointments supports young people in developing their confidence, builds trust and encourages them to take ownership over their own health. By taking control over their own health, any treatment plans are much more likely to be successful and young people feel as though they have much more control over their lives.

Young people should be offered the opportunity to be seen alone during health appointments in line with their age and ability to understand. This will support the development of independence skills and also plays an important part in safeguarding. During a consultation the adults needs can dominate; therefore young people can become less visible. Young people may not feel able to share sensitive issues or report any abuse in front of their carer; therefore it is important they are able to speak in confidence during their appointments.

It is understood that, subject to assessment of competence, 16-17 year olds are able to give consent for themselves, they should also be afforded the same level of confidentially as adults and therefore are entitled to make decisions whether their personal information is shared. Consideration should always be given to safeguarding as the welfare of the child is paramount (Please see section 19 of this guidance for further information regarding information sharing).

Health of looked after children

Although many looked after children have the same or similar health needs to their peers, the extent is often greater due to their past experiences. Two thirds of looked after children have been found to have at least one physical complaint, such as speech and language problems, bedwetting, coordination difficulties and eye or sight problems[ix]. In addition to physical health problems, almost half of looked after children have a diagnosable mental health disorder compared with one in ten of the general population of children. Conduct disorders are most prevalent, with many others having emotional disorders or hyperactivity. 11% are reported to be on the autistic spectrum and many others have developmental problems[x]. Delays in identifying and meeting emotional well-being and mental health needs can have far reaching effects on all aspects of looked after children's lives, including their chances of reaching their full potential and leading happy and healthy lives as adults[xi]. Immunisations are often incomplete; this is frequently identified when children become looked after and addressing this will form part of the health care plan.

Due to their greater needs, statutory timeframes have been put in place to ensure all looked after children will receive an initial heath assessment (IHA) within 20 days of becoming looked after, usually completed by a community paediatrician. Following that; children under 5 years old receive a review health assessment (RHA) every 6 months and children aged 5 to 18 years receive a review health assessments annually, usually completed by a Specialised Looked After Children's Nurse. To ensure the child's health plan is of high quality, the health assessment should use relevant information drawn together beforehand and given to the health professional undertaking the assessment. This will include information held in the primary care record which primary care has a responsibility to share.

When children reach 18 years old they are provided with a health history - making their own relevant health information available to them.

Even though looked after children have regular health assessments, GPs and the primary care team have an important part to play in supporting carers, children and young people to develop resilience and in identifying and referring problems early. GPs take a holistic approach to the whole family registered with them and are responsible for primary physical and mental health.

Unaccompanied minors

Unaccompanied asylum-seeking minors are young people aged under 18 years who are applying for asylum in their own right. They are separated from both parents and not being cared for by an adult with legal responsibility for them. Unaccompanied minors have usually travelled from their original country without their parents or legal guardian. They are looked after children and have the same rights and access to care as UK children. Their status, age and circumstances can be uncertain and they may have experienced significant hardship prior to arriving in the UK; they may have witnessed or experienced trauma and be suffering extreme loss.

The literature suggests that unaccompanied minors have significant physical and mental health needs which is reported to be as high as 48%[xii] of the cohort. These are influenced by access to limited healthcare in their home country, their experience of hardship (including the witnessing and experiencing of traumatic events), and the duration and conditions on their journey to the UK. The most important health issues relate to communicable disease (such as tuberculosis), dental health, nutrition, sexual and reproductive health and mental health issues such as post-traumatic stress.

These additional health needs should be taken into account including having clear screening and referral guidelines for unaccompanied minors[xiii]. Further resources regarding unaccompanied minors health can be found on the UASC Health website[xiv].

Care leavers

Care leavers are likely to have additional mental and physical health needs and the impact of their social circumstances may exacerbate any health issues. Additional problems may include: risk taking behaviour, substance use, youth justice issues, poor financial circumstances and poor educational achievement.

The local authority is required under the Children and Social Work Act 2017[xv] to provide support to care leavers until their 25th birthday as many care leavers may have no significant care figure or responsible adult in their lives. The Act did not place any requirement for health services to have any additional specified responsibility towards care leavers[xvi]; however Clinical Commissioning Groups ‘must be mindful of the specific requirements of care leavers when commissioning health services as detailed in the Leaving Care Act 2000[xvii].

Whilst it is important to be aware of the needs and possible vulnerabilities of care leavers, it is important to ensure that they are able to take ownership of their health and therefore encouraged to make their own decisions in their health. While 'Care Leaving flagging' is possible in primary care, it is felt that best practice would be to ask for the care leavers consent prior to being 'flagged' when they reach adulthood. When young people reach 18 they are provided with a health history, it is expected as part of this that the specialist looked after children's team will discuss with the young person whether they would support a flag being applied to their records within primary care. The team will then record the young person's wishes and share that with primary care along with their health history and it would be anticipated that primary care would then action this.

Adoption

For a number of children who become looked after, their permanency plan will be for adoption and there are a number of ways in which a GP may be asked to contribute to their adoption journey:

- NHS Kent and Medway Clinical Commissioning Group commission adoption medical advisers to assess children and give advice to the local authority agency decision maker and to prospective adopters prior to matching[xviii]. The medical report is required by statute, used for court and helps to ensure that the child's health care needs are met.
- It is important that GPs share all relevant health information with the adoption medical advisers in relation to the child in question or their birth parents (with consent). GPs may be asked to undertake screening investigations deemed important prior to 'matching' panel or during the court process.
- The adoption medical report will only include relevant information about the birth family that may impact on the health of the child that is to be adopted. This third party information needs to be held (with care) in the record to ensure continuity of health information regarding any risks to future health such as genetic predispositions and potential need for future screening.
- The child will need to be registered with the GP practice using their birth name (not the name of the prospective adopters) until an Adoption Order is granted although the notes can specify and primary care staff use a 'known as' name – for example reception staff could use the name prospective adopters specified the child is to be called in announcements.
- The demographic details of a child placed with prospective adopters can be shielded on the NHS spine through 'sensitive flagging' if there are any concerns regarding the safety of the placement. This can be requested through the NHS digital back office.[xix] The social worker will need to consent to this request representing the local authority that holds parental responsibility. The prospective adopters may be asked by the social worker / medical adviser to then request this via the general practitioner.
- When an Adoption Order is granted by the court, the parental responsibility is held exclusively by the adopted parents and the birthparents no longer hold this. Under current adoption arrangements, the General Register Office for England & Wales

(GRO) notifies the Personal Demographics Service (PDS) (Spine) National Back Office (NBO) that an Adoption Order has been granted.

- The adopted child is given a new NHS number. All previous health information relating to that child should be merged into a newly created health record ensuring continuity of healthcare. However, demographic or identifiable details regarding birth family will need to be removed from 'contacts' on placement with adopters to avoid errors in contact and redacted from any records ensuring this information is not shared or visible to the adoptive child or family.

Adult health medicals

As part of the assessment process for prospective foster carers and adopters, health information is requested.

- It is important that both health and lifestyle factors are considered as these may have implications for a placement and are considered alongside positive attributes that the applicants may have to offer a child or children. The adoption and fostering agencies need 'to satisfy themselves that applicants are robust enough to meet the demands of parenting on a daily basis' and 'have a reasonable expectation' to remain well in order to safeguard and support a child including to adulthood in long term and permanency matching.
- GPs are asked to assess prospective carers and provide relevant past health history over the last ten years. The medical adviser, commissioned by NHS Kent and Medway CCG, will write a report and give an independent opinion on whether the health or lifestyle issues identified may have an impact on the child or need further exploration. They may request further more detailed information to give an informed decision and may contact involved specialist services with consent.

Private fostering

Children who are cared for under a private fostering arrangement are not considered to be 'looked after children' and therefore the local authority's responsibilities towards them are very different to those considered to be 'looked after children'.

Private fostering is when a child aged under 16 (or 18 if disabled), is looked after for 28 days or more by someone who is not a close relative of the child. This is known as a private arrangement and the National Minimum Standards for Private Fostering (2005)[xx] and Children Regulations 2005 apply (Private Arrangements for Fostering)[xxi].

By law, the local authority must be notified of private fostering situations, therefore if any employee within the practice becomes aware of a child who is privately fostered, they have a statutory duty of care to inform the local authority:

- For children living in Kent, the Kent County Council private fostering team can be contact on: 03000 411111
- For children living in Medway, the Medway Council private fostering team can be contacted on: 01634 335726 or privatefostering@medway.gov.uk

2. Introduction

Primary care plays a vital role in ensuring healthy outcomes for children and young people – particularly those who are vulnerable. Children and young people who are looked after by the local authority have often experienced significant neglect, including neglect of health needs, and/or trauma that may require a medical response. It is therefore vital for this 'at risk' group of children that there is continuity of health care, appropriate careful management of health records, access to routine surveillance, immunisations and prioritisation of referral to secondary or tertiary care when required.

The complexity of corporate parent responsibilities includes: issues of consent and confidentiality, statutory guidelines regarding health assessments, adoption and fostering regulations and relevant NICE guidance. This requires creation and development of a separate policy regarding looked after children for primary care.

3. Scope

This best practice guidance applies to all staff employed by the practice including; all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students and any other learners undertaking any type of work experience or work related activities.

4. Purpose

This guidance is provided by the Kent and Medway CCG in their commissioning role, to support primary care and strive for continuous improvement in providing equitable, effective, safe, timely, efficient and child-centred healthcare for children and young people who experience the care system.

The guidance aims to promote effective inter-agency working for looked after children across the Kent and Medway CCG and primary care. Key arrangements and responsibilities for looked after children are set out demonstrating how corporate accountability will be met whilst adhering to guidance that promotes best practice.

5. Engagement

This guidance has been developed by the CCG Looked after Children's team for use in primary care.

6. Context

At 31st March 2019, the numbers of children looked after by local authorities in England increased, up 4% to 78,150 from 75,420 in 2018, continuing increases seen in recent years. This is equivalent to a rate of 65 per 10,000 in 2019, which is up from 64 per 10,000 in 2018 and 62 per 10,000 in 2017[xxii].

The number of children starting to be looked after has fallen slightly at end of 2019, by 2%. 31,680 children started to be looked after in the year ending 31st March 2019, down from 32,050 in 2018.

The number of children ceasing to be looked after has fallen again by 2% to 29,460, from a high of 31,850 in 2016. After falls in the last 3 years, the average duration of the latest period of care rose slightly this year to 808, up from 772 days in 2018 and 772 days in 2017.

Note: National data is published in September for the previous year. Therefore the most up to date national data available for this report is March 2019.

Local data for Kent and Medway can be found in appendix two and three.

7. Legal framework

In UK law a child is 'looked after' if they are in the care of the local authority for more than 24 hours.[xxiii] Legally this could be when they are:-

- living in accommodation provided by the local authority with parental agreement (Section 20)
- the subject of an interim or full care order (Section 31)
- the subject of an emergency protection order to remove them from immediate danger
- detained in a secure children's home, secure training centre or young offender institution
- an unaccompanied asylum-seeking minor

For the purposes of this document, (as described in the Children Acts 1989[xxiv] and 2004[xxv]) a child or young person is anyone who has not reached their 18th birthday. A child ceases to be 'looked after' when they are either adopted, returned home, placed on a Special Guardianship Order (SGO) or reach 18 years of age.

Children Act 1989[xxvi] is the primary legislation setting out local authority responsibility to children 'in need', including looked after children. Section 22 imposes a duty on local authorities to safeguard and promote the welfare of each child they look after.

Children Act 2004[xxvii] requires local authorities, CCGs and NHS England to cooperate to promote the health and welfare of looked after children (Section 10).

Children and Social Work Act 2017[xxviii] requires local authorities publish their local offer for care leavers, provide personal advisers to care leavers up to the age of 25, provide extra support to promote educational achievement in relation to looked after children and those previously looked after, with a focus on improvements of outcomes for children going through the court process in particular timescales surrounding permanence and adoption options. The CCG remain an accountable corporate parent for looked after children and have representation on the corporate parenting board. The expectations of what a 'good' corporate parent is improved in the Act and this will directly influence the offer to looked after children and care leavers from the CCG and other partners.

The Care Planning, Placement and Case Review (England) Regulations (2010)[xxix] sets out the functions and responsibilities of local authorities and partner agencies under Part 3 of the Children Act 1989 ('the 1989 Act'), which concerns the provision of local authority support for children and families. In particular it describes how local authorities should carry out their responsibilities in relation to care planning, placement and case review for looked after children.

8. Relevant key guidance

There are a number of pieces of legislation and guidance which inform responsibilities and requirements with regard to working with looked after children; the key documents are summarised below.

- **The statutory guidance: Promoting the Health and well-being of looked after children (Department for Education and Department of Health, 2015)**[xxx] stipulates that all commissioners of health services should have appropriate arrangements and resources in place to meet the physical and mental health needs of looked after children. CCGs must be able to access the expertise of a designated doctor and nurse for looked after children. They retain responsibility for looked after children who are placed out of area and must ensure that their care continues uninterrupted and that arrangements are in place for smooth transitions into adult care.
- **Looked After Children: Knowledge, skills and competence of healthcare staff (Intercollegiate Role Framework, 2015)**[xxxi] sets out the specific knowledge, skills and competencies which health staff require in order to work with looked after children.
- **NICE Guidance PH28: Looked After Children and Young People (2010 updated 2015)**[xxxii] aims to enable children's health and social care services to meet their obligations to improve the health and well-being of looked after children. The recommendations cover local commissioning, multiagency working, care planning, placements and timely access to appropriate health and mental health services. Please note that this guidance is currently under review to reflect the changing needs of the population; however until published the guidance as above remains in place.
- **NICE Quality Standard QS31: Looked After Children and Young People (2013)**[xxxiii] gives specific measurable statements around the health and well-being of looked after children, young people and care leavers for all services.
- **Who Pays? Determining Responsibility for payments to providers (NHS England, 2013)**[xxxiv] provides guidance on how to determine who pays for health services for looked after children who are placed out of area. [xxxv]
- **Improving mental health support for our children and young people (Social Care Institute for Excellence, 2017)**[xxxvi] this report sets out findings from the evidence of the Expert Working Group and views of children and young people. It makes recommendations to address findings which will improve the mental health and well-being of looked after children.

9. Consent pertaining to looked after children

It is important to enquire under what legal basis a looked after child is accommodated in order to ensure valid consent is obtained from the correct person. Considering the circumstances of each looked after child should aid the protection of the child's rights and check that the parent(s)' legal rights are not overlooked or unlawfully overridden.

Young people aged 16 or 17 are regarded as adults for the purposes of consent and therefore entitled to the same duty of confidence as adults.

If a child under 16 is competent to consent for himself or herself to a particular intervention then further consent from the person/s with parental responsibility (PR) will not be required. Nevertheless it is good practice to encourage involvement of those with parental responsibility in decision making.

A Gillick competent child can consent to assessment and treatment; the 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. [xxxvii] The child must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions. A competent child is legally entitled to withhold consent to treatment. However, even though the child or young person may be considered to be Gillick competent, there are some situations where their refusal can be overridden by those with parental responsibility. If the treating doctor believes that the withholding of consent may be detrimental to the patient's wellbeing, legal advice may be required. It may be necessary for a court to determine whether treatment can be given against the wishes of the competent young person.[xxxviii]

Fraser Guidelines: Lord Fraser specifically addressed the dilemma of providing contraceptive advice to girls without the knowledge of their parents. Fraser guidelines are narrower than Gillick competencies and relate specifically to contraception.[xxxix]

The clinician should always seek consent to share. If the parent or child declines consent, a clinician can still decide to share in the best interests of the health and wellbeing of that child or for public safety reasons.

Section 20 of the Children Act 1989 – Voluntary Care:

If a child is accommodated by a local authority for a continuous period of more than 24 hours but not subject to a care or placement order, they are likely to be subject to Section 20 of the Children Act 1989.[xl] The child is still deemed to be a looked after child but the parents retain full parental authority. Consent for medical treatment should be obtained from the child's parent. The child's social worker will be able to support the obtaining of consent from the parent with parental responsibility.

Section 31 of the Children Act 1989 [xli]– Care Order:

Consent for medical treatment of a looked after child subject to a care or placement order could be obtained from the child's parents as well as the local authority (i.e. all those with parental responsibility), but it is the local authority under Section 33 Children Act 1989[xlii]

that determines the level at which parents exercise their parental responsibility in respect of their child. In essence, the local authority has the final say.

Regardless of age, emergency treatment to save life or prevent deterioration can be given without consent.[xliii]

Foster carers never hold parental responsibility for a fostered child; therefore they can only make decisions about the child where that authority has been delegated to them by the local authority and/or the parents.[xliv] Consent for medical treatment must otherwise be obtained as above.

For some decisions that are made by a person other than the child's carer, it may be expected that the carer will implement the decision. For example, parents or the local authority may agree to the provision of Children and Young People's Mental Health Service (CYPMHS), but ask the carer to take the child to appointments. This is not delegation of decision making to the carer, as the decision will have been taken by those with parental responsibility and a medical professional, but it will enable the delivery of the service to continue without the need for ongoing support from social workers. The child's Placement Plan should make clear what the expectations of the carer are in such cases.[xlv]

Detailed guidance for doctors regarding consent for treatment 0-18 years can be found on the GMC website.[xlvi]

When writing a referral for a looked after child, it should made clear that they are "looked after" and the name of the social worker or team manager (if known) at the local authority included on the referral as they are the corporate parent for the child.

10. The child's voice and the importance of seeing young people alone

No child is too young to have a voice and it is important that their wishes and feelings are heard and documented appropriately. Children and young people should be at the centre of any decision making, which not only promotes their self-esteem but supports them in developing their own story about their lives.

Promoting engagement with health appointments supports young people in developing their confidence, builds trust and encourages them to take ownership over their own health. By taking control over their own health, any treatment plans are much more likely to be successful and young people feel as though they have much more control over their lives.

Young people should be offered the opportunity to be seen alone during health appointments in line with their age and ability to understand. This will support the development of independence skills and also plays an important part in safeguarding. During a consultation the adults needs can dominate; therefore young people can become less visible. Young people may not feel able to share sensitive issues or report any abuse in front of their carer; therefore it is important they are able to speak in confidence during their appointments.

It is understood that, subject to assessment of competence, 16-17 year olds are able to give consent for themselves, they should also be afforded the same level of confidentially as adults and therefore are entitled to make decisions whether their personal information is shared. Consideration should always be given to safeguarding as the welfare of the child is paramount (Please see section 19 of this guidance for further information regarding information sharing).

11. Placements

There are a variety of placement options that local authorities will utilise in order to meet the needs of the looked after child in their care including:

- Foster placements
- Children's homes
- Secure units
- Placed for adoption
- Semi-independent living accommodation
- Living with parents
- Residential schools
- UASC reception centres

12. Health of Looked After Children

Most children enter the care system as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences.

Two thirds of looked after children have been found to have at least one physical health complaint, such as speech and language problems, bedwetting, coordination difficulties and eye or sight problems.[xlvii]

Generally the health and well-being of young people leaving care has consistently been found to be poorer than that of young people who have never been in care. For example, there are higher levels of teenage pregnancy and drug and alcohol abuse.[xlviii]

Almost half the children in care have a diagnosable mental health disorder compared to 1 in 10 of the general population.[xlix] Conduct disorders are most prevalent, with many others having emotional disorders or hyperactivity. 11% are reported to be on the autistic spectrum and many others have developmental problems.[l] Delays in identifying and meeting emotional well-being and mental health needs can have far reaching effects on all aspects of looked after children's lives, including their chances of reaching their full potential and leading happy and healthy lives as adults.[li]

Due to the neglect that some looked after children have experienced it is likely that they may have an incomplete immunisation history. This is often identified when they enter the care system and addressing this will form part of their health care plan – advising them to

attend their GP practice to have any outstanding immunisations.[lii] For those young people (including unaccompanied minors) where their immunisation schedule is not known, health professionals are advised to follow the NHS guidance '*Vaccination of individuals with uncertain or incomplete immunisation status.*'[liii]

Due to likely greater health needs, statutory timeframes have been put in place to ensure all looked after children receive an initial heath assessment (IHA) within 20 days of becoming 'looked after'. This is usually completed by a community paediatrician. Following this, children under 5 years old receive a review health assessment (RHA) every 6 months; those children aged 5 to 18 years receive review health assessments annually usually completed by a specialist Looked after Children's nurse. When children reach 18 years old they are provided with a health history making their own relevant health information available to them.

To ensure the child's health plan is of high quality, the health assessment should use relevant information drawn together beforehand and given to the health professional undertaking the assessment. This will include information held in the primary care record., which primary care has a responsibility to share.

Even though looked after children have regular health assessments, GPs and the primary care team have an important part to play in supporting carers, children and young people to develop resilience and in identifying and referring problems early. GPs take a holistic approach to the whole family registered with them and are responsible for primary physical and mental health.

13. Unaccompanied minors

Unaccompanied asylum-seeking minors are young people aged under 18 years who are applying for asylum in their own right. They are separated from both parents and not being cared for by an adult with legal responsibility for them. They are looked after children and have the same rights and access to care as UK children. A child may move between being unaccompanied and accompanied during the time their asylum applications are being considered, e.g. a child arrives alone but later united with other family members already here, or a child arrives with parents or relatives but is later abandoned, or a victim of trafficking, or brought in on false papers with an adult claiming to be a relative.

Unaccompanied minors have travelled from their country of origin usually without parents or legal guardian. Status, age and circumstances can be uncertain and they may have experienced significant hardship prior to coming to the UK. They may have witnessed or experienced trauma and be suffering extreme loss. There are a number of reasons why children may leave their home country including:[liv]

- fear of persecution - due to religion, nationality, ethnicity, political or social group
- parents having been killed, imprisoned or disappeared
- in danger of being forced to fight or become a child soldier
- war / conflict

- poverty / deprivation
- sent abroad by parents / family
- trafficking

Most unaccompanied minors are aged between 15 - 17 years although a small number of children are younger. Unaccompanied minors arrive via a number of routes and methods of travel. They can arrive with adults alleging to be their family but may not be related and are essentially unaccompanied and therefore may be in a private fostering arrangement. Professionals should not assume children are safe in such arrangements and should refer to local authority private fostering procedures. If child protection concerns are raised then safeguarding protocols and procedures should be followed.

The literature suggests[lv] that unaccompanied minors have significant physical and mental health needs. These are influenced by access to limited / basic healthcare in their home country, experience of hardship (including witnessing and experiencing traumatic events) and the duration of and conditions experienced on their journey to the UK. The most important health issues relate to:

- communicable diseases (e.g. Tuberculosis screening and vaccination)
- dental health
- nutrition (e.g. anaemia)
- sexual and reproductive health
- mental health issues including post-traumatic stress

The prevalence of symptoms consistent with a mental illness among unaccompanied minors has been reported as up to 48%. The most common types of mental illness reported in this cohort are post-traumatic stress symptoms, mood disorders and agoraphobia. Unaccompanied minors may also have delayed presentation of mental illness necessitating ongoing surveillance and repeat assessment over time.[lvi]

Establishing a normal rhythm of life is an important component to recovery from trauma. Unaccompanied minors will not always need Child and Young People Mental Health service (CYPMHS) support and may simply need someone trusted to talk to as well as stability and education.[lvii]

CCGs must obtain assurance that these additional health issues are taken into account, including established clear screening and referral guidelines for unaccompanied minors. [lviii]

Further resources regarding unaccompanied minors health can be found on the UASC Health website. [lix]

14. Care Leavers

Care leavers are defined as[lx]:

- eligible young people are those aged 16 or 17 years old who have been ‘looked after’ for 13 weeks or more since the age of 14, including those who remain looked after

- relevant young people aged 16 or 17 who are no longer looked after, having previously been in a category of eligible young person
- former relevant young people aged 18 to 25 who have left care having previously either been eligible or relevant or both.

Care leavers are likely to have additional mental and physical health needs and the impact of their social circumstances may exacerbate any health issues. Additional problems may include risk taking behaviour, substance use, youth justice issues, poor financial circumstances and poor educational achievement. Care leavers may have no significant care figure or responsible adult in their lives and remain vulnerable to exploitation.

Care leavers receive the same health support as any other young person of this age with no extra health support from the looked after children's nursing teams. Their GP may be the only health provider that they have contact with.

The *Children and Social Work Act 2017* [lxi] requires local authorities to provide support to care leavers until their 25th birthday, and to publish the local offer[lxii] to this group of young people. The Act does not require health to have specified additional responsibly towards care leavers above what is set out in *Promoting the Health and well-being of looked after children (2015)*[lxiii]. This document states that Clinical Commissioning Groups must be mindful of the specific requirements of care leavers as detailed in the *Leaving Care Act 2000*[lxiv] when commissioning health provision. In addition they are required to ensure that plans are in place to enable young people leaving care to continue to obtain the healthcare that they need. CCGs must put arrangements in place to ensure a smooth transition from child to adult health services.

Whilst it is important to be aware of the needs and possible vulnerabilities of care leavers, it is important to ensure that they are able to take ownership of their health and therefore encouraged to make their own decisions in their health. While 'Care Leaving flagging' is possible in primary care, it is felt that best practice would be to ask for the care leavers consent prior to being 'flagged' when they reach adulthood. When young people reach 18 they are provided with a health history, it is expected as part of this that the specialist looked after children's team will discuss with the young person whether they would support a flag being applied to their records within primary care. The team will then record the young person's wishes and share that with primary care along with their health history and it would be anticipated that primary care would then action this.

15. Adoption

A number of children who enter the care system will have a permanency plan of adoption. There are a number of important roles that the GP plays in a child's adoption journey.

The CCG commission adoption medical advisers (usually community paediatricians) to provide holistic adoption medical assessments and reports of children that are being considered for adoption. They give advice to the local authority agency decision maker and to prospective adopters prior to matching. The role of the adoption medical adviser is set

out in the Adoption Regulations: AAR 8 and described in the Department of Education 'Statutory Guidance regarding Adoption'.[lxv] The role includes ensuring the child is examined, advising regarding reports on the child's health and health information obtained about the child's parents and siblings. The medical adviser writes a comprehensive summary on the child's health (AAR 17) for court and the child's permanence report and is consulted on the arrangements for assessing and meeting the child's health care needs (AAR 36)[lxvi].

It is important that GPs share all relevant health information with the adoption medical advisers in a timely way when requested. This may be in respect of the child in question or of their birth parents if relevant consents have been obtained. The signed consents to obtain information will be sent to the GP with request for information.

The general practitioner may be asked to undertake screening investigations that the medical adviser considers important prior to a 'matching' panel (such as for blood borne infection screening) and this would need to be arranged at the earliest opportunity in the best interest of the child to avoid delays to the panel and court processes.

The robust adoption medical report provided by the adoption medical adviser will be need to be incorporated into the child's primary care record as the child's main health record. This will provide a useful summary of past health and developmental issues and is also intended to provide a record of the information shared with prospective adoptive parents prior to or at placement with them.

The adoption medical report will only include relevant information about the child's birth family that may impact on health of the child that is to be adopted. This third party information needs to be held (with care) in the record to ensure that the child has access across their lifetime to health information regarding any risks to future health such as genetic predispositions and potential need for future screening. Demographic or identifiable details regarding birth family will need to be removed from 'contacts' on placement with adopters and redacted from any records ensuring these are not shared or visible to the adoptive child or family. The general practitioner will need access to and be enabled to hold in mind the relevant birth family health information when managing the health of an adopted child or young person.

When a child is first placed with prospective adopters, parental responsibility is usually still shared between the local authority, with some responsibility still retained by the birth parents - including the naming of the child. The child will need to be registered with the GP practice using their birth name (not the name of the prospective adopters) until an Adoption Order is granted although the notes can specify and primary care staff use a 'known as' name – for example reception staff could use the name that prospective adopters specify in announcements in the waiting room or on correspondence to the prospective adopters address.

The demographic details of a child placed with prospective adopters can be shielded on the NHS spine through 'sensitive flagging' if there are any concerns regarding the safety of the

placement. This can be requested through the NHS digital back office.[lxvii] The social worker will need to consent to this request representing the local authority that holds parental responsibility. The prospective adopters may be asked by the social worker / medical adviser to then request this via the GP.

At adoption, when an Adoption Order is granted by the Court, the parental responsibility is then held exclusively by the adopted parents and the birth parents no longer hold this.

Under current adoption arrangements, the General Register Office for England & Wales (GRO) notifies the Personal Demographics Service (PDS) (Spine) National Back Office (NBO) that an Adoption Order has been granted.

The adopted child is given a new NHS number. All previous health information relating to that child should be merged into a newly created health record ensuring continuity of healthcare. However, any information relating to the identity or whereabouts of the birth parents should not be included in the new record with particular care taken to ensure birthparents and previous carers details are removed as contacts or relationships. The change of name, NHS number and transfer of previous health information into a new health record should take place for general practitioner held records, other health provider and hospital records in a timely way. There should not therefore be any difficulty in obtaining information about the child's early health history or previous treatment. Kent and Medway CCG seeks assurance from health providers that these key principles are followed and that when a child is adopted all health records held by that organisation are managed appropriately ensuring continuity of care.

16. Private fostering

Children who are cared for under a private fostering arrangement are not considered to be ‘looked after children’ therefore the local authority’s responsibilities around them are very different from other looked after children.

Private fostering is when an individual who is not a close relative of the child looks after a child under the age of 16, or 18 if disabled, for 28 days or more. This is known as a private arrangement and the Children (Private Arrangements for Fostering) Regulations 2005 apply.[lxviii]

By law the local authority must be notified of private fostering situations. This maybe by the child’s parents, the private foster carer and or anyone else involved in the arrangements.

If an employee within the practice becomes aware of a child who is privately fostered, they have a statutory duty of care to inform the local authority. This is to ensure that arrangements are in place to provide the appropriate care and support to the child and the carer. This includes the placement of language students from overseas. Confidentiality will not be breached by informing the local authority. This legislation is in place to protect and safeguard children. This duty will be referred to in mandatory safeguarding / looked after children training.

The private foster carer should be informed that the local authority will be contacted unless this places the child at risk. If child protection concerns are raised then safeguarding protocols should be followed.

For children living in Kent, the Kent County Council private fostering team can be contacted on: 03000 411111[lxix]

For children living in Medway, the Medway Council private fostering team can be contacted on: 01634 335 726 or privatefostering@medway.gov.uk[lxx]

17. Adult health medicals

Coram BAAF states (on the Adult Health 'AH' form) that 'the requirements to collect information on prospective adoptive applicants and foster carers are laid down in the relevant adoption and fostering Regulations for England, Northern Ireland, Scotland and Wales[lxxi]. Many children who are in the care system have a history of neglect and/or physical, sexual or emotional abuse. Others may have come into care as a result of other family dysfunction or problems such as parental substance misuse or mental health problems.' Looked after children 'may experience frequent moves and interrupted schooling. At the same time many are coping with the effects of separation and loss whilst struggling to recover from the factors which led then into care in the first place. This vulnerable group to children has a higher incidence of developmental delay, incomplete immunisations and routine healthcare, attachment issues, poor school attendance and mental health problems. Prospective adopters and carers will therefore need to have robust physical and mental health to be able to parent these vulnerable children.'

Health information requested in respect of carers is needed to 'secure the future wellbeing of any child placed.' It forms part of the assessment process on suitability of applicants and assists with appropriate matching. It is important that health-related lifestyle factors are considered as these may have implications for a placement and are considered alongside positive attributes applicants may have to offer a child or children. The adoption and fostering agencies need 'to satisfy themselves that applicants are robust enough to meet the demands of parenting on a daily basis' and 'have a reasonable expectation' to remain well in order to safeguard and support a child including to adulthood in long term and permanency matching.

GPs, as per local arrangements, are asked to assess prospective carers and include relevant past health history having considered 10 years of health records. Due to the tight timescales of panels and courts, GPs are requested to respond swiftly to requests for assessments and completion of 'Adult health' forms. This demonstrates working together towards safeguarding children.

The medical adviser, commissioned by Kent and Medway CCG, then gives an independent opinion on whether the health or lifestyle issues (as identified by the general practitioner) may have an impact of a child or need further exploration. They may request further detailed information in order to be able to give an informed opinion; the prospective carer

will be asked to give consent in order for the medical adviser to contact specialists involved in the patient's care. Alternatively the GP can facilitate the process by asking permission to share all relevant health reports and letters with the medical adviser when they meet with the prospective carer. The medical adviser then writes a comprehensive summary on the prospective adopter's health (AAR 30)[lxxii] to be included in the prospective carer's report for the adoption or fostering panel.

The medical adviser does not have to copy the applicant into their advice – as they are advising the agency. However, it is good practice for a copy of their advice to be sent to the patient's GP. They may send additional health recommendations separately as part of a duty of care.

The prospective carer is presented at the Adoption or Fostering Panel before recommendation to proceed. For adoption from April 2020 this will be at a Regional Adoption Agency Panel.[lxxiii] The adoption medical adviser will attend the Adoption Panel. However there may not be any health representation at the Fostering Panel and thus it is necessary to reiterate the importance of all relevant health information being available so that the medical adviser can give robust written advice.

18. Roles and responsibilities

The roles and responsibilities for health care staff are laid out in the 'Intercollegiate Role Framework; Looked after children, Knowledge, skills and competences of health care staff 2015'. All staff members should be aware of their responsibilities towards looked after children set out below:[lxxiv]

Level 1: All staff including non-clinical managers and staff working in healthcare settings

Core competencies include individuals having an understanding of whom looked after children young people and care leavers are and understanding their role in working together with other professionals to meet the needs of this group of vulnerable children and young people

Level 2: Minimum level for all non-clinical and clinical staff who may have some contact with children, young people and/or parents/carers

Core competencies include those at Level 1 as well as;

- Uses professional and clinical knowledge, and understanding of who constitutes a looked after child, young person and care leaver and is able to identify any healthcare issues that relate to previous maltreatment or life experience
- Able to identify and refer a looked after child, young person and care leaver suspected of being a victim of trafficking or child sexual exploitation; at risk of female genital mutilation (FGM) or having been a victim of FGM, at risk of exploitation by radicalisers
- Acts as an effective advocate for the looked after child, young person or care leaver

- Recognises the potential impact of previous maltreatment on the health and wellbeing of a looked after child, young person, or care leaver including possible speech, language and communication needs
- Clear about own and colleagues' roles, responsibilities, and professional boundaries, including raising concerns about the care received by the looked after child, young person or care leaver
- As appropriate to role, able to refer to social care if a safeguarding/child protection concern identified in relation to a looked after child, young person or care leaver (aware of how to refer even if role does not encompass referrals)
- Documents safeguarding/child protection/care concerns in relation to the looked after child, young person or care leaver in order to be able to inform the relevant staff and agencies as necessary, maintains appropriate record keeping, and differentiates between fact and opinion
- Shares appropriate and relevant information with multi-disciplinary professionals
- Acts in accordance with key statutory and non-statutory guidance and legislation including the UN Convention on the Rights of the Child and Human Rights Act

Level 3: All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the health needs of a looked after child/ young person or care leaver. All General Practitioners would ordinarily require these Level 3 competencies.

Core competencies include those set out in Level 1 and 2 as well as;

- Able to respond appropriately when working with looked after children to the impact of adverse life events, including how family health history, mental health and parental lifestyle choices impact on the child's health and development
- Able to apply knowledge of the physical, developmental, emotional and mental health needs/ risks for looked after children and offer appropriate health promotion advice as appropriate to role
- Able to initiate interventions to improve child resilience and reduce risk of emotional harm as appropriate to role
- Able to recognise the potential impact of a parent's/carer's physical and mental health or lifestyle on the wellbeing of a child or young person
- Able to demonstrate an understanding of the interdependence between health, education and social care with regard to looked after children
- Knows own capabilities and when to seek support from the specialist looked after children team
- Able to share information appropriately, taking into account consent and confidentiality issues related to looked after children
- Able to contribute to inter-agency assessments, the gathering of information and where appropriate analysis of risk
- Able and willing to provide empathy and support for the looked after children and their carers

Level 4: Specialist medical, nursing and health professionals for looked after children including Named professionals and Medical Advisers for Fostering and Adoption.

Core competences include those set out in Level 1, 2 and 3, as well as;

- Able to undertake statutory looked after children/adoption health assessments, including those with complex healthcare needs
- Able to analyse holistic health chronologies and provide a written comprehensive report detailing the implications of the information for the child's current and future health and wellbeing
- Able to formulate a meaningful individual healthcare plan/adoption report and monitor its implementation
- Able to identify and manage attachment disorder, emotional trauma, and where appropriate the assessment of parental capacity for parents, kinship carers, foster carers and adoptive parents
- Able to initiate interventions to improve child resilience and reduce risk of emotional harm
- Able to act as a key conduit and contact point between the child or young person and their carer, where they have difficulties accessing health services

19. Information sharing

Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding but has been highlighted as a difficult area of practice. It is important to keep a balance between the need to maintain confidentiality and the need to share information to protect others. Decisions to share information must always be based on professional judgement about the safety and wellbeing of the individual and in accordance with legal, ethical and professional obligations. Information may also be shared where a child or young person is at risk of serious harm.

The '*Seven Golden Rules'* of information sharing are set out in the "*Information Sharing Advice for practitioners*" (2018)[lxxv]. This guidance is applicable to all professionals charged with the responsibility of sharing information:

- The Data Protection Act [lxxvi] or General Data Protection Regulation is not a barrier to sharing information [lxxvii]
- Be open and honest
- Seek advice
- Share with informed consent
- Consider safety and well-being
- Necessary, proportionate, relevant, accurate, timely and secure
- Keep a record of your actions

Where there are concerns about a person's welfare, discussions and decisions made and the reasons for those decisions must be recorded in writing in the person's medical records.

The Caldicott Principles also provide guidance regarding information sharing; these were developed in 1997 following a review of how patient information was handled across the NHS.[lxxviii]

Principle 1 - Justify the purpose(s) for using confidential information
Principle 2 - Don't use personal confidential data unless it is absolutely necessary
Principle 3 - Use the minimum necessary personal confidential data
Principle 4 - Access to personal confidential data should be on a strict need-to-know basis
Principle 5 - Everyone with access to personal confidential data should be aware of their responsibilities
Principle 6 - Comply with the law
Principle 7 - The duty to share information can be as important as the duty to protect patient confidentiality

Each organisation should have a Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. All NHS organisations and local authorities which provide social services must have a Caldicott Guardian. [lxxix]

20. Implementation

Practice staff should be informed and advised of this best practice guidance and it should be available for review within the practice.

21. Quality assurance and monitoring

Kent and Medway CCG are the commissioners of local health services and have a responsibility to ensure that all organisations with which they have a contract are carrying out their responsibilities to looked after children.

Kent and Medway CCG have a process in place for assuring health services specifically for looked after children meet the statutory requirement.

The Looked after Children's team have developed a 'Practice checklist and benchmarking tool' that the team can distribute to primary care practices to support in their assurance to the CCG that their statutory obligations towards looked after children are being met - see appendix 1.

22. Guidance review

This guidance will be reviewed three years from the date of issue. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, as instructed by the senior manager responsible for this guidance.

23. Governance

This guidance will be approved via the CCG governance structure prior to publication.

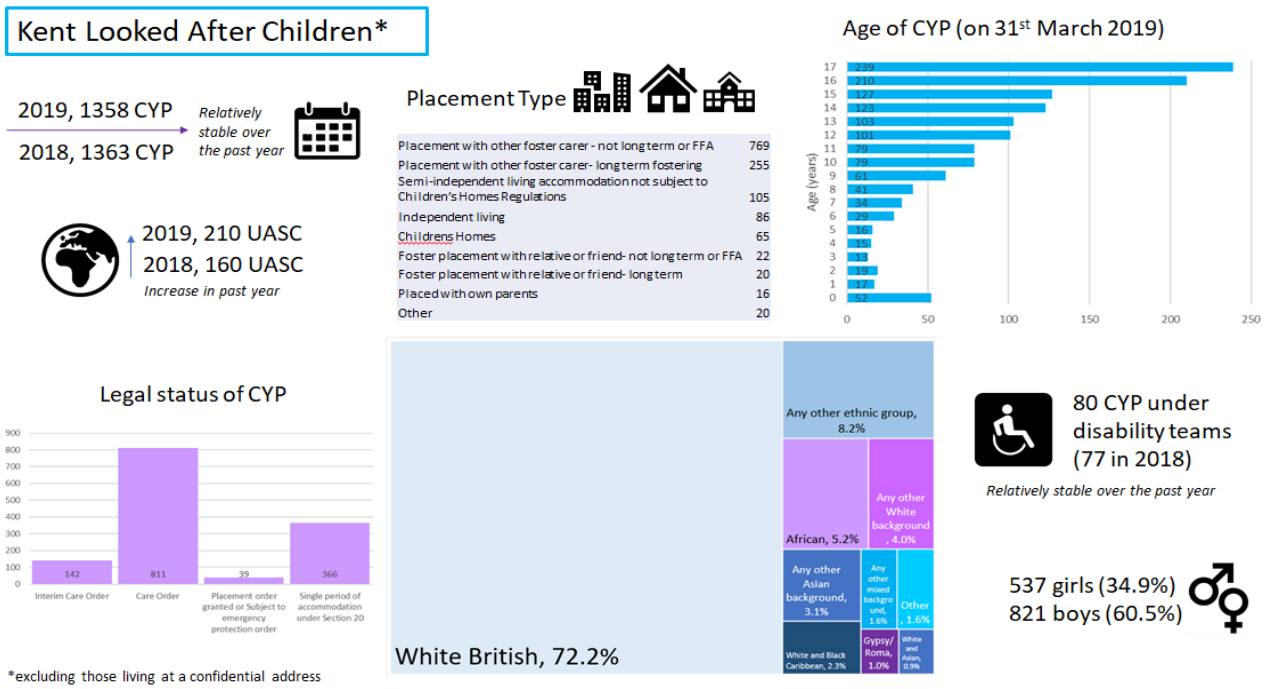
End of guidance

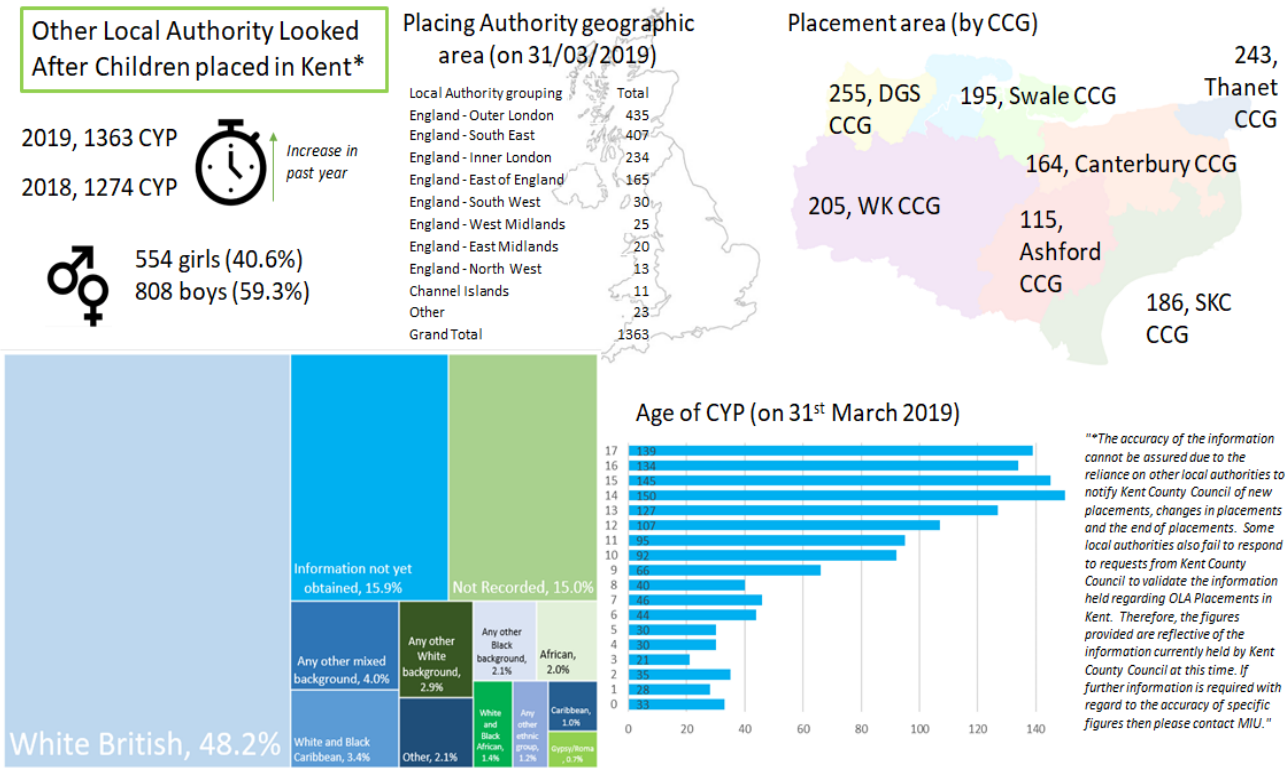
24. Appendix 1- Practice check list and benchmarking tool

	Yes	No	Comments
Are your staff team all trained and able to demonstrate specific knowledge, skills and competencies as set out above in Looked After Children: Knowledge, skills and competence of staff (Intercollegiate Role Framework, 2015)? [lxxx]			
Are all professionals in the practice aware of the local authority (LA) private fostering procedures and statutory duty to inform the LA if aware that a child is, or concerned that a child maybe, in a private fostering arrangement?			
Does your practice respond swiftly to requests for information sharing regarding the health of looked after children, children on the adoption pathway, relevant birth parents and potential or existing carer demonstrating good working together towards safeguarding children?			
Are you aware of local arrangements regarding assessment of carers including your practice role in providing all relevant past health history having considered 10 years of health records?			
Do you have a notification / coding system in place so practitioners are able to identify which patients are foster carers, kinship carers or special guardians?[lxxxi]			
Do you have a notification / coding system in place so that practitioners are able to identify which children registered with the practice are looked after (including children placed into Kent and Medway by other local authorities)?[lxxxii]			
Do you have a clear standing operating procedure in respect of looked after children that includes the checking of legal status of a child, relevant local authority contact details recorded and appropriate consents being sought?			
Are health practitioners working at the practice aware of the importance of undertaking			

recommended screening investigations for unaccompanied minors and for prior to Adoption Panel (such as for blood borne infection) and arranged at the earliest opportunity in the best interest of the child to minimise public health risks and to avoid delays to the panel and court processes?			
Are the child's statutory health assessments incorporated into the GP - held record as the child's main health record (including the comprehensive Adoption medical report) and health care plans checked for actions prior to filing?			
Does the practice have a standard operating procedure in respect of managing a child's health records when an Adoption Order is granted and new NHS number issued? All health information should be transferred to the new record so there is no difficulty in obtaining information about the child's early health history or previous treatment and ensuring continuity of care.			
Are health practitioners working in the practice aware of the additional mental and physical health needs that care leavers may have that could impact their health into adulthood?			

25. Appendix 2- Kent's looked after children profile





26. Appendix 3- Medway's looked after children profile

Medway Looked After Children*

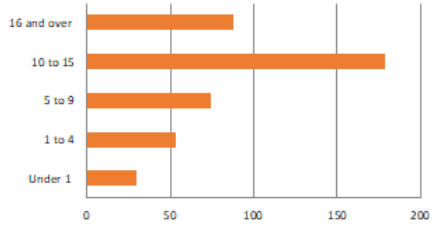
2019: 424 CYP
2018: 414 CYP
Relatively stable over the past year

187 girls (44%)
237 boys (56%)

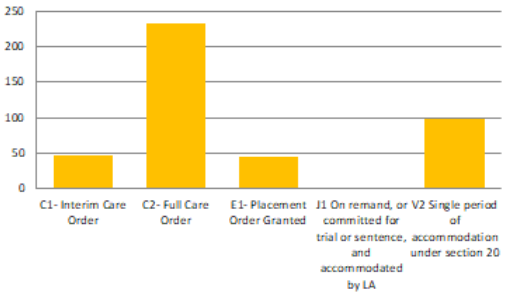
Placement Type

Placement with other foster carer - not long term or FFA	277
Placement with other foster carer- long term fostering	47
Young Offender Institution or Prison	1
Supported lodgings/ accommodation	20
Children's Home	25
Foster placement with relative or friend- not long term or FFA	27
Foster placement with relative or friend- long term	6
Placed with own parents or someone with parental responsibility	6
Placed for adoption with placement order- not with current foster carer	10
Residential school (not a registered children's home)	4
Other	1

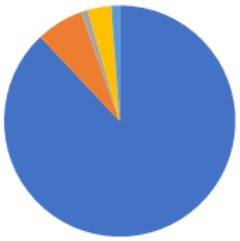
Age of CYP (on 31st March 2019)



Legal Status of CYP



Ethnicity of CYP



48 CYP with a disability

11 Unaccompanied Asylum Seeking Children (UASC)

Other Local Authority Looked After Children placed in Medway*

2019: 477 CYP
2018: 448 CYP
Increase in past year

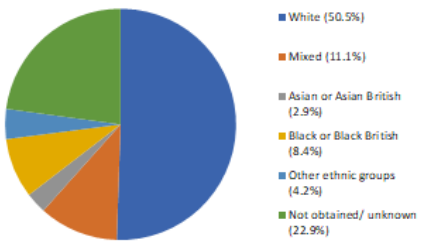
180 girls (42%)
273 boys (53%)
24 unknown (5%)

24 Unaccompanied Asylum Seeking Children (UASC

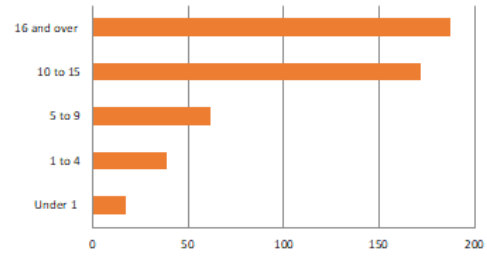
Placing Authority geographic area (on 31/03/2019)

Local Authority grouping	Total
England – London (including borders)	248
England - Kent	141
England – Surrey	13
England – Remainder of South East	28
England - East	16
England – South West	6
England - Midlands	13
England - North	5
Other- Isle of White, Scotland and Ireland	5
Unknown	2
Grand Total	**477**

Ethnicity of CYP



Age of CYP (on 31st March 2019)



""The accuracy of the information cannot be assured due to the reliance on other local authorities to notify Medway Council of new placements, changes in placements and the end of placements. Some local authorities also fail to respond to requests from Medway Council to validate the information held regarding OLA Placements in Medway. Therefore, the figures provided are reflective of the information currently held by Medway Council at this time.

27. Appendix 4 - Registering looked after children at the practice

At registration

A child may be identified as a looked after child through a variety of ways; a notification from a looked after children's team, a registration form, information volunteered from a carer/ parent or via the receipt of a statutory health assessment. Once confirmation of looked after status is ascertained the practice should:

Accept the child/young person as a fully registered patient and avoid registering as a temporary patient

Ensure that the following information is recorded:

- Name of carer
- Name and contact details of their allocated social worker
- Parental responsibility
- Other agencies involved

This information may need to be obtained from the carer at registration as the previous clinical records may not be available initially.

Highlight the records in such a way as to ensure all team members are aware of the 'looked after child' status, including relevant the code to their notes as Major Active Problems on the summary screen.

Request previous records urgently and summarise all relevant health and social care information

Allocated a named GP within the practice

Invite a child for a new patient medical. For all children this allows or an open communication with them and their carer, and for older children provides a valuable health promotion opportunity

Main principles

- The lead health record for a looked after child should be the GP held record. All health assessments should be form part of this record
- If a looked after child moves to a new GP practice, the transfer of their records should be 'fast tracked'
- GP's should ensure timely access to GP or appropriate health professionals for a looked after child who requires consultation
- Information held within the records will complement the health assessments undertaken by the looked after children's teams
- GP's should maintain a record of the child's statutory health assessment and contribute to any necessary action within the health care plan
- When writing a referral for a looked after child, it should be made clear that the child is looked after and include the name of the social worker or team manager at the local authority

Looked after children from out of area

- Where a looked after child moves into a new area, the 'originating CCG' remains the responsible CCG for commissioning of services
- Children who originate from out of area will be registered with a GP close to where they live
- Arrangements for primary care are determined by GP registration

Importance of sharing information

To ensure a child's health assessment is of high quality, the assessment will use relevant information drawn together prior to the assessment. This will include information in the GP held record, therefore a summary will be requested by the looked after children's teams.

GP's should provide summaries of the health history of a child who is looked after, including information on immunisations and covering their family history where relevant and appropriate, and ensure that the information is passed promptly to the looked after children's team who are undertaking the assessment

Consent/ parental responsibility

- It is important to enquire as to what legal basis the looked after child is accommodated under to ensure valid consent is obtained
- Section 20 of the Children's Act 1989- voluntary care: Parental responsibility is retained by the child's parents therefore they are needed to provide consent for medical treatment
- Section 31 of the Children's Act 1989- Care order: Parental responsibility is jointly held by the child's parents and the local authority. However the local authority under Section 33 of the Children Act 1989 can determine at which level the parents can exercise their parental responsibility, therefore the local authority would have the final say and would provide consent for medical treatment.
- Foster cares never hold parental responsibility, therefore are only able to make certain decisions about a child when delegated authority has been provided to them.
- Young people aged 16-17 are regarded as adults for the purpose of consent therefore entitled to the same duty of confidence as adults
- The Gillick principles should be applied as to when a child is under 16 years old

Useful links:

RCGP: processing and storing of safeguarding information: https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/-/media/F3529AA8BA864A6B9D4FC884D010BD3A.ashx

Promoting the health and well-being of looked- after children: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

Who Pays: determining responsibility for payment to providers?: https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

28. Appendix 3- Unaccompanied minors

A definition:
Unaccompanied minors are young people under 18 years who are applying for asylum in their own right; are separated from both parents and not being cared for by an adult who has legal responsibility for them.

They are looked after children and have the same rights and access to care as UK children and will be placed with foster carers or in semi-independent placements.

General health
Many unaccompanied minors will suffer from a variety of general health complaints including abdominal pains, backaches and headaches - which at times are associated with gastrointestinal infections. Poor nutrition and constipation are common, often due to the change in diet. Vitamin D deficiency has been found, as have parasites such as Giardia and Helicobacter.

Many skin complaints and infestations commence on the journey to the UK due to overcrowding, poor sanitary conditions and inadequate nutrition. Skin infestations such as Scabies and Tinea capitis are common and not always recognised by the young people so may persist without medical attention.

Many unaccompanied minors will struggle with sleep as they have often travelled by night. Many are nocturnal, struggle to settle and frequently have nightmares. These difficulties often contribute to poor concentration and often will impact on their emotional wellbeing.

Language barriers
Many unaccompanied minors will require interpreting services and this necessitates a longer appointment. Interpreters will need to be arranged by the health provider as they are not provided by children's social care for these young people.

Unaccompanied minors should have access to translated documents to support their understanding. This is especially important when they are providing consent for treatment. Most unaccompanied minors are old enough to provide their own consent with an interpreter. If they are not competent there may be delegated authority to foster carer and the social worker should be contacted if needed

The journey
Unaccompanied minors have often travelled from their original country without their parents or legal guardian.

Their status, age and circumstances can be uncertain and they may have experienced significant hardship prior to coming to the UK; they may have witnessed or experienced trauma including the death of a parent or carer and be suffering extreme loss.

There are a number of reasons why children may leave their home country, including: fear of persecution, their religion, nationality, ethnicity, political opinion or social group, parents having been killed, imprisoned or disappeared, war, conflict, poverty, deprivation and being sent abroad by parents/family.

Emotional health and wellbeing
Unaccompanied minors are at high risk of mental illness. The prevalence of symptoms consistent with a mental illness in UASC has been reported as up to 48%. The most common mental illnesses reported in UASC are: post-traumatic stress disorder (PTSD), mood disorders and agoraphobia.

77% of UASC suffer from anxiety, sleep disturbance and/or depressed mood on arrival. Unaccompanied minors may have delayed presentations of mental illness, necessitating ongoing surveillance and repeat assessment over time.

Screening needs:
Within this group of young people there have been cases of reactivation of latent TB as well as known high endemic rates of blood borne infections in the country of origin or transit. All unaccompanied minors are therefore screened for Tuberculosis, Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV). Screening requests are made at the statutory Initial Health Assessment and results will be sent to Primary Care for follow up.

All unaccompanied minors are referred for vision and dental checks ups at IHA due to high rates of visual defects and dental caries.

Most unaccompanied minors will need to start the immunisation schedule 'for those with unknown immunisation status' as recommended by Public Health England as their immunisation status is nearly always unknown or unproven.

For further information

For a variety of resources to support the health needs of unaccompanied minors please see: www.uaschealth.org

NHS E Guidance for interpreting services in Primary Care: https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf

29. Appendix 4- Children on an adoption journey

Children with a permanency plan of adoption

For a number of children who become looked after, their permanency plan will be for adoption and there are a number of ways in which a GP may be asked to contribute to their adoption journey.

NHS Kent and Medway Clinical Commissioning Group commission Adoption Medical Advisers to assess children and give advice to the Local Authority Agency Decision Maker and prospective adopters prior to matching. The medical report is required by statute, used for court and helps to ensure that the child's health care need is met.

It is important that general practitioners share all relevant health information with the Adoption Medical Advisers in relation to the child in question or their birth parents (with consent). General practitioners may be asked to undertake screening investigations deemed important prior to 'matching' panel or during the Court process.

The Adoption Medical Report will only include relevant information about birth family that may impact on health of the child that is to be adopted.

Main principles

The lead health record for a looked after and adopted child should be the GP held record. All health assessments should be form part of this record ensuring continuity of records.

Third party information needs to be held (with care) in the record to ensure that the child has health information regarding any risks to future health such as genetic predispositions and potential need for future screening.

When first placed with adopters, the child will need to be permanently registered with the GP practice using their birth name (not the name of the prospective adopters) until an Adoption Order is granted although the notes can specify and primary care staff use a 'known as' name.

Many children who have been adopted have a risk of future neurodevelopmental disorders, attachment difficulties and difficulties related to past trauma. Family history and potential exposure to drugs or alcohol in pregnancy are often relevant. There should be no delay in asking for further Community Paediatric or CYPMHS assessment if concerned about a child's progress.

Safety concerns

The demographic details of a child placed with prospective adopters (and not yet formally adopted) can be shielded on the NHS spine through 'sensitive flagging' if there are any concerns regarding the safety of the placement. This can be requested through the NHS digital back office. The social worker will need to consent to this request representing the local authority that holds parental responsibility. The prospective adopters may be advised by the social worker or medical adviser to then request this via general practitioner.
https://digital.nhs.uk/services/demographics/restricting-access-to-a-patients-demographic-record

New NHS number

The adopted child is given a new NHS number when an Adoption Order is granted. All previous health information relating to that child should be merged into a newly created health record ensuring continuity of healthcare. However, demographic or identifiable details regarding birth family will need to be removed from 'contacts' on placement with adopters and redacted from the new record.
https://pcse.england.nhs.uk/news/2018/march/registration-process-for-adopted-patients/
https://pcse.england.nhs.uk/media/1247/adoption-medical-records-practice-guide.pdf

Consent/ parental responsibility

When an Adoption Order is granted by the Court, the parental responsibility is then held exclusively by the adopted parents and the birthparents no longer hold this.

Under current adoption arrangements, the General Register Office for England & Wales (GRO) notifies the Personal Demographics Service (PDS) (Spine) National Back Office (NBO) that an Adoption Order has been granted.

Post Adoption support

The placing Adoption Agency (including voluntary sector) provides post adoption support and may offer therapeutic input. For Kent and Medway local authorities, this is now provided from October 2020 by the regional adoption agency "Adoption Partnership South East."

Useful links:

Coram BAAF (Network of organisations and individuals involved with children on a care system journey) https://corambaaf.org.uk/
First4Adoption (The National Adoption Information service) https://www.first4adoption.org.uk/adoption-support/
Adoption UK (Leading charity providing support, community and advocacy) https://www.adoptionuk.org/
New Family Social (Network of LGBQT+ adoptive and fostering families) https://newfamilysocial.org.uk/

30. Appendix 5- Care leavers registered at the practice

Care Leaver – Definition

- Eligible young people aged 16 or 17 who have been looked after for a period or periods of time, start care after the age of 14, or are still in care
- Relevant young people aged 16 or 17 who are no longer looked after, having previously been in a category of eligible young person
- Former relevant young people aged 18 to 25 who have left care having previously either been eligible or relevant or both.
- Care Leavers may prefer to be referred to as 'care experienced' rather than as a 'care leaver.'

Physical and emotional health & wellbeing

Care leavers are likely to have additional mental and physical health needs and the impact of their social circumstances may exacerbate these health issues

Additional problems may include risk taking behaviour, substance use, youth justice issues, poor financial circumstances and poor educational achievement

They may have no significant care figure or responsible adult in their life. Care leavers remain vulnerable to exploitation.

Statutory Considerations

The *Children and Social Work Act 2017* required local authorities to provide support to care leavers until their 25th birthday, and to publish the local offer to this group of young people. The Act did not require health to have an additional responsibly towards care leavers above what is set out in *Promoting the Health and well-being of looked after children (2015)*. This document states that Clinical Commissioning Groups must be mindful of the specific requirements of care leavers as detailed in the *Leaving Care Act 2000* when commissioning health provision.

In addition CCGs are required to ensure that plans are in place to enable young people leaving care to continue to obtain the healthcare they need and that arrangements are in place to ensure a smooth transition from child to adult services.

Health Post 18yrs

In relation to general health post 18 years old these young people receive the same health support as any other young person of this age e.g. support services and ED but no extra health support from the specialist children in care teams or social care. Their GP may be the only health provider.

A 2020 large, nationally representative study of dependent children resident in England and Wales, those who had been in care during childhood had a higher risk of mortality long after they had left care on average, mainly from unnatural causes. Children in care have not benefitted from the general decline in mortality risk over time.

Useful links

Corporate parenting principles to looked after children and care leavers : https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683698/Applying_corporate_parenting_principles_to_looked-after_children_and_care_leavers.pdf

Association of childhood out of home care status with all-cause mortality up to 42 years later: office of National Statistics Longitudinal Study: https://link.springer.com/epdf/10.1186/s12889-020-08867-3
Personal advisers for care leavers: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683701/Extending_Personal_Adviser_support_to_all_care_leavers_to_age_25.pdf

Kent County Council local offer for care leavers: https://www.kent.gov.uk/about-the-council/strategies-and-policies/childrens-social-work-and-families-policies/care-leavers-local-offer

Medway Council local offer for care leavers: https://www.medway.gov.uk/info/200260/local_offer_for_care_leavers/761/local_offer_for_care_leavers

31. Appendix 6- Adult health assessments/ health of foster carers

Regulatory framework

Relevant adoption and fostering regulations for England, Northern Ireland, Scotland and Wales set out the requirement to collect information on prospective adoptive applicants and foster carers.

Health information requested in respect of carers is needed to ensure the future wellbeing of any child placed. It forms part of the assessment process on suitability of applicants and assists with appropriate matching.

Coram BAAF point out that adoption and fostering agencies need 'to satisfy themselves that applicants are robust enough to meet the demands of parenting on a daily basis' and 'have a reasonable expectation' to remain well in order to safeguard and support a child including to adulthood in long term and permanency including matching.

The Adoption Agencies Regulations 2005 require a medical examination of a prospective adopter to be sent to the adoption agency's medical adviser prior to progressing to consideration of approval as an adopter (in Stage 1 of the assessment process).

Main principles for GPs

Due to the tight timescales of panels and courts, GPs are requested to respond swiftly to requests for completion of 'Adult health' AH/AH2 forms. This demonstrates working together towards safeguarding children. It is in the child's best interest through avoidance of delay in safely placing children with alternative or permanent carers.

GPs, as per local arrangements, are asked to assess prospective carers through

- a holistic assessment
- including physical examination for AH
- having reviewed 10 years of records
- considering health-related lifestyle factors are as these may have implications for a placement and are considered alongside positive attributes applicants may have to offer a child or children
- including details of investigations
- calculating QRisk3
- If the applicant is found to be obese or smoking, there is an expectation that NICE guidance will be followed by GP

The GP's report is completed on a request basis and classified as provided within "collaborative arrangements." The agency will usually pay foster carers fees and prospective adopters will usually pay their own fees.

https://www.bma.org.uk/pay-and-contracts/fees/fees-for-gps/

Role of the Medical Adviser and Panel

The medical adviser (MA)

- gives an independent opinion on whether the health or lifestyle issues (as identified by the general practitioner) may have an impact of a child or need further exploration.
- writes a comprehensive summary on the relevant aspects of the prospective adopter's health (AAR 30). This is included in the prospective carer's report for the adoption or fostering panel.
- does not have to copy the applicant into their advice – as they are advising the agency. However, it is good practice for a copy of their advice to be sent to the patient's GP.

The prospective carer is presented at the Adoption or Fostering Panel before recommendation to approve. A medical adviser attends the Adoption Panel. There may not be any health representation at the Fostering Panel reiterating importance of relevant health information being available for MA report.

Consent/ sharing of information

Initial consent to share with the Adoption Medical Adviser is on the Part B of AH/AH2 form. The Adviser may request further detailed information to be able to give an informed opinion; the prospective carer will need to give consent to contact any specialists involved. The GP can facilitate the process by asking permission and sharing all relevant health reports when they meet with the prospective carer for appointment.

Safety of the child in care: Code Approved Foster Carer: EMIS 133N SYSTMONE XaF0D

Clearly identify patients at the practice who are carers and hold details of their social worker. Consider needs of vulnerable children in their care if they present with significant physical or mental illness or lifestyle issues.

Useful links:

Coram BAAF (Network of organisations and individuals involved with children on a care system journey) https://corambaaf.org.uk/
RCGP Toolkit with coding: Royal College of General Practitioners Child Safeguarding Toolkit: Practice Resources: Coding and Management of Safeguarding Information in General Practice

32. Appendix 7- the use of language with looked after children and care leavers

Background

Looked after children and care leavers have in recent years expressed concerns over the use of the language of the care system when communicating with or about them. Professionals interacting with these children and young people should take note of these sensitivities and endeavour to use language and terms acceptable to and preferably developed in consultation with the young people themselves.

Children and young people have been asked about their wishes and feelings on the day to day language used either with them, or to talk about them. Examples are set out on this page:

'Language that cares'

In March 2019 The Adolescent and Children's Trust (TACT) Fostering and Adoption produced a collaborative document with children and young people that's aim was to change the language of the care system, 'Language that cares – Changing the way professionals talk about Children in Care'.

The aim of the document was 'to change the language of the care system. Language is a powerful tool for communication but sometimes the way that it is used in social care creates stigma and barriers for understanding. Language is power, and we want children and young people to feel empowered in their care experience'.

Children and Young People - Preference examples from 'Language that cares'

Birth/Biological parents
We prefer: Parents; Family Mum or tummy mummy; dad.

Care Leaver
We prefer: Care experienced adult

In care
We prefer: Another home away from home; Living with a different family in a different home

Peers
We prefer: friends

Siblings
We prefer: Our brothers and sisters; people who are related to me

The Adolescent and Children's Trust (TACT) explains there is not an absolute list of all words in the care system. Different children and young people would have varied preferences for the language used. The document starts a healthy discussion about the way we communicate with children and young people and encourages positive relationships between young people and their workers.

The 'Challenge Card'

A challenge card [2] was issued by Kent young people to their Corporate Parents in September 2019 to ensure that professionals 'Mind their Language' when working with children and young people. It acknowledged the power of language and words that are chosen wisely can break down barriers.

Examples:
LAC

"LAC makes it seems like you are lacking knowledge or need to be looked after."

"It makes it sound like you're stupid or missing something."

Use: Child in Care, Young Person

Placement

"It makes me feel like an object being put somewhere." "It doesn't make me feel like I'm going to be part of the family…it's cold and not loving."

Use: Where I live, Home, My House

Young people are telling professionals they want day to day conversations with their workers to reflect how they really speak and use words and phrases they would choose. As demonstrated language associated with the care system can stigmatise those within it and further differentiate them from other young people.

Useful links:

https://www.tactcare.org.uk/content/uploads/2019/03/TACT-Language-that-cares-2019_online.pdf
Language that cares – Changing the way professionals talk about Children in Care
TACT Fostering & Adoption. March 2019

Corporate Parenting Challenge Card: Mind your language – A report issued by Kent young people and agreed by the Young Adult Council (YAC) and OCYP

33. Appendix 8- Helpful contacts

Organisation	Email Address	Telephone Number
Kent & Medway CCG (K&M CCG) Looked After Children's Team	**kmccg.lac@nhs.net**	07585 883020
Kent & Medway CCG (K&M CCG) SEND Team	**kmccg.kmsend@nhs.net**	01634 335075
Kent & Medway CCG (K&M CCG) UASC Health Website	**www.uaschealth.org**	07585 883020
Kent & Medway CCG (K&M CCG) Safeguarding Team	**Kmccg.safeguarding@nhs.net**	07387 546109
Kent Community Health Foundation Trust (KCHFT) Initial Health Assessments & Initial Adoption Referrals (IHA & IAM):	**kcht.vsklacinitial@nhs.net**	
Kent Community Health Foundation Trust (KCHFT) Adoption Medical Referrals	**kentchft.LACRAM@nhs.net**	
Kent Community Health Foundation Trust (KCHFT) Review Health Assessment Referrals (RHA)	**kentchft.LACRHA@nhs.net**	
Kent Community Health Foundation Trust (KCHFT) Children from other local authority placed into Kent referrals	**kcht.OLALAC@nhs.net**	
East Kent Hospitals University Foundation Trust (EKHUFT) Rainbow Centre (MASH)		Community Paediatrics: 01233 651927
East Kent Hospitals University Foundation Trust (EKHUFT) Greenbanks Centre (MASH)		Reception: 03000 420003
Medway Community Health (MCH) Snapdragons Centre	**medch.lac@nhs.net**	0300 123 3444
Kent Safeguarding Children Multi-agency Partnership	**Website:** **https://www.kscmp.org.uk/** **Email: kscmp@kent.gov.uk**	Reception: 03000 421126
North East London Foundation Trust (NELFT) Children & Young People Mental Health Service (CYPMHS) Single Point Access (SPA)	**NELFT Website** **https://www.nelft.nhs.uk/services-kent-children-young-peoples-mental-health**	Kent SPA: 0300 123 4496 (Option 1, then Option 3) Medway SPA: 0300 300 1981
Local Authority Private Fostering Teams	**Kent Website:** **https://www.kent.gov.uk/education-and-children/adoption-and-fostering** **Medway:** **privatefostering@medway.gov.uk**	Kent: 03000 411111 Medway: 01634 335726
Local Authority Care Leavers Service	**Kent Website: www.kent.gov.uk/about-the-council/strategies-and-policies/childrens-social-work-and-families-policies** **Medway Website:** **https://www.medway.gov.uk/info/200170/children_and_families**	

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