6 March 2014	ITEM: 8
Corporate Parenting Committee	
Health of Looked After Children	
Report of: Roland Minto – Service Manager, Placements and Support	
Wards and communities affected: All	**Key Decision:** Non-Key
Accountable Head of Service: Barbara Foster Head of Service, Care and Targeted Outcomes	
Accountable Director: Carmel Littleton, Director Children's Services	
This report is Public	
Purpose of Report: to provide report, at the request of members on recent and current performance on providing appropriate Health Checks for Looked After Children.	

EXECUTIVE SUMMARY

The recent mock inspection in Thurrock has highlighted that we need to improve our data on the health checks for looked after children and young people so as to achieve the best possible health care and outcomes for them.

1. RECOMMENDATIONS:

1.1 **The members of the Corporate Parenting Committee are asked to note the contents of the report, and support officers in rectifying some of the problems identified.**

2. INTRODUCTION AND BACKGROUND:

2.1 Previous reports presented to the Corporate Parenting Committee in November 2012 and March 2013 described the local structures for overseeing and promoting appropriate healthcare for Looked After Children in Thurrock, and also detailed progress against the relevant recommendations from the joint Ofsted/CQC Inspection from early summer 2012.

2.2 Looked After Children, and in particular care leavers, have historically tended to have poorer health outcomes than other young people their age. This has led to a heightened profile around the performance of local authorities in meeting their obligations to ensure all checks are carried out in a timely fashion.

2.3 This report will therefore focus specifically on the most recent data available, and outline some of the key challenges that need to be addressed. The report was originally scheduled for this Committee in December 2013, but was deferred as we were still awaiting release of the comparative national data. As such therefore comparative data relates to the financial year 2012-2013.

3. REPORTED PERFORMANCE

3.1 In December 2013 the Government published the latest figures for all local authorities, which were essentially generated from the annual SSDA903 return. For Health checks figures are reported on two specific cohorts of children, those who have been looked after for at least twelve months at 31st March, and the subset of these children who are under 5 at that date.

3.2 The expectation is that all children should have an Initial Health Assessment (IHA) on entering care, and a Review Health Assessment (RHA) each year thereafter. Because of the criterion of being looked after for a year, the published data effectively becomes a review of the RHA figures.

3.3. Thurrock's reported performance completion of yearly Health Reviews for 2012-13 was disappointing. There were 165 children who formed the cohort. Of these 135 (81.8%) had had their check recorded. This was almost exactly in line with the East of England Average, but below the National average of 87.2%. The 2012-13 performance represented an apparent decline against the previous year when we reported 88.8% (Regional average – 78.5%; National 86.2%).

3.4 The same statistical release also publishes the figures for children who have a recorded dental check in the previous period, and those whose immunisation records are up to date.

3.5 For dental checks the reported figure (again taken from the same cohort) is 78.7% (Regional average - 80.7%; National - 82%). For the previous year the figure recorded was 88.8%. (Regional average - 79.9%; National 82.3%).

3.6 The figure for having an up to date record of immunisations was only 63.6%, compared to 82.7% regionally and 83.1% nationally. However this did represent an improvement locally against the previous year when only 48.1% were recorded. (Regional average – 79.89%; National - 83.1%).

3.7 Taken at face value all these figures suggest insufficient attention has been paid to ensuring the relevant checks are being initiated on behalf of children. However on investigation of individual children's situations the issue has frequently been one of inconsistent recording/updating on children's electronic records, so that we are almost certainly suffering from under-reporting of actual performance. Focusing on this was almost certainly the main reason behind the 15% increase in reported immunisation histories on the previous year.

3.8 Unfortunately the electronic recording system used by our colleagues in Health does not “talk” to our own, so for all the relevant data to be pulled through into our SSDA903 return we require manual updating of the system, usually by case holding Social Workers, and this is needs much closer monitoring by Team Managers to ensure there is no under-reporting for 2013-14.

3.9 A spreadsheet is in operation to monitor Review Health Assessments, which was regularly reviewed and updated by an Admin Officer in one of the Throughcare Teams, but there have been genuine capacity problems in ensuring this is done consistently over the last year. The ideal solution would be the identification of one specific admin post to review all the relevant Health data, but realistically we are unlikely to have the resource to do this. However because of other changes that are proposed in the near future we may be able to release some admin capacity, which would ease the situation.

3.10 The published figures also include a figure for children under 5 who have had a “Developmental check” in the last period. Thurrock appears to be a consistent under-performer against this. However following dialogue with Health colleagues about what is being entered by other authorities it appears that we have been consistently “underselling” ourselves by not recording any routine checks completed on under 5s against this. This in part a reflection of some of our data capture and generation practices, which will be discussed below.

3.11 Current completion rates on RHAs for the year 2013-14 are showing as 61.8% for over 5s, but as there are several weeks to go for the reporting period, both Review Assessments that are arranged but still to be undertaken, and those which have taken place but need recording on the system, should push this figure significantly higher by March 31st.

4. ISSUES AND FUTURE CHALLENGES:

4.1 Some specific problems do need further exploration in relation to the recording of dental and optical checks for children, as clinical advice has changed so that dentists now frequently recommend greater periods between routine check ups, and some opticians are also refusing to see children more than every two years.

4.2 The Department of Education Report which accompanied the release of the statistics noted that compliance with health checks declines generally as children enter their mid-teens. This is certainly the experience in Thurrock, and we are clear that young people have rights to refuse. We are therefore grateful for the flexible approach shown by our colleagues in Health in seeking creative ways to encourage and persuade some young people to participate in assessments.

4.3 Nevertheless there is a strong ethical case for respecting the wishes of young people, some of whom argue that undergoing health assessments which are

not required for peers who are not looked after is another unnecessary reinforcement of their being treated “differently” to others.

4.4 Without underestimating the possibility that some children may genuinely be missing important health checks, officers are clear that presenting an accurate picture has been undermined by some of our data recording practices. We currently have a report which is automatically updated on a daily basis from our electronic recording system. Unfortunately this will only ever be as valuable as the quality of the information available, and we have clearly identified that significant under-reporting is an issue.

4.5 Nevertheless we also accept that the report itself is in urgent need of being reconfigured. The current design was created a few years ago, and a review of its effectiveness is overdue. The report on the recent “mock inspection” identified the difficulty in distinguishing between Initial and Review Health Assessments, and we need to ensure that our report can provide “at a glance” figures for both. The relevant Service Manager will be working with the Data Team to ensure that as we enter the new reporting year the tool we are using is appropriate to our future needs, and is constructed to ensure that potential slippage is noted and addressed at an early stage.

5. CONSULTATION (including Overview and Scrutiny, if applicable)

N/A

6. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

6.1 Work to improve the health of looked after children and young people is consistent with Corporate Priority 4 outlined below.

- **Corporate Priority 4: Improve health and well-being**

  - Ensure people stay healthy longer, adding years to life and life to years
  - Reduce inequalities in health and well-being
  - Empower communities to take responsibility for their own health and well-being.

7. IMPLICATIONS

7.1 <u>Financial</u>

Implications verified by: **Mike Jones**
Telephone and email: **mxjones@thurrock.gov.uk**

There are no immediate financial implications

7.2 <u>Legal</u>

Implications verified by: **Lindsey Marks**

Telephone and email: **01375 652054**
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There are no immediate financial implications

7.3 **Diversity and Equality**

Implications verified by: **Teresa Evans**
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The significant Equality and Diversity implications arising from this report stem from the need for carers to have awareness of medical conditions which disproportionately affect different sectors of the community, such as Sickle Cell Trait, as well as professionals generally recognising both the physical and emotional needs of Unaccompanied Asylum Seeking young people.

There are also equality implications in the identified future inclusion of children on remand as Looked After Children.

7.4 **Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

N/A

BACKGROUND PAPERS USED IN PREPARING THIS REPORT (include their location and identify whether any are exempt or protected by copyright):

N/A

APPENDICES TO THIS REPORT:

N/A

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