



Royal College
of Nursing

RCN survey of nurses working with looked after children





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Contents

Introduction	4
About the respondents	4
Looked after children caseloads	4
Facilities for looked after children	10
Service models for looked after children	13
Nursing roles for looked after children/ children in care	17
Issues and concerns	24
Conclusion	25
References	26

Introduction

In 2013, the RCN held several networking events for nurses working with looked after children.

Nurses who attended the October 2013 event raised numerous issues and concerns related to changes in NHS structures, commissioning of services, workload and capacity, roles and responsibilities, as well as the potential perverse impact of the introduction of a Payment by Results (PbR) tariff and unsafe working practices.

A survey of RCN members working with looked after children was undertaken during December 2013 and January 2014 which explored caseloads, ways of working and information about designated and named nurses' roles and responsibilities.

About the respondents

158 members responded to the survey advising they worked with looked after children/children in care. Respondents were represented equitably across all RCN regions/boards, although there was a slightly greater percentage from London and the South East.

The comments included within this publication have been edited for readability without losing context.

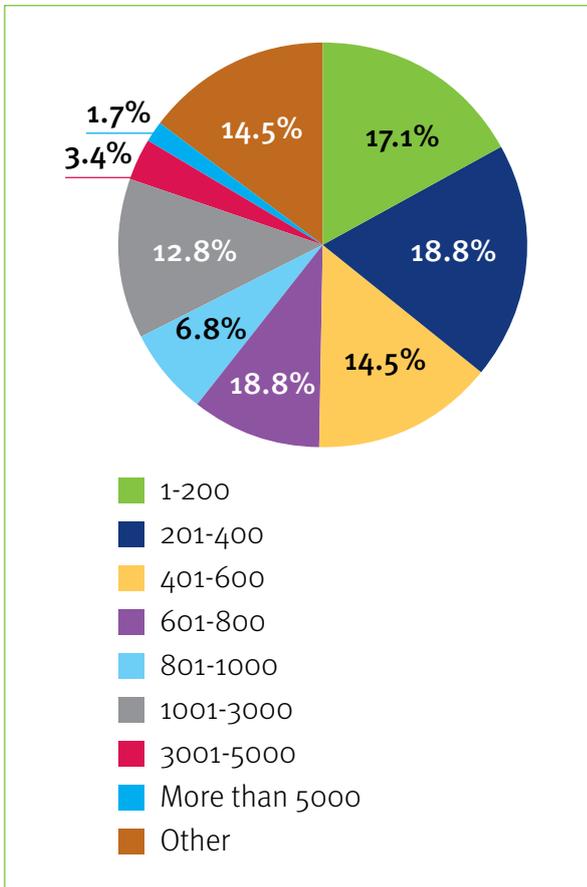
Looked after children caseloads

The majority of respondents did not know the total child (0-18years) population for their county/borough. Some of those responding indicated that the number of children and young people equalled 23 per cent of the total population, and in a specific area could be anything from 30,000 to over two million. In some areas it was acknowledged that this was expected to increase even more by 2020. Many respondents stated that they knew the number of children and young people on their individual caseload but did not know the total child population for their area.

In terms of the number of looked after children and young people, 50.4 per cent of respondents stated there were between one and six hundred looked after children in their area. A further 17.1 per cent stated there were between six hundred and one thousand, and a further 16.2 per cent stated that looked after children were between one thousand and five thousand. 1.7 per cent stated that there were in excess of five thousand (see Figure 1). The findings highlight that respondents covered varied geographical areas.

The term looked after children is used to describe any child who is in the care of the local authority or who is provided with accommodation by the local authority social services department for a continuous period of more than 24 hours. This covers children in respect of whom a compulsory care order or other court order has been made. It also refers to children accommodated voluntarily, including under an agreed series of short-term placements which may be called short breaks, family link placements or respite care. www.legislation.gov.uk/ukpga/1989/41/part/III/crossheading/duties-of-local-authorities-in-relation-to-children-looked-after-by-them

Figure 1: Number of looked after children and young people



We are a net importer of other authorities' children which continues to place stress on local services. In addition to this a significant number of these children receive a poor service from their local authority and a number of them are placed back into their local authority when they reach independence causing them additional problems including isolation.

The comments from respondents above illustrate a number of concerns and highlight some difficulties in service planning and provision. The fluctuation in numbers of children entering the care system and the shift towards swifter permanency arrangements for children have been well documented nationally and are indicative of changes in social care practice and political response. There were 92,000 looked after children across the UK in 2013. The Department of Health in England statistical release of 2013 states that there were 68,110 looked after children at 31 March 2013; an increase of two per cent compared to 31 March 2012.

Variances in numbers locally and nationally pose difficulties for the commissioning and provision of adequate health care for the increasing numbers of looked after children and those children who remain vulnerable despite permanency arrangements, which are often subject to disruption. The disruption continues due to a poor recognition of need and lack of investment in specialist services in many areas.

We have seen a 50 per cent increase in the numbers over the last three years. My organisation has provided no additional nurses to support this work.

The number of looked after children has decreased significantly over the last 18 months, seeing a month on month reduction in numbers. As of 18 months ago we have over 800 children. We have seen sharp increases in SGOs (special guardianship orders) granted which is felt to be the main contributory factor in these decreases.

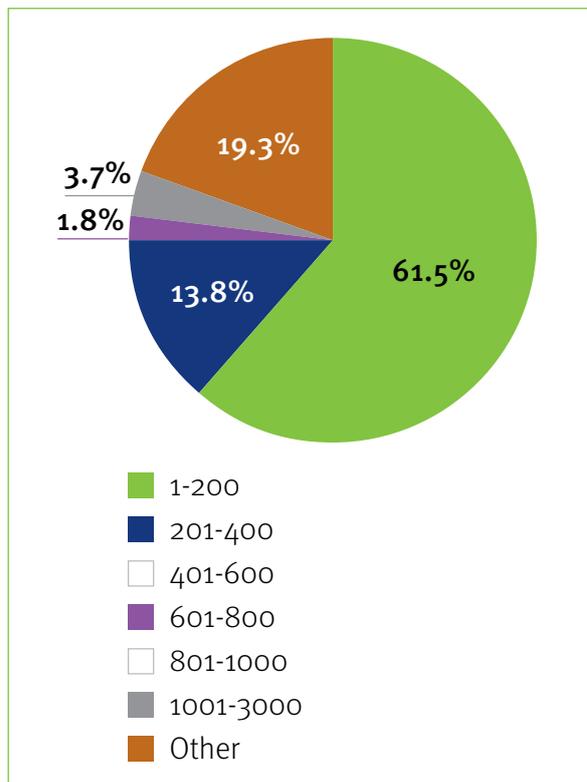
It is unknown how many LAC (looked after children) are placed in the city, as notification of changes of placement ie leaving the city, is poor nationally.

The poor exchange of timely placement information by social care departments to health services, particularly for children placed outside of their local authority area remains challenging. The difficulties in supporting children in care and care leavers when they move area are often underestimated. These concerns should be considered in any revision of the statutory health guidance.

Looked after children placed out of county/borough

Over 61.5 per cent of respondents advised that 100 to 200 looked after children were placed out of the county/borough in the previous year. 13.8 per cent stated that between 200 and 400, and a further 1.8 per cent that between 600 and 800 children were placed out of the county/borough. 3.7 per cent stated that between 1,000 and 3,000 were placed out of the county/borough in the previous year (see Figure 2).

Figure 2: Number of looked after children placed out of county/borough



Most infants are placed locally at first but there is considerable pressure on suitable places.

We have one of the lowest numbers of children placed out of county due to having a specialist foster care service which takes many of our complex children.

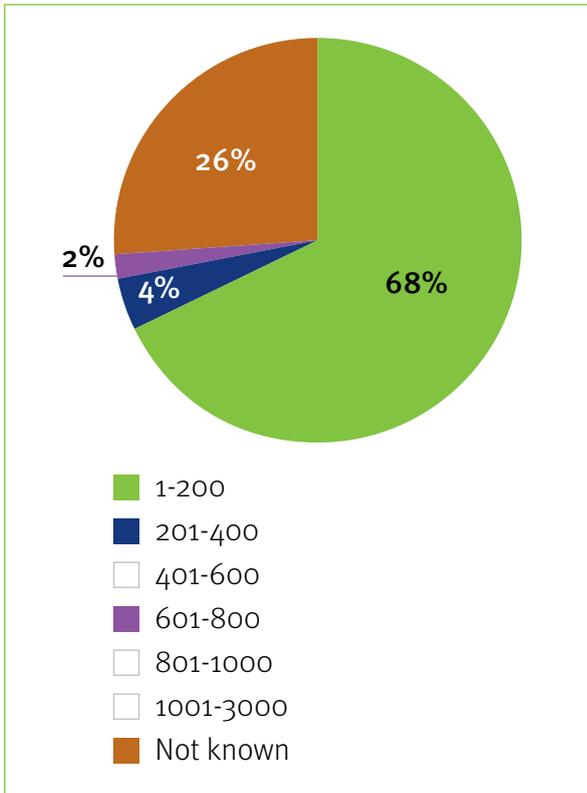
We continue to have difficulties getting health assessments completed for our children placed out of area. Some areas are saying due to capacity issues they are unable to complete even when payment is offered, sometimes they are completed but there are huge waiting lists. Paperwork is simply being returned with no alternative being offered. Some areas are saying they do not provide a service for out of county children. Equally for children placed in this area from out of county authorities, some areas send their own nurses to complete which is fine but often we do not get copies of these completed health assessments despite requests being made which means we can sometimes be unaware of the health needs of children placed here which I feel is a risk. Further guidance on this is required.

Our county covers a large geographical area. Children can be living a long way from their home but still be living within the borough.

Unaccompanied asylum seeking children within the looked after children caseload

68 per cent of respondents stated that there were between one and two hundred unaccompanied asylum-seeking children within the looked after children caseload. While four per cent advised there were between 200 and 400, a further two per cent stated that there were between 600 and 800 unaccompanied asylum seeking children within the looked after children caseload (see Figure 3).

Figure 3: Number of unaccompanied asylum seeking children within the looked after children caseload



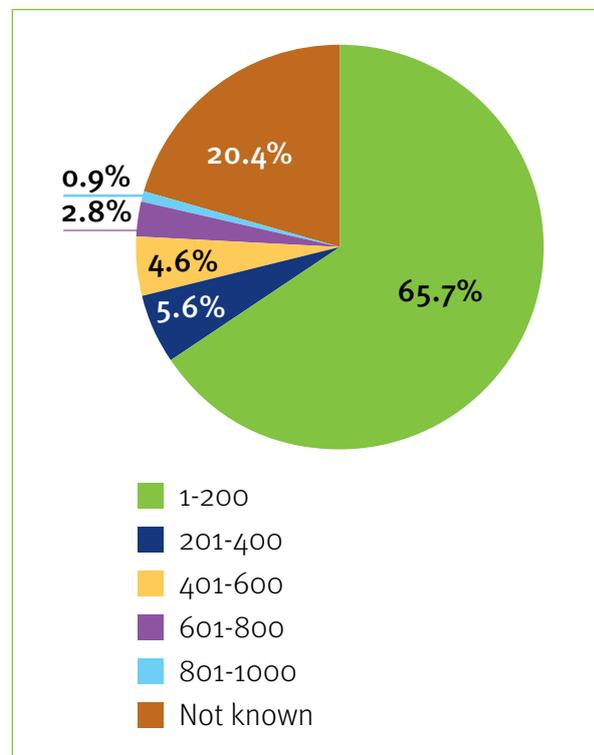
Several respondents added comments which included:

- I have a team member take a lead with this cohort of looked after children as they have very specific and at times complex needs. I also have a GP who has developed a special interest who conducts the initial health assessment.
- We do not have a reception centre for asylum seekers locally anymore so we have very low numbers and these are young people who have been in the system a few years.
- The numbers of unaccompanied asylum seekers within our county is very small. I do not think there are many members of staff that fully understand their possible needs.

Care leavers

65.7 per cent of respondents stated that they were responsible for between 100 and 200 care leavers. 5.6 per cent advised they had between 201 to 400 on their caseload, 4.6 per cent have between 401 and 600, 2.8 per cent have between 601 and 800, and 0.9 per cent have between 801 and 1,000 (see Figure 4).

Figure 4: Number of care leavers on caseload



- Once young people leave care at 18 we no longer have responsibility for them. We are trying to have funding agreed for a leaving care nurse.
- It is not a bespoke looked after children's team, although the practitioners work with them leaving care service to help and support with health requirements.
- We currently are not commissioned to provide a service for care leavers. I have been lobbying for this service for a number of years and have just highlighted to commissioners the care leavers strategy and responsibilities in inspection/statutory documents.

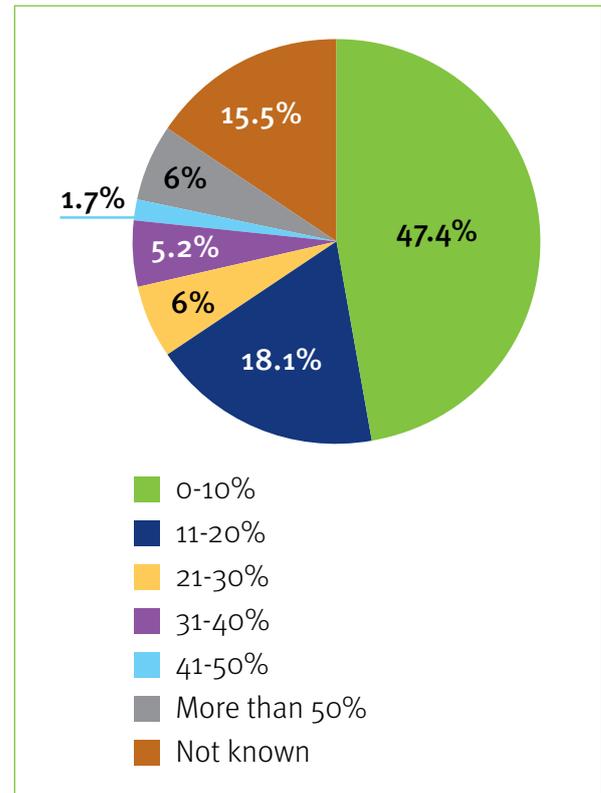
We currently provide a full service for those young people on care orders but service is expanding to facilitate a service provision for all care leavers under the care of the 16+ team.

Several issues are illustrated by the above comments. There is a need to clarify and define the term care leavers so that all areas are looking at the same age range. In addition, the above statements show that some areas provide services to care leavers, but others are not commissioned or do not have the capacity to do so. These issues should be clarified in order to standardise, support and meet the health needs of this group of young people as per the *Care leaver strategy* (2013). It is important to ensure that provision for care leavers is fed into the forthcoming revision of the statutory guidance for looked after children.

Looked after children with physical disabilities and learning difficulties

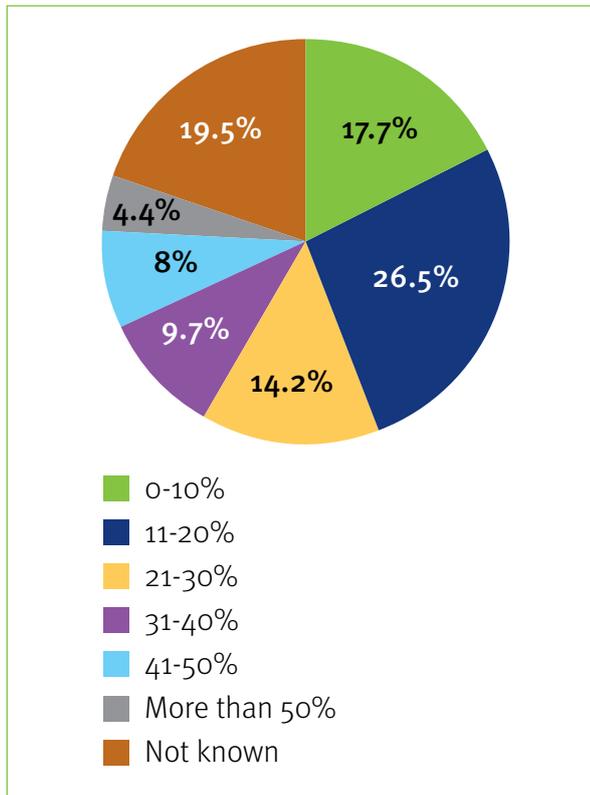
47.4 per cent of respondents stated that under 10 per cent of looked after children on their caseload had physical disabilities. 18.1 per cent advised this was between 11 and 20 per cent, and six per cent stated this was more than 50 per cent of their caseload (see Figure 5).

Figure 5: Percentage of looked after children on caseload with physical disabilities



4.4 per cent of respondents highlighted that more than 50 per cent of their caseload had learning difficulties, while 44.2 per cent stated that up to 20 per cent of looked after children on their caseload had learning difficulties (see Figure 6).

Figure 6: Percentage of looked after children on caseload with learning difficulties



We see more looked after children with learning difficulties, in fact most of those we see have either some learning difficulties or are not reaching their potential in school.

Residential resources for children with learning disabilities are limited within the local authority area which means that the majority of these children have to be placed out of area.

The children I look after are children with learning disabilities and complex nursing needs. We provide short stay breaks for the child. The current LAC documentation is not really applicable for the purpose but there is no other available...

Lack of residential placements is an ongoing concern. We are reviewing how respite is regarded under LAC status.

Disabled children constitute a notable proportion of the looked after children population, though there is uncertainty relating to the definitions of ‘disability’ as interpreted by the local authority and those as defined by health services. There is a clear need for a national approach for clear and consistent interagency definitions and measurement in order to determine need and identify appropriate provision.

Irrespective of definition, it is clear that a consistent and cohesive system is required to enable these vulnerable children to have their health needs met. Variance in the interpretation of guidelines for determining LAC status by local authorities compromises being able to meet the needs of these children, for example when guidance criteria is not applied for those disabled children in overnight accommodation for more than 75 nights. There is need for interagency clarity on the interpretation of guidance and the provision of services nationally. Placements can be difficult and challenging to find, but health services need to take a more central role within the decision-making process of placements and within support systems for disabled children in care.

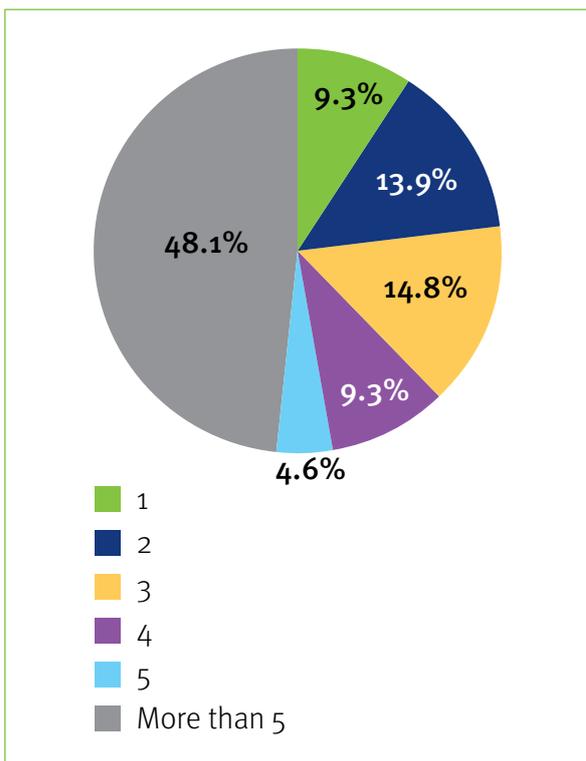
The transition to adult services also poses potential areas of concern if eligibility criteria for adult services are not met. Finding suitable accommodation and appropriate support can be difficult, particularly if placed out of the originating authority area. A united approach between different authorities towards meeting the needs of this vulnerable group of young people is needed in order to prevent poor outcomes. Improving the assessment process and the communication of information, particularly at points of transition will aid the delivery of improved plans of care.

Facilities for looked after children

Residential children's homes

Over 90 per cent (90.7 per cent) of respondents stated that there were two or more residential children's homes in their county/borough. 48.1 per cent had more than five residential children's homes in their county/borough (see Figure 7).

Figure 7: Number of residential children's homes



Each of our six specialist nurses for looked after children has a group of residential homes for which they are the named link nurse. We also have a secure children's home, with two whole time equivalent nurses.

There is a mixture of local authority homes for children with disabilities (most beds provide respite care) and a secure unit. There is an increasing number of small privately run children's homes across the three local authorities. The number of these is of concern.

There are not enough, and those that are around are often not able to care for children with physical disabilities as the buildings are often converted houses that cannot accommodate wheelchairs and other equipment. They are often staffed by inexperienced staff who often do not speak much English.

They are all privately run, we no longer have any local authority run homes. These do tend to pop up without much notice or communication so as soon as they are identified my team will visit and ensure good communication processes are in place and homes are aware of what support can be offered by the LAC team.

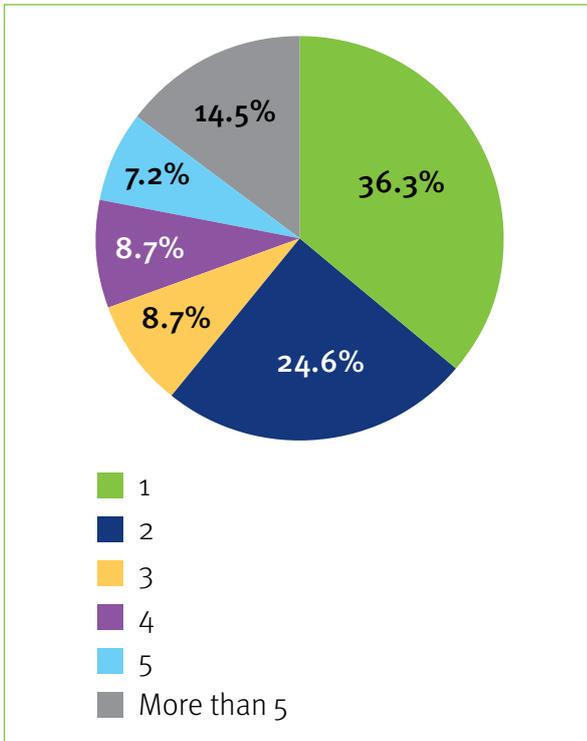
There are fewer local authority residential children's homes in the county but many more independent residential children's homes in which a large number of looked after children are placed by external (responsible) authorities.

The above comments show the wide range of residential units that health professionals work with, including privately run units. In some areas, there is a shortage of local authority facilities which means that children are placed outside of county/borough. Other areas use privately run homes to place children with some of these units appearing without notice, which does not aid good working relationships. There appears to be some concern regarding some homes as standardised basic facilities may raise governance issues, for example, staff should be adequately trained and able to support and advocate for the child while they are placed there.

Residential special needs schools

62.2 per cent of respondents advised that there were residential special needs schools in their county/borough. 14.5 per cent advised there were more than five residential special needs schools in their area, while 36.2 per cent had only one residential special needs school (see Figure 8).

Figure 8: Number of residential special needs schools (where at least one exists in the area)



The school advertises a service which addresses mental health issues and draws a lot of funding for this, but then accesses local child and adolescent mental health services (CAMHS) when a crisis occurs, expecting local services to solve issues. There needs to be very clear procedures in place to ensure children’s needs are met and this needs collaborative working.

They are often charity run, therefore need funding approved by local authority – a long, time consuming and frustrating process.

One of our team is a registered learning disability nurse and this has proved invaluable in the provision of care and expertise as part of our holistic health service.

Responses indicate a need for greater collaboration between health, social care and education when commissioning placements in residential special needs schools to ensure adequate health provision. It is particularly the case for ensuring that access to ongoing psychiatric care and appropriate therapeutic interventions of an adequate

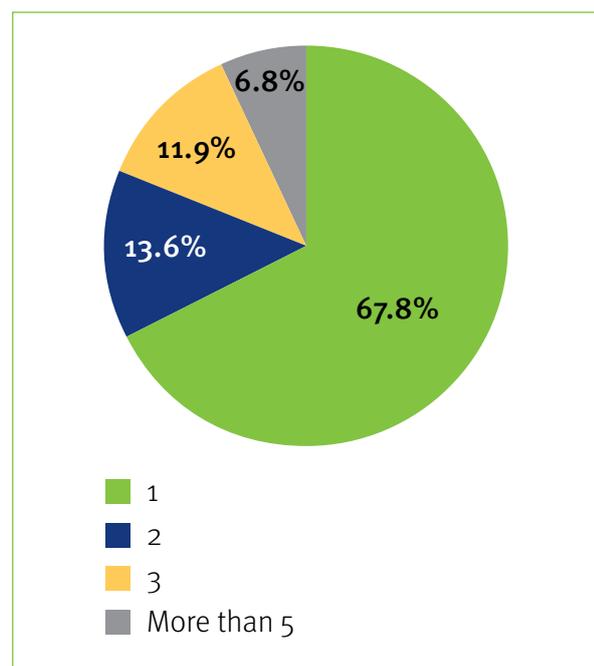
standard are available for children and young people placed in these settings, many of which are independently run and provide placements for children from outside the area. More consideration from social care and health services needs to be given when placing looked after children who require access to CAMHS to ensure they can access and receive the services they require.

To enable good provision of health services to meet the needs of children and young people placed into a different area it is vital that there is collaboration between the placing and receiving clinical commissioning groups (CCGs). Current service models as demonstrated in this survey and the recent Ofsted Thematic inspection (2014b) show how these differences impact on the ability of professionals to work collaboratively when looked after children are placed out of the area.

Secure children’s units

52 per cent of respondents highlighted that there were secure children’s units in their county/borough. 67.8% advised there was one secure children’s unit in their area, while 6.8% stated there were more than five secure children’s units in their area (see Figure 9).

Figure 9: Number of secure children’s units



This is a clear unmet need; young people are misplaced in open children’s home/CAMHS Tier 4/secure provision because there is no secure children’s home.

We are aware of at least three smaller independent units being used as secure children’s units.

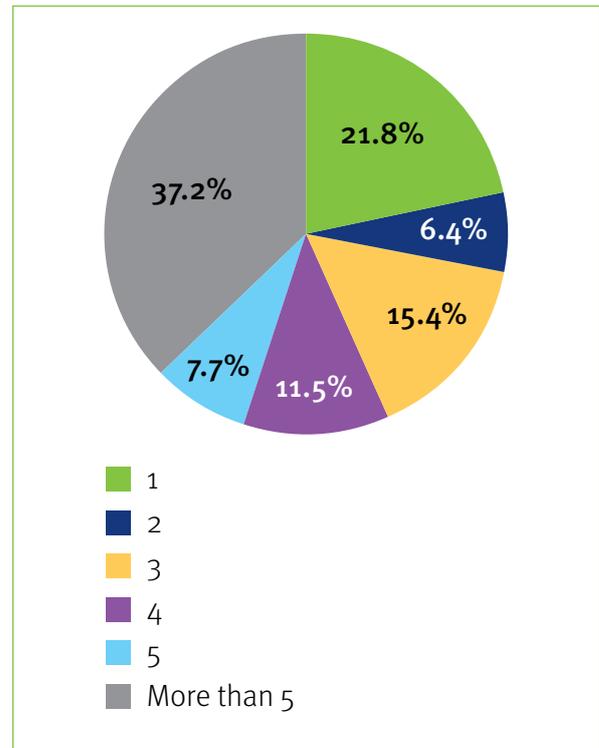
Currently in the process of commissioning a pilot retained remand foster care scheme through independent fostering providers.

The *National minimum standards for children’s homes* (DfE, 2011) states that apart from the measures essential to the home’s status as a secure children’s home or refuge, children resident in secure units or approved refuges should receive the same care services, rights and protections as they should in other children’s homes. These survey comments highlight practice models demonstrating how different interpretations of practise can lead to a significant variance in services for looked after children and young people.

Independent companies providing services for looked after children

81.1 per cent of respondents highlighted that there were independent companies providing care for looked after children in their county/borough. 37.2 per cent advised there were more than six such companies in their area (see Figure 10).

Figure 10: Number of independent companies



These facilities are not thought through. They are used in an emergency and driven by profit. The young people who reach this point have complex needs or are difficult to engage and highly risky. Staff are not skilled or trained to manage them in these settings.

Several of these independent companies accept looked after children with complex needs eg at risk/subject to child sexual exploitation. There are increased demands on health practitioners.

It is not always clear what health facilities or therapeutic interventions are being offered in these establishments or what the placing local authority has contracted with the home.

Concerns around cost, qualifications of therapeutic staff and staff in general in some placements, others however are excellent. All now have to apply to be part of the area and recommended for use to the local authorities within our area.

Service models for looked after children

Some respondents provided quite a detailed outline of the service model in their area, while others gave little detail about ways of working. As can be seen from the following examples there is a variety of models in existence across the country, with a mixed picture of roles and responsibilities and health assessments. While some teams follow children and young people wherever they are, most do not, instead working in a collaborative way with the local team in which the child is placed.

Model of provision within borough/county

We have a team of specialist children in care nurses who hold caseload responsibility for looked after children placed in localities. They are the named nurse for a caseload to promote continuity for their clients, to build relationships and work closely with foster carers to promote placement stability. The nurses are co-located for part of the week with the local children in care social work team and work as part of virtual integrated team including children in care psychology and children in care education colleagues. If a child or young person requests to have their health care provided by a member of universal services this will be facilitated but it is very unusual. The specialist nurses undertake statutory health assessments, monitor implementation of health plans, provide individualised packages of care, and train and support foster carers, residential workers, other health professionals and social workers. The specialist nurses attend the 'missing and child sexual exploitation forums' (to identify and plan interventions to protect children who go missing or who are at risk of child sexual exploitation) and the resource and care panels (to identify children who are at risk of care and either encourage alternative preventative interventions or support care planning at entry into the care system).

The service is in disarray: it was a county-wide service and is now being re-designed following some funding being withdrawn by the county council.

The service is now funded by the county council for the administration part of the team, and health fund the clinical side. One whole time equivalent (WTE) specialist nurse post has been lost. My role as designated nurse (Band 8a, one WTE) and the remaining specialist nurse posts (Band 7, one WTE) were all down-banded to a 7 and 6. The designated nurse role was tagged onto the designated safeguarding nurse role in commissioning.

We have no specific community paediatrician or GP who undertake health assessments. Arrangements vary around the county. There are two medical advisers for adoption: one comes under our community NHS trust, one sits in the acute side. Neither of them come under the team/service's control. I developed a process with the county council in 2010 to arrange the administration of the health assessment process for all looked after children placed both in and out of the county.

As clinical nurses we work with 16 year plus and younger non-engaging looked after children. We undertake review health assessments for this age group, visit the homes and provide health promotion support.

Becoming looked after, and receipt of notification, would trigger a request for an initial LAC health assessment, which is completed by a paediatrician in the community. Review health assessments are completed by the LAC nurse, health visitor, school nurse or paediatrician. The LAC nurse responsible arranges requests for reviews. A health plan is completed with each health assessment. The health plan forms a report for the placement review. For those placed here from outside of the area we continue as above but there is a charging protocol.

It is a bit fragmented, the designated doctor for looked after children sits with one provider, the Band 6 LAC nurse sits with a different provider, the designated nurse sits in the CCG and the LAC admin team are based in the local authority. Health visitors and school nurses undertake review health assessments.

In seven CCGs, designated nurses provide the strategic advice and support to commissioners.

Five provider teams co-ordinate the health care for the child who originates from their area regardless of where they are placed. There is no cross charging for assessments of children who originate within the three local areas and are placed within the three local areas.

The originating CCG responsible for commissioning services adheres to the PbR guidance and tariffs. The same level of service is offered to children from other local areas as those who originate here.

Paediatricians commissioned to undertake initial health assessments, health visitors and school nurses carry out review health assessments, the health adviser for young people in care works with 15-19 year olds. Each provider team comprises of a named nurse for LAC, health adviser for young people in care and a team administrator. Developing GPs with special interests carry out initial health assessments for children aged 13+ who do not need to see a paediatrician. We are aiming to develop nurse-led initial health assessments for these young people.

There is a designated full-time nurse for both safeguarding and LAC which sits within the CCG. There is a named nurse for LAC and care leavers – based within the provider services – managed by the school nurse manager. Currently this post is for 30 hours all year round over four days, the post is funded by 2.5 days from provider services and 1.5 days from the local authority. The current post holder is based within a social care base with the child care social workers, supervising social workers, leaving care personal advisers, virtual school and a multi-agency team named nurse, housing adviser, two learning partnership south-west workers, communication worker and specialist social worker and child psychologist (CONSULT). The named nurse receives management support from both the local authority (social care manager) and health as well as supervision from the designated nurse. There is currently a named doctor for LAC provided by the acute services, there is some limited clerical time provided by the school nursing service for the named nurse and community children's services for the doctor. There has been no

investment by health to the LAC health provision for the past 10 years – a review of the named nurse has just been carried out by provider services and an action plan has been developed with the recommendation of further funding being needed for an additional nurse and dedicated clerical time to support the named nurse in her work.

The provider team is based at the local acute hospital, there is a designated nurse who has a split post (22.5 hours provider and 15 hours with the CCG), four full-time Band 7 named nurses, a designated doctor (four sessions), community paediatricians (four sessions to undertake initial health assessments and adoption assessments), and three full-time and two part-time clerical people. All health assessment work is carried out by the team for the majority of looked after children placed in the area and for a significant minority of the local authority children placed out of area. The nurses provide foster carer training, 1:1 support for children/young people, carers and other professionals and a range of other health-related work for looked after children as required. The team also support the acute hospital staff with their care and understanding of looked after children.

Initial health assessments are carried out by the community paediatrician (named for LAC).

Review health assessments for under five year olds are undertaken by health visitors, and for over five year olds by nurses for children in care. Health promotion and support is provided by nurses for looked after children to all children in care in the area by the nurses for children in care.

Model of provision out of borough/county

Ofsted (2014) state within the thematic inspection *From a distance: looked after children living away from home*, that 'children placed out of area were less likely to receive effective educational and health support than if they were living within their home area, or nearby. The further a child was living from his/her home, the less effective that support became'. Comments within this survey demonstrate that there is a very mixed service with unclear commissioning pathways, often with an expectation that some practitioners travel vast distances to complete health assessments but who would not have the ability to deliver follow up care in the area where the child/young person is placed. The commissioner/provider split has had a significant impact on the ability for looked after children placed out of area to receive timely and effective health services. Ofsted (2014) comment that the further a child is living away from home the less likely that services offered from home could be offered or sustained.

The specialist nurses for looked after children hold responsibility for a number of geographical areas covering the whole of the UK. From April 2014 we will be undertaking health needs assessments (HNAs) of looked after children placed out of area within an 80 mile radius.

Five provider teams co-ordinate health care for children placed outside the three local areas within the host area. Host areas are informed that they will be paid to carry out the assessment in line with PbR guidance & tariffs. There is lots of difficulty in getting host areas to agree, and they are always outside timescales.

Children's out of borough placements are authorised at a multiagency panel comprising of representatives from health, social and education. Placements are joint funded as agreed at panel.

The LAC nurse will travel approx 20 miles outside of the borough to do health assessments. The remainder will be done by an appropriate health professional – GP, out of borough (OOB) LAC nurse, school nurse or health visitor.

We send a letter with the child's details on it to the LAC health team where the child is placed requesting for the health assessment to be completed. When the form agreeing funding for this to take place is completed by the designated nurse and sent off, the health assessment is completed and returned to us.

We do not currently have funding to travel outside of area to complete RHA's so we would contact the LAC team where the child is placed to request this.

When we are notified by our local authority of an LAC movement out of county we would send a notification letter to the receiving LAC team which includes a copy of the last health assessment so any outstanding health issues are flagged up. The notification letter also includes information on any risk factors ie if child has history of self harm, frequent absconding etc. We request to be notified of any A&E attendances. Any invites for LAC reviews are forwarded to the placement LAC team. We request the local authority copies any minutes to both my team as the originating area and the host team, so we can review these and ensure there are no outstanding health issues or concerns not being addressed. Social workers contact the LAC team if there are any issues with accessing health services for children placed out of area, these are occurring more and more frequently and barriers related to funding. The named nurse for LAC will liaise with the host area to try and get these issues resolved in the first instance and if required flag to the designated nurse if no resolution is found.

All of the area's looked after children who are placed outside of the area are allocated a specialist nurse who will request the child's health assessment and ensure it is completed to a high quality in a timely manner. Even though placed out of district the LAC nurse will continue to oversee the child's health needs/plan.

We have one 0.6 WTE nurse specialist who works with those looked after children placed in our county on an individual SLA basis, which is how the role is funded.

The named nurse in the team oversees the looked after children from our county who are placed in other areas.

Most (but not all) LAC provider teams are commissioned to work with all looked after children within their borough. There are no current systems in place to address the PbR tariff. Our children placed outside of the County CCG will pay for health assessments providing minimum quality standards have been met. The in-house LAC health team will co-ordinate with the receiving provider to ensure that health needs are being met.

We follow the children/young people wherever they are placed.

Within our cluster we have an agreement that we don't charge each other. The quality of the assessments undertaken out of area are variable. Some are undertaken by GPs who have not received training and they never complete part C of the British Association for Adoption and Fostering (BAAF) form. Some areas do not undertake a review of LAC health assessments of young people over 16 years either their own or on out of area placed there. It's all a mess and needs addressing nationally.

We really try to work hard with the independent reviewing officer (IRO) to ensure health plan outcomes are achieved at the review meetings. We are developing with the local area to ensure the health outcomes are embedded within the specification and contract for the placement.

All looked after children who are resident in the area are treated in the same way. The nurses do not undertake foster carer training for independent agencies but will do 1:1 work with the carers if asked. Health assessments carried out on other authorities children are cross charged under the LAC tariff. A few local authorities send their own nurses to the area to undertake health assessments but we are not informed of this activity which leads to an unclear picture of the health needs of the LAC population in the area.

When a child is placed out of county, notification goes to the designated nurse for children in care (CIC) for the receiving area. This includes a copy of the child's most recent health assessment and health care plan. Health assessments are requested via the same route. The specialist CIC nurse will continue to maintain contact with that child/young person and their carers and liaise with their colleagues in the area that the child is placed in, and with the care provider to monitor the implementation of the health plan and ensure access to appropriate local services. This will be reported at the child's reviews.

When a child returns to the area the designated nurse for the other area is notified.

The responses above indicate the need for revision to the statutory guidance, to give clear direction on the commissioning arrangements for the health provision for children and young people in and out of county placements, alongside further development of the tariff arrangements, the development of out of county care pathways, and care packages. In the best interests of looked after children and care providers, out of county/borough children should be linked to local services in their placement area.

Links with acute children's services

91.2 per cent of respondents stated that there were links between the looked after children's team and the local acute children's services. There is a need to consider the highlighting of looked after and/or care leaver status across health services taking into account the views of the children and young people themselves.

Nursing roles for looked after children/children in care

Designated nurses

92 per cent of respondents stated there was a dedicated designated nurse for looked after children in their county/borough. There were some areas where the designated nurse was not a dedicated role.

The designated nurse role is a health board role covering the whole board and incorporated as part of designated nurse for safeguarding across the trust. Each county has a specialist nurse responsible for the geographical area.

The post sits in the provider organisation, and as such delivering a direct service to LAC. There is a need to identify an additional strategic post to advise commissioners without reducing the capacity to deliver services to looked after children.

The nurse is also the service manager for the LAC team within provider services. This poses a conflict of interest when reporting to the CCG. I am the only designated LAC nurse within the local area. The rest are designated safeguarding nurses with designated LAC attached. I am often excluded from decisions/meetings about LAC as the local lead always goes to the designated safeguarding nurses.

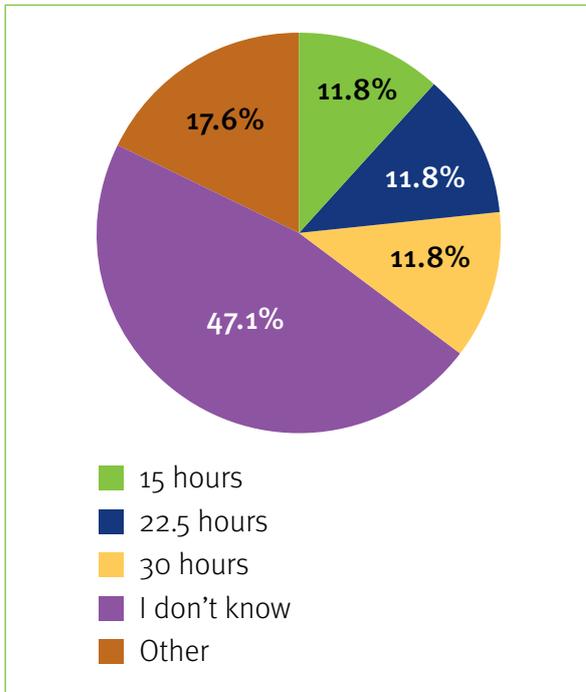
The designated nurse for looked after children is part of a consultant nurse for safeguarding post which includes the designated role for safeguarding children, and safeguarding adults. This post is within commissioning. The designated nurse for looked after children should be a separate role.

This post is part commissioning and part provider. The designated nurse manages the specialist children in care nurses. This split role has compromised the strategic function.

The comments reflect the current disparity in the interpretation of the designated nurse role for looked after children. Many of these role variations are based on historical arrangements and have not altered in line with changes to NHS structures. In many instances participants reported problems resulting from failure to separate the commissioning and provider functions. It had compromised the strategic function of the designated nurse for looked after children and their ability to provide impartial advice to commissioners or to represent looked after children's issues effectively to the local safeguarding children board (LSCB) and other strategic bodies. It should also be highlighted that where the role of designated nurse for looked after children has been subsumed into or under the role of the designated nurse for safeguarding, respondents report that looked after children's issues and specialist staff are often seen as secondary to safeguarding, and the distinct needs of looked after children remain unrecognised and unmet.

While 85.5 per cent advised the dedicated designated nurse post was full-time, 14.5 per cent stated this was part-time. Where the post was part-time the number of contracted hours of the designated nurse for looked after children varied, with nearly 50 per cent being contacted for 30 hours per week (see Figure 11).

Figure 11: When not full-time, the number of hours a designated nurse works



Several respondents expressed concern about the time and capacity to undertake the role if the post was part-time.

I am only commissioned for one day per week. This is a role that needs to be commissioned full-time as I am unable to fulfil all the functions of my role as outlined within the statutory guidance and this in turn impacts on the development of the service. I also manage 11 staff.

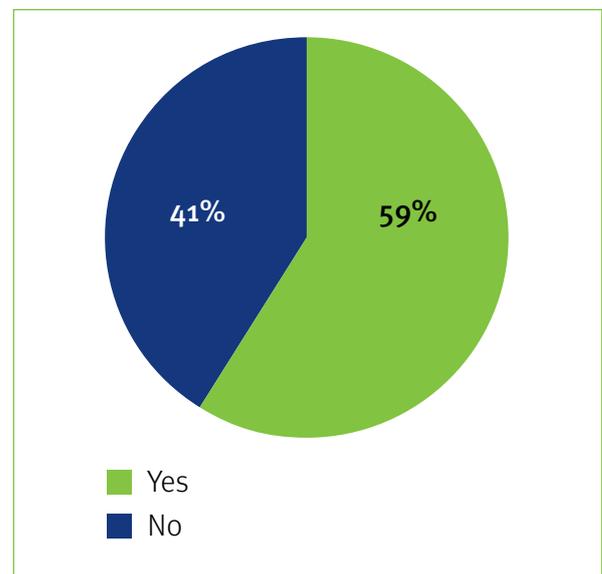
The designated nurse for safeguarding children had the designated nurse for LAC added to her job description. She did not apply for the job and has had to fit it in with an already busy full-time job. The designated LAC post should be a separate role.

There are currently 15 hours for this post and it is a split post with the other 22.5 hours being worked as the lead nurse for the provider. However this will be changing and the post moved to create two stand alone posts: a full-time lead nurse in provider and a designated post in the CCG. The number of hours for the designated post is unclear at the moment.

Nearly 60 per cent of respondents stated that the designated nurse post was located within a commissioning organisation (see Figure 12).

That so many of the designated nurse looked after children posts which have been created in commissioning are part-time is of concern. It indicates a lack of understanding by commissioners of the complexity of the role and the many areas of contracting which are affected and should be monitored in relation to service provision for looked after children and care leavers, and the service provision required to meet the quality standards outlined in the NICE guidelines. A greater awareness by chief executives and board members of their responsibilities towards looked after children and care leavers may go some way to highlighting these issues and should be reflected in the revisions to the intercollegiate framework and the statutory health guidance.

Figure 12: Is there a designated nurse post sitting within the commissioning organisation?



My one day per week is on an SLA to the provider arm. Currently the commissioners are difficult to engage with. They see the designated nurse LAC role as secondary to designated nurse for safeguarding. We are the Cinderella nurse in a Cinderella service.

I work in that function which has advantages in order to inform commissioners of service strengths/gaps. What is apparent is that isolation from the provider unit is not always positive. The function struggles to influence strategic direction for provider services for LAC and is seen as very separate. In the CCG the functions for this role have diversified into the wider safeguarding agenda and vulnerable adults, leaving less time for LAC work.

The designated nurse post is hosted by a provider organisation but reports to the commissioning group, and the provider organisation. The commissioning group does not currently wish to host the designated nurse for CIC although the designated nurse for safeguarding post has just moved to commissioning. It has been inferred that a move to the commissioning group would make the post holder vulnerable to redundancy.

Only 55.8 per cent of designated nurses attend the corporate parenting board as the organisation's representative.

A standing agenda slot is available for health updates to the corporate carers. The named nurse from the provider service sits on the corporate parenting board.

In our county as designated nurse I am part of the multi-agency LAC improvement group that feeds into the corporate parenting panel. I attend the corporate parenting panel as invited by county councillors. Since the May election, education have frequently been invited to present. We are still lobbying for health to be invited.

The designated nurse did attend the corporate parenting board but the local authority did not wish to have a provider so this function was delegated to one of the children's commissioning team. The designated nurse for CIC currently sits on the corporate parenting managers meeting. The designated nurse for CIC sits on the LSCB performance group.

76.5 per cent of respondents highlight that the designated nurse attends the local safeguarding children's board as the organisation's representative for looked after children.

The local safeguarding board seems very far removed from the day to day management of these risky, vulnerable, [possibly] suicidal and probably homeless young people who are sometimes exploited and addicted to drugs. Their role is very unclear to the system and the people who work in it.

I have never been invited to partake in the LSCB nor invited to supply up to date information/reports. I know that the previous designated nurse for safeguarding felt involvement such as mine was inappropriate.

A recent change in the terms of reference for the LSCB has resulted in the need to revise the management structure of the designated nurse for CIC because to sit on the LSCB, the designated nurse for CIC will have to be accountable to the safeguarding executive of either the provider organisation or the commissioning group. This is currently under discussion.

Dedicated named nurse for looked after children

69.2 per cent of respondents stated there was a dedicated named nurse for looked after children in their county/ borough.

My role incorporates the named nurse for LAC, transitions and leaving care and children's home components. The role is under extreme pressure as additional resources are needed.

The named nurse role is essential for tracking and monitoring of LAC movements; auditing of health assessments; ensuring health needs of LAC placed out of area are met; training health visitors, school nurses and foster carers; monitoring of A&E attendances and supporting social workers to navigate complicated health systems.

I am a named nurse for safeguarding children working within a mental health and community trust. However I also manage the looked after children's health team as well as the youth offending health team.

The CIC health team is hosted by the acute service provider and so this is an integral part of the designated nurse function currently.

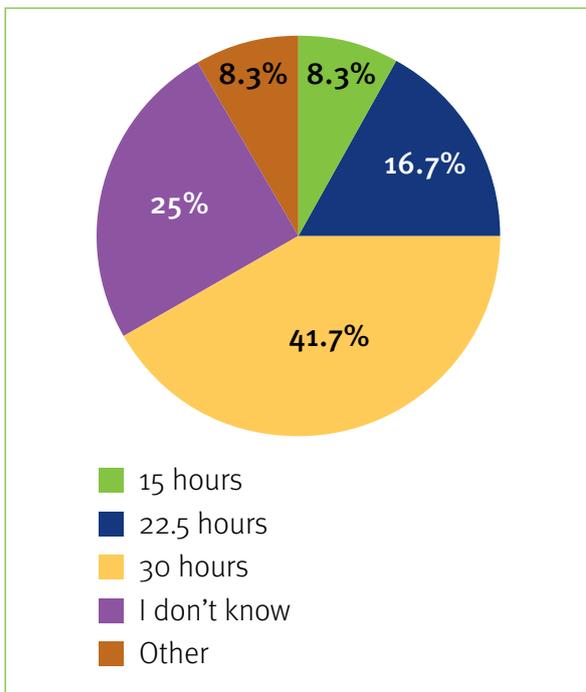
While 82.3 per cent advised the dedicated designated nurse post was full-time, 17.7 per cent stated this was part-time.

Named nurses in each of the five provider organisations are full-time. Health advisers for young people in care are part-time 0.6 or 0.8 WTE.

This post carries a large caseload which is combined with strategic responsibilities (as there has been a vacancy for a designated nurse). This is not comparable to other neighbouring boroughs who have similar numbers of LAC.

Where the post was part-time the number of contracted hours of the named nurse for looked after children varied, with just over 40 per cent being contacted for 30 hours per week and 8.3 per cent indicating this was for only 7.5 hours per week (see Figure 13).

Figure 13: The number of part-time hours the named nurse works



Role and function of the named nurse

Some respondents provided a detailed outline in respect of the role and function of the named nurse.

Co-ordinate health care for the child, provide training for own staff and, in partnership with other provider teams, for foster carers. Monitor and audit service delivery. Lead service development within own organisation and in partnership with a designated nurse to ensure consistency across the whole health economy.

Manage a team of LAC nurses. Design policy and enhance standards. Undertake health reviews. Advice, training, immunisation and research.

Provide a comprehensive health service to looked after children and to care leavers. Promote positive physical and emotional health. Undertake health assessments of children looked after both in county and out of county where possible. Facilitate training courses for foster carers and other professionals about the health needs of LAC and care leavers including sexual health. Is the medical adviser to the foster panel. Is a member of the corporate parenting board. Attends skills to foster course. Promotes the health and wellbeing of looked after and children care leavers to all health professionals and a wider audience. Attends the area's LAC nurses group. Monitor health assessments of LAC placed outside of the area, monitor SDQs, delegate health reviews to be undertaken for children looked after by other local areas to trained school nurses/ health visitors and audits these to ensure quality. Undertake internal audits, write policies. Work closely with the designated nurse for LAC within the CCG.

Monitor mental health and risk. Attend LAC reviews and update all professionals involved. Is an advocate and a voice for young people. Is the core contact for all the professionals involved.

It is a new role so is being developed at present but supports the lead/designated nurse. Provides supervision for LAC nurses.

Liaise with school nurses who undertake the health assessments. Ensure the best outcomes are achieved for LAC. Signpost to young people the services they may be unaware of. Collate information from BAAF health assessments and share with social workers.

Care planning. Liaising between professionals. Annual health assessment; information gathering and organising of health assessments. Manage a caseload. Health education support to carers and care placements.

Audit all health assessments. Responsible for the co-ordination of IHA and RHA services. Tracking and monitoring of all LAC, placement moves, notifying receiving area, ensuring good communication channels are in place. Training health visitors, school nurses and foster carers.

Key contact for social workers providing advice supporting health issues. Ensure quality assurance and governance in place. Provide regular supervision for staff. Manage LAC team. Completion of annual report and health needs analysis. Monitoring of all A&E attendances for LAC and domestic violence involving looked after children. Ensure local policies are in place and ensure these reflect any changes in government policy. Work closely with local authority and designated nurse for LAC re strategic development of services etc.

Service manager of LAC and youth offending services. Strategic lead and lead for CSE.

Complete statutory review health assessments. Provide health interventions as necessary. Make referrals as appropriate. We run an immunisation clinic and run drop in sessions for care leavers, smoking cessation, C Card distribution, accompany young people to appointments such as sexual health and hospital appointments and are developing a teenage pregnancy pathway. We do targeted sex and relationship education sessions. Training for carers and social workers. We co-facilitate support groups for carers with social worker colleagues.

The named nurse will carry out health assessments, work 1:1 with children/young people, carers and other professionals. Foster carer training and training for other professionals. Support for the acute trust on understanding the needs of LAC and the consent issues for LAC who need treatment. We have a range of skills in the team including a mental health nurse and a learning disability nurse.

Co-ordination, leadership, champion, trainer, innovator and advocate, ensures the profile of children and young people who are looked after is raised.

The designated nurse works in CCG. The named nurse provides the training, consultation, ensures systems are in place for HAs, monitors quality and cost, delivers the annual report to CCG/LA and works with the local area, but the designated nurse for LAC should be the health lead in the local area. I would see it as the role I currently do as the team leader: providing a link between health provider and commissioning services and the county council, driving forward the LAC and care leaver agenda, monitoring and auditing health needs of LAC.

Train health and social care on the health needs of children in care; service development; support the designated nurse with the annual report; liaise between social care and health to obtain best outcomes for children in care ; and work with commissioners on service development and need.

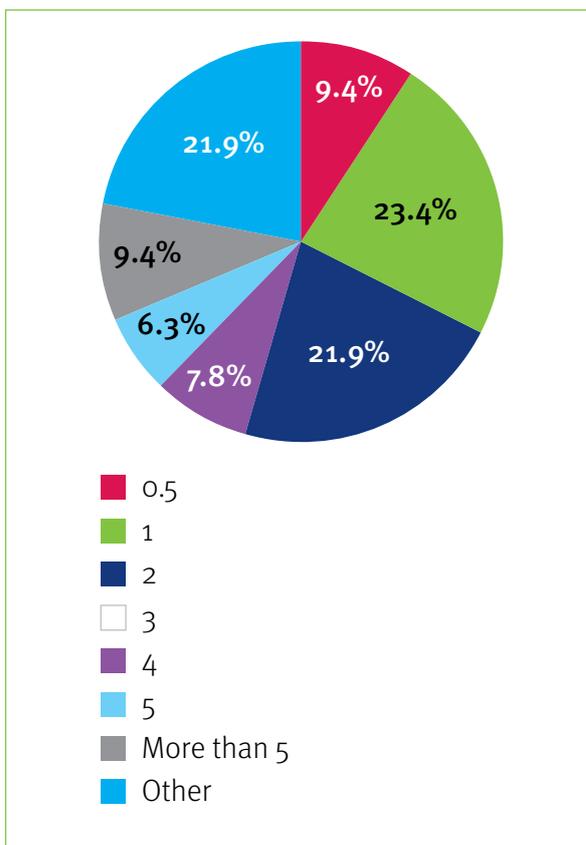
Respondents gave a number of examples where the role of named nurse was clearly within the provider organisation and was instrumental to the monitoring of service delivery, the supervision and management of specialist staff and the provision of training, advice and supervision to the wider health staff group.

The delineation of provider and commissioning functions ie named nurse in provider and designated nurse in commissioning, appears from these responses to be an effective model and should be reflected in revisions to the intercollegiate framework.

Specialist nurses for looked after children

60.6 per cent of respondents stated there were specialist nurses for looked after children. The number of specialist nurses in the team varied from 0.5 WTE to more than 5 WTE (see Figure 14).

Figure 14: The number of specialist nurses



The caseload per specialist nurse varied from around 50 to 150, with the majority stated between 100 and 110.

Role and function of specialist nurse

Some respondents provided a detailed outline in respect of the role and function of the specialist nurse.

Each LAC child is allocated an LAC nurse who is responsible for co-ordinating the child's health assessments, completing the health assessments, overseeing care etc.

They organise annual health assessments (or six monthly for under five year olds), provide foster carer training, have a named nurse against individual children's homes, sit on the foster panel, attend LAC reviews, check the health needs of looked after children are being met, liaise with professionals, and provide training for school nurses and health visitors.

This role is shared with one WTE RGN. They undertake health assessments; support young people living semi and [fully] independently; provide training and support to foster carers/county council staff and young people; provide health promotion advice; train and provide support for health professionals; liaise with designated nurse in commissioning; and provide data and information for the organisation board.

They undertake the statutory health assessments and monitor the implementation of health plans including signposting or referral to other services and liaison; advice, support and supervise a range of professionals and carers; training for a range of professionals and carers; CSE forums; resource and care panels, and professional meetings and safeguarding.

Co-ordinate all health assessments, lead professional responsibilities for children over 16, and those not in mainstream education. Liaise and train health and social care staff, CYP and carers on health needs of LAC and are a source of expert advice that ensure audit etc is completed as appropriate.

The main responsibility of LAC staff nurse working with 11-15 year olds is to complete RHAs, attend LAC reviews, and ensure any identified health needs are met. They support foster carers to address health needs, immunisation pick ups.

The health adviser post working with children over 16 also completes RHAs, attends LAC reviews but also supports young people to access universal services particularly those living independently eg supports young person to register with GP, how to access sexual health services, accompanying young people if requested. Immunisation pick ups.

Both roles include lots of health promotion work: sessions offered to residential units, supported lodgings etc.

Training, advice and consultation to other professionals, and act as a caseload holder for 16-18 year olds, unaccompanied asylum seeking children (UASC), LAC in residential care homes and hard to reach young people.

The respondents of this survey have, by describing their services, demonstrated the very wide interpretation nationally of the structure of nursing roles and their responsibilities with the specialist LAC nurse teams. With wide diversity of grading and expectations of the role, respondents have reflected that the current structure of services varies considerably from area to area with similar roles being given different job titles. It is therefore unlikely that professionals outside of the LAC nurse teams/services would necessarily understand the role function and purpose of these teams or indeed the professionals within them. The respondents also indicate that there has been little thought to succession planning within the LAC nurse services. These responses indicate that there is a need for a clear professional structure and definition of professional roles within looked after children's nursing which sits alongside the safeguarding structure and not within it.

Issues and concerns

Many respondents made additional comments about looked after children and the service provision. These highlighted inequity and parity issues, as well as cutbacks in services.

At a national level I think the work and world of LAC nurses needs some serious recognition, government support and funding regarding branding and status. We all work incredibly hard to promote the health of vulnerable children but still have 'Cinderella service' status. The RCPCH [Royal College of Paediatrics and Child Health] guidance seems to be ignored largely within organisations and LAC amalgamated into safeguarding roles. As a professional, I worry for the future of LAC nursing and whether it will still be around in five years. The commissioner/provider split has been very unhelpful and is impacting on children's health which I feel is really sad.

It is of concern that in both commissioning and provider arenas the specialist nature of the work with this vulnerable client group continues to be misunderstood. The role of the designated nurse for children in care is often perceived as secondary to that of safeguarding and it is often suggested that the two functions can be combined. These two posts require different knowledge and skills bases. The merging of the two roles compromises the necessary strategic drive to promote service development/improvement across both the health economy and local authority and to highlight the very specific safeguarding needs of the looked after population. It should not be forgotten that looked after children's nursing and the role of the designated nurse for looked after children are relatively new in health services and therefore misunderstood and in some areas underdeveloped. There is a need to re-establish the role within commissioning (NHS England- safeguarding) and consider the links with Public Health Commissioning and reinvigorate service provision for Looked after Children to promote positive outcomes and reduce the long term costs of social, educational and health inequalities for this vulnerable group.

Health services and the professionals who work in them need to be seen as equal to safeguarding colleagues and not an inferior service eg the designated nurse for safeguarding (8b) monitors the designated nurse (8a) for no equity in our area. Our designated nurse for safeguarding is new into post (the designated nurse for LAC did the reference for the post holder and was staggered to find her own role in the job description for safeguarding)... What happens to LAC professionals mirrors what happens to LAC in general.

I think this vulnerable group of children and young people deserve a better service than they currently get across the country. Many areas prioritise their own health advisers for looked after children before those that are out of area so these are not done in a timely fashion. Some areas refuse to serve out of area altogether as they have too big a workload and it would be impossible for someone to go to another area for one health adviser, and really costly.

There continues to be difficulties with the notification of children placed into this area from other local authorities and health providers. This leads to a lack of knowledge of the health needs of the LAC population and issues when the child/young person comes into the hospital either for planned treatment or as an emergency. Cross charging for health assessments has led to an inadequate service for some with nurses travelling into other areas to see their children and not knowing what services can be tapped into when a health need is found at the health assessment.

The issue of tariffs needs to be addressed on a national basis as well as some work on standardisation of services and expectations for LAC across the country. There needs to be a standard set for number of LAC nurses compared to the number of LAC across the country as there is a significant discrepancy in this.

Others felt their service provision overall was good.

For a large and complex county I think we have a good service model and work well in partnership with the three LAs, seven CCGs, five provider organisations, GPs and acute trusts. Standardised service specifications are in place.

Conclusion

This report has been produced taking into account the views and experiences of nurses working with looked after children/children in care. Many issues have been raised by the nurses who responded to this survey.

The report shows that there is a considerable variation in caseloads throughout the country, with a wide range of different ways of working and providing services. It can be seen that in some areas, more children are placed outside of county/borough boundaries than others. A recent paper raises concerns for looked after children who are placed outside of their home county/borough. In most cases, nurses express concerns that a robust information system is required when placements change. Lack of information continues to affect service delivery and may have a significant impact upon the receipt of timely services for those children who experience multiple placement moves.

In meeting the needs of various groups of looked after children, respondents again indicated a variation of service provision. In some areas there were dedicated team members for unaccompanied asylum-seeking children and care leavers, however, some areas did not have the capacity or were not commissioned to provide services. Another vulnerable group of looked after children were those with identified physical and learning difficulties. Nurses stated that these children required consistent systems in order for their needs to be met especially at the point of transition to adult services.

Most looked after children nurses reported that they had residential children's homes within the county/borough. Some noted, however, that there was a shortage of homes locally resulting in children being placed out of county/borough. Comments made suggested that homes should have standard facilities with adequately trained staff. This is of particular concern with the introduction of independent providers and privately run units. Nurses also commented on the need to standardise practice for looked after children placed within secure children's units.

LAC nurses provided information relating to a wide range of service models for looked after children services throughout

the country. This results in a wide variation of service depending on the area in which the child is looked after. Some LAC health teams travel to wherever their looked after child is placed, some have a larger team than others, some teams sit within safeguarding services. One person commented that it is a bit fragmented.

From this report, it is clear that the variation in service provision means that in some areas looked after children receive a poor or limited service in comparison to others. Although service models can differ to reflect local need, it is imperative that standardisation of services for this vulnerable group is in place to ensure high quality health care and to promote positive health outcomes for looked after children, no matter where they come into care.

Nurses also provided information relating to their roles. A wide range of role titles with varying responsibilities were described. In particular, the role of the designated nurse for looked after children is unclear in its function, strategic role, and chain of accountability. This has become more evident following the provider/commissioner split, and there is a need for clarity of this role. Time and capacity were key issues for respondents, with some staff noting difficulty in fulfilling some roles as they were part-time positions. Unless roles are clarified and capacity issues addressed, the health service for looked after children and care leavers will be misunderstood and unrecognised with the resultant risk of marginalisation of this vulnerable group of children and young people. The forthcoming update of the Intercollegiate Framework must address these issues in order to move forward.

Additional comments made raised concerns relating to the looked after children service being secondary to safeguarding, and concern that where both are combined, in some areas looked after children become marginalised and the 'Cinderella service' is overwhelmed and lost within safeguarding. Looked after children nurses feel that it is imperative that there is equity with safeguarding and a clear role structure in place that sits alongside safeguarding and not within it to ensure the best outcomes for looked after children.

In conclusion, there is a need to address the wide variations of caseloads, service provision, and capacity within looked after children health teams. In addition, clarity of roles of

health care professionals working with looked after children needs to be addressed. Overall, it is important to ensure excellent health services are provided towards all looked after children no matter where they come into care or where they are placed and addressing the variations highlighted in this report will go some way to moving services forward for looked after children and give clearer definition to professional roles and service design.

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