

## **Changes to legislation and guidance since ‘Promoting the health and well-being of looked-after children 2015’ was originally published**

Department of Health became Department of Health and Social Care in January 2018.

From 1 July 2022, integrated care boards (ICBs) have replaced clinical commissioning groups (CCGs) as a result of the Health and Care Act 2022.

Public Health England has now been replaced by the Office for Health Improvement and Disparities (OHID), which is part of the Department of Health and Social Care, and by the UK Health Security Agency (UKHSA).

Monitor became part of NHS Improvement in April 2016. NHS Improvement then merged with NHS England to become NHSEI, which in July 2022 became simply NHS England.

Updated [‘Who Pays?’](#) guidance came into effect from 1 July 2022.



Department  
for Education



Department  
of Health

# **Promoting the health and well- being of looked- after children**

**Statutory guidance for local authorities,  
clinical commissioning groups and  
NHS England**

**March 2015**

# Contents

Summary	5
About this guidance	5
Terms used in this guidance	6
How to use this guidance	6
Expiry or review date	6
What legislation does this guidance refer to?	6
Who is this guidance for?	6
Main points	7
Supporting all looked-after children: joint responsibilities	9
Context	9
Overarching principles	9
Planning health services for looked-after children	11
Commissioning health services	12
The responsible commissioner	13
The role of the designated doctor and nurse	15
Planning and providing services to promote the health of individual looked-after children	16
The care planning framework	16
Notification of placement	16
Information sharing	17
Health assessments, plans and reviews	17
Mental health services	21
Special educational needs (SEN)	22
The role of social workers in promoting health	23
The roles of Virtual School Heads (VSHs) and designated teachers	24
The role of Independent Reviewing Officers (IROs)	24
The contribution of primary care teams	25
Health professionals and the role of named health professionals for looked-after children	25
Placement out of authority	26
Supporting foster carers and children's homes to promote health	27

Children detained under the Mental Health Act or in custody	28
Transitions from care	29
Annex A: Age-appropriate health assessments	32
Recommended content	32
Annex B: Strengths and Difficulties Questionnaire (SDQ)	34
Annex C: Principles of confidentiality and consent	36
Children aged 16 and 17	37
Children aged 15 and under	37
Annex D: Some terms used in this guidance	39
Further information	41
Useful resources and external organisations	41
Other relevant departmental advice and statutory guidance	41

# Summary

## About this guidance

This is joint statutory guidance from the Department for Education and the Department of Health. It is for local authorities, clinical commissioning groups (CCGs) and NHS England and applies to England only.

This guidance is issued to local authorities, CCGs and NHS England under sections 10 and 11 of the Children Act 2004 and they **must** have regard to it when exercising their functions.

It is also issued under section 7 of the Local Authority Social Services Act 1970. This requires local authorities in exercising their social services functions to act under the general guidance of the Secretary of State. Local authorities **must** comply with this guidance unless there are exceptional reasons that justify a departure.

This guidance replaces the *Statutory Guidance on Promoting the Health and Well-being of Looked After Children*, which was issued in November 2009 to local authorities, Primary Care Trusts and Strategic Health Authorities. The guidance published in 2009 has been updated to reflect reforms to the National Health Service following the Health and Social Care Act 2012. It also takes account of other reforms such as changes to the special educational needs legislative framework and the cross-Government mental health strategy, which emphasises that mental health is as important as physical health.

This guidance should be read in conjunction with:

- [The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review](#)
- [The Children Act 1989 Guidance and Regulations Volume 3: Transition to Adulthood](#)
- [The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services](#)
- [Guide to the Children's Homes Regulations, including the Quality Standards](#)
- [Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies](#)
- [Who Pays? Determining responsibility for payments to providers](#)
- [National Tariff Payment System](#)

## Terms used in this guidance

There is a glossary of technical terms used in this guidance. This can be found at Annex D.

## How to use this guidance

The main points summarise the high level information local authorities, CCGs and NHS England need to know. More details about each point and further guidance are set out in the rest of this document.

## Expiry or review date

This guidance will be reviewed in 2020 or sooner if deemed to be necessary.

## What legislation does this guidance refer to?

- The Children Act 1989 and associated regulations<sup>1</sup>
- The Children Act 2004
- The Mental Capacity Act 2005 – Deprivation of Liberty Safeguards
- The National Health Service Act 2006
- The Mental Health Act 2007
- The Health and Social Care Act 2012
- The Care Act 2014
- The Children and Families Act 2014.

## Who is this guidance for?

This guidance is for:

- all local authority managers and staff who have responsibilities for looked-after children, including Directors of Public Health, commissioners of placements, and staff who support and supervise carers
- commissioners of health services for children
- NHS England
- designated and named professionals for looked-after children
- GPs, optometrists, dentists and pharmacists
- Lead Members for Children's Services in local authorities
- managers and staff of services for care leavers, and Personal Advisers

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<sup>1</sup> [The Care Planning, Placement and Case Review \(England\) Regulations 2010.](#)

- teachers
- health visitors, school nurses and any other professional who is involved in the delivery of services and care to looked-after children.

## Main points

- The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.
- The local authority that looks after the child must arrange for them to have a health assessment as required by *The Care Planning, Placement and Case Review (England) Regulations 2010*.
- The initial health assessment must be done by a registered medical practitioner. Review health assessments may be carried out by a registered nurse or registered midwife.
- The local authority that looks after the child must ensure that every child it looks after has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment. The health plan forms part of the child's overall care plan.
- When a child starts to be looked after, changes placement or ceases to be looked after, the responsible local authority should notify, among others, the CCG – or, in the case of a placement out of authority, both the originating and the receiving
- CCG (or local health board in the case of a child looked after by a local authority in England but living in Wales) – and the child's GP. If the child is moved in an emergency, the notifications should happen within five working days. Prompt notifications are essential if initial health assessments are to be completed in good time.<sup>2</sup>
- Looked-after children should never be refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.

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<sup>2</sup> The person to notify in the CCG could be the designated nurse, who should in turn inform the named professional and the local looked-after health team.

- CCGs and NHS England have a duty to cooperate with requests from local authorities to undertake health assessments and help them ensure support and services to looked-after children are provided without undue delay.
- Local authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area.
- The health needs of looked-after children should be taken into account in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).
- Every local authority should have agreed local mechanisms with CCGs to ensure that they comply with NHS England’s guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for looked-after children and to resolve any funding issues that arise.<sup>3</sup>
- If a looked-after child or child leaving care moves out of the CCG area, arrangements should be made through discussion between the “originating CCG”, those currently providing the child’s healthcare and the new providers to ensure continuity of healthcare. CCGs should ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care for the child.
- Local authorities, CCGs and NHS England should ensure that plans are in place to enable children leaving care to continue to obtain the healthcare they need.
- Looked-after children should be able to participate in decisions about their health care. Arrangements should be in place to promote a culture:
  - where looked-after children are listened to
  - that takes account of their views according to their age and understanding, in identifying and meeting their physical, emotional and mental health needs<sup>4</sup>
  - that helps others, including carers and schools, to understand the importance of listening to and taking account of the child’s wishes and feelings about how to be healthy.<sup>5</sup>

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<sup>3</sup> [Who Pays? Determining responsibility for payments to providers.](#)

<sup>4</sup> Local authorities have a duty to (i) agree the child’s care plan with parents or others with parental responsibility, unless aged 16 or 17 (in which case they can agree it themselves) [Care Planning Regulations 2010, Regulation 4]; (ii) ascertain and give due consideration to their wishes and feelings when making decisions for looked-after children [Children Act 1989 s22(4) and (5)].

<sup>5</sup> In this guidance the term ‘carer’ means foster carer or residential care worker.

# Supporting all looked-after children: joint responsibilities

## Context

1. Most children become looked after 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. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.

## Overarching principles

2. Parents want their children to have the best start in life, to be healthy and happy and to reach their full potential. As corporate parents, those involved in providing local authority services for the children they look after should have the same high aspirations and ensure the children receive the care and support they need in order to thrive.

3. Local authorities have a duty under the Children Act 1989 to safeguard and promote the welfare of the children they look after, wherever they are placed. Directors of Children's Services, Directors of Public Health and Lead Members for Children's Services have a responsibility to ensure there are systems in place so that this duty is properly discharged.

4. This must be done in accordance with the relevant Regulations.<sup>6</sup> These Regulations set out the requirements governing the development and review of a looked-after child's care plan. That plan includes their health plan.

5. The NHS has a major role in ensuring the timely and effective delivery of health services to looked-after children. [The Mandate to NHS England](#), [Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies](#) and [The NHS Constitution for England](#) make clear the responsibilities of CCGs and NHS England to looked-after children (and, by extension, to care leavers). In fulfilling those responsibilities the NHS contributes to meeting the health needs of looked-after children in three ways: commissioning effective services,

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<sup>6</sup> The Care Planning, Placement and Case Review (England) Regulations 2010.

delivering through provider organisations, and through individual practitioners providing coordinated care for each child.

6. Under the Children Act 1989, CCGs and NHS England have a duty to comply with requests from a local authority to help them provide support and services to looked-after children.

7. Local authorities, CCGs and NHS England can only carry out their responsibilities to promote the health and welfare of looked-after children if they cooperate. They are required to do so under section 10 of the Children Act 2004.<sup>7</sup>

8. The Health and Social Care Act 2012 places a legal duty on CCGs to work with local authorities to promote the integration of health and social care services.<sup>8</sup> The Government's Mandate to NHS England includes an explicit expectation that the NHS, working together with schools and children's social services, will support and safeguard looked-after children (and other vulnerable groups) through a more joined-up approach to addressing their emotional, mental and physical health needs.

9. Effective channels of communication between all local authority staff working with looked-after children, CCGs, NHS England and health service providers, as well as carers – along with clear lines of accountability – are needed to ensure that the health needs of looked-after children are met without delay. Looked-after children themselves (according to age and understanding) should also have the information they need to make informed decisions about their health needs.

10. Staff working with looked-after children who are delivering health services should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different. They should in particular:

- ensure looked-after children are able to access universal services as well as targeted and specialist services where necessary
- receive supervision, training, guidance and support.

11. Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning of child

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<sup>7</sup> Under the Children Act 1989 'relevant partners', which are required to cooperate with local authorities in making arrangements to improve children's well-being in their area, are: district councils, where there are two-tiers of local government, clinical commissioning groups, NHS England, Young Offenders Institutions, police and probation services, schools, further education colleges and sixth form colleges.

<sup>8</sup> Section 14Z1(2) of the National Health Service Act 2006 inserted by section 26 of the Health and Social Care Act 2012.

and adolescent mental health services (CAMHS). They should also plan for effective transition and consider the needs of care leavers.

## Planning health services for looked-after children

12. The starting point for planning health services for looked-after children should be the statutory Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). The [statutory guidance](#) on JSNAs and JHWSs states that health and wellbeing boards will need to consider the needs of vulnerable groups such as looked-after children and adopted children.<sup>9</sup> The information gathered as part of that process should be used to identify gaps in provision to meet the physical and mental health needs of looked-after children and inform strategic commissioning priorities.

13. CCGs and the officers in the local authority responsible for looked-after children's services should:

- recognise and give due account to the greater physical, mental and emotional health needs of looked-after children in their planning and practice
- give equal importance (parity of esteem) to the mental and physical health of looked-after children and follow the principles in the national document [Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis](#)
- agree multi-agency action to meet the health needs of looked-after children in the area
- ensure that sufficient resources are allocated to meet the identified health needs of the looked-after children population, including those placed in their area by other local authorities, based on the range of data available about their health characteristics
- take into account the views of looked-after children, their parents and carers, to inform, influence and shape service provision, including through Children in Care Councils and local Healthwatch where they are undertaking work in this area
- arrange the provision of accessible and comprehensive information to looked-after children and their carers.

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<sup>9</sup> Health and wellbeing boards comprise: a representative from each CCG whose area falls within or coincides with the local authority area, the Director of Children's Services, the Director of Public Health, the Director of Adult Social Services and a representative from the local Healthwatch organisation.

14. Understanding the emotional and behavioural needs of looked-after children is important. Local authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional well-being of individual looked-after children.<sup>10</sup> SDQ scores can be aggregated to help quantify the needs of the local looked-after children population and should be used by local authorities and CCGs as they develop their JHWSs.<sup>11</sup> More information about the use of the SDQ for individual looked-after children can be found in Annex B. If they wish, local authorities may use other tools to supplement the SDQ.

## Commissioning health services

15. CCGs are the main commissioners of health services, with the exception of:

- certain services commissioned directly by NHS England (primary care, high secure psychiatric services, highly specialist in-patient mental health services, other specialised services and the majority of health services for prisoners and members of the armed forces)
- health improvement services commissioned by local authorities; and
- health protection and promotion services provided by Public Health England.

16. 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.

17. Services for individual children placed out of the CCG area should be consistent with the responsible commissioner guidance [Who Pays? Determining responsibility for payments to providers](#) (see pages 12 and 13 of that guidance).

18. CCGs should ensure:

- they can access the expertise of a designated doctor and nurse for looked-after children (see page 13). Where a designated professional is employed by a different NHS organisation, this will need to be set out in a local agreement

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<sup>10</sup> The SDQ is an internationally validated brief behavioural screening questionnaire about 4-16 year olds. It exists in three parts: one for the carer, another for the child's teacher and a third part for the child. While the Department for Education requires local authorities to provide SDQ data to be completed for looked-after children by their foster carer or residential care worker, local authorities should not see this as purely a data collection exercise by central government with which they must comply.

<sup>11</sup> The NSPCC/Rees Centre University of Oxford report in the Impact and Evidence Series, *What Works in Preventing and Treating Poor Mental Health in Looked-After Children?*, found that 'Use of the Strengths and Difficulties Questionnaire (SDQ) with looked-after children has been shown to provide a good estimate of the prevalence of mental health conditions...'

- when looked-after children move placement or move into another CCG area and are currently receiving, or on a waiting list for, health services, their treatment continues uninterrupted. Looked-after children should be seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service. The length of a placement should not affect a child's access to services
- arrangements are in place to ensure a smooth transition for looked-after children and care leavers moving from child to adult health services.

19. NHS England should ensure:

- looked-after children are always registered with GPs and have access to dentists near to where they are living. This is a shared responsibility with the local authority for the children it looks after
- when looked-after children need to register with a new GP (e.g. when they enter care or change placement), the transfer of GP-held clinical records is 'fast-tracked'.

20. Commissioners, whether they sit within the responsible local authority, CCGs or NHS England, should commission services which meet the following requirements:

- health professionals contributing to the care planning cycle for looked-after children should have the appropriate skills and competences and receive continuing professional development<sup>12</sup>
- providers have arrangements in place for relevant training and clinical supervision of professionals contributing to the healthcare of looked-after children, including those who are employed by the local authority
- clinical governance and audit arrangements are in place to assure the quality of health services for looked-after children.

## The responsible commissioner

21. NHS England guidance [Who Pays? Determining responsibility for payments to providers](#) provides the framework for establishing responsibility for commissioning

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<sup>12</sup> See the Royal Colleges' intercollegiate framework, *Looked-after children: knowledge, skills and competences of health care staff*.

an individual's care within the NHS.<sup>13</sup> Local authorities and CCGs should have agreed local mechanisms to ensure this guidance is followed when making placement decisions for looked-after children and for resolving any funding disputes that may arise. This is essential to avoid delays in looked-after children being assessed for, and accessing, the services they need.

22. NHS England expects that any disputes will be resolved locally, ideally at CCG level, with reference to the guidance in *Who Pays?* In cases that cannot be resolved at CCG level, NHS England should be consulted and should arbitrate where necessary.

23. When a child is first placed, the local authority looking after them has a shared responsibility with the relevant CCG to ensure that a full health assessment takes place and that a health plan is drawn up and implemented.

24. The local authority should inform, among others, the relevant responsible CCG in writing of its intention to place a child in its area and advise whether the placement is intended to be long or short-term. Some placements need to be arranged urgently and prior notification will not always be possible. In these cases, in accordance with Regulation 13(3)(f) of the *Care Planning, Placement and Case Review (England) Regulations 2010*, the local authority is expected to notify the relevant responsible CCG within five working days or as soon as reasonably practicable.

25. Out of authority placements of looked-after children are dealt with in a different way. Where a CCG or a local authority, or both where they are acting together, arrange accommodation for a looked-after child in the area of another CCG, the "originating CCG" remains the responsible CCG for the services that CCGs have responsibility for commissioning. That is the case even where the child changes his or her GP practice.

26. The originating CCG is responsible for commissioning the child's statutory health assessment(s).

27. Arrangements for primary healthcare are determined by GP registration.

28. CCGs and NHS England should ensure that a child is never refused a service, including for mental health, on the grounds of their placement being short-term or unplanned.

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<sup>13</sup> The sections of that guidance of particular relevance to looked-after children are paragraphs 29-31 and paragraphs 71-75.

## The role of the designated doctor and nurse

29. Designated doctors and nurses have a very important role in promoting the health and welfare of looked-after children. The role is:

- to assist CCGs and other commissioners of health services in fulfilling their responsibilities to improve the health of looked-after children
- intended to be strategic, separate from any responsibilities for individual looked-after children (although the professionals in these posts may also provide a direct service to children outside their designated role).

30. Any job description should be jointly agreed by the CCG as commissioner of the local service for looked-after children, the health organisation from which the designated doctor or nurse is employed, if different, and the relevant local authority. Model job descriptions and person specifications can be found in the [Royal Colleges' intercollegiate framework](#).

31. In line with [Working Together to Safeguard Children](#) and NHS England's [Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework](#), CCGs should have appropriate systems in place for discharging their responsibilities for safeguarding. That includes securing the expertise of designated doctors and nurses for looked-after children. There is unlikely to be a single model, and local CCGs should consider the range of duties for any post, whilst ensuring that the workload is realistic.

# Planning and providing services to promote the health of individual looked-after children

## The care planning framework

32. As an integral part of care planning, social workers must make arrangements to ensure that every looked-after child has:

- their physical, emotional and mental health needs assessed
- a health plan describing how those identified needs will be addressed to improve health outcomes
- their health plan reviewed in line with care planning requirements, or at other times if the child's health needs change.

33. This must be done in accordance with *The Care Planning, Placement and Case Review (England) Regulations 2010*.

## Notification of placement

34. When a child starts to be looked after or changes placement, the local authority must, before the placement is made, notify the child's GP, parents (except where clearly inappropriate) and those caring for the child. When a child starts to be looked after, changes placement or ceases to be looked after, the local authority must also notify in writing:

- the CCG for the area in which the child is living
- the CCG and the local authority for the area in which the child is to be/ has been placed.<sup>14</sup>

35. Prompt notification by local authorities and appropriate information sharing will enable CCGs to fulfil their duties and meet timescales for health assessments.

36. If placements are made in an emergency, written notification must be provided within five working days of the start of the placement unless not reasonably practicable to do so.

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<sup>14</sup> The person to notify in the CCG could be the designated nurse, who should in turn inform the named professional and the local looked-after children health team.

## Information sharing

37. Local authorities, CCGs and NHS England as well as providers of services should ensure that there are effective arrangements in place to share information about a child's health. These arrangements should balance the need to know with the sensitive and confidential nature of some information. Fear about sharing information should not get in the way of promoting the health of looked-after children.<sup>15</sup>

38. The lead health record for a looked-after child should be the GP-held record. The initial health assessment and health plan, and subsequent review assessments and plans, should be part of that record.

39. Information on the principles of confidentiality and consent is at Annex C.

## Health assessments, plans and reviews

### Health assessments and plans

40. Local authorities are responsible for making sure a health assessment of physical, emotional and mental health needs is carried out for every child they look after, regardless of where that child lives. Regulation 7 of the *Care Planning, Placement and Case Review (England) Regulations, 2010* requires the local authority that looks after them to arrange for a registered medical practitioner to carry out an initial assessment of the child's state of health and provide a written report of the assessment.

41. The initial health assessment should result in a health plan, which is available in time for the first statutory review by the Independent Reviewing Officer (IRO) of the child's care plan. That case review must happen within 20 working days from when the child started to be looked after.<sup>16</sup>

42. The statutory health assessment should address the areas specified in section 1 of Schedule 1 of the care planning regulations. These areas are:

- the child's state of health, including physical, emotional and mental health

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<sup>15</sup> NHS organisations and local authorities should have in place information sharing protocols that reflect the [HMG guidance \*Information sharing: guidance for practitioners and managers\*](#). [The Health and Social Care Information Centre](#) brings together helpful resources and guidance on information governance.

<sup>16</sup> Regulation 33(1) of the Care Planning, Placement and Case Review (England) Regulations 2010.

- the child's health history including, as far as practicable, his or her family's health history
- the effect of the child's health history on his or her development
- existing arrangements for the child's health and dental care appropriate to their needs, which must include
- routine checks of the child's general state of health, including dental health
- treatment and monitoring for identified health (including physical, emotional and mental health) or dental care needs
- preventive measures such as vaccination and immunisation<sup>17</sup>
- screening for defects of vision or hearing
- advice and guidance on promoting health and effective personal care
- any planned changes to the arrangements
- the role of the appropriate person, such as a foster carer, residential social worker, school nurse or teacher, and of any other person who cares for the child in promoting his or her health.

43. CCGs, NHS England and NHS service providers have a duty to comply with requests from local authorities in support of their statutory requirements.<sup>18</sup> Where a looked-after child is placed out of area, the receiving CCG is expected to cooperate with requests to undertake health assessments on behalf of the originating CCG. For guidance on who pays for assessments, see the section in this guidance on the responsible commissioner.

## The principles of a good health assessment and planning

44. Health assessments should:

- not be an isolated event but, rather, be part of the dynamic and continuous cycle of care planning (assessment, planning, intervention and review) and build on information already known from health professionals, parents and previous carers, and the child himself or herself. That includes routine health checks received through the universal healthy child programme 0-5 years and 5-19<sup>19</sup>

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<sup>17</sup> Gov.uk: [Comprehensive information on immunisation, including the current routine childhood vaccination schedule](#); and [an algorithm that is helpful where either children born overseas arrive in the UK and need further immunisation, or UK-born children have missed some or all of their routine immunisations](#).

<sup>18</sup> Section 27 of the Children Act 1989.

<sup>19</sup> The outcomes of these checks are normally notified to parents. For looked-after children they should be notified to the main carer and the child's social worker. For children accommodated under

- focus on emotional and mental well-being as well as physical health
- inform other aspects of care planning, such as the impact of a child's physical, emotional and mental health on his or her education
- be undertaken with the child's informed consent, if he or she is 'competent' to give it<sup>20</sup>
- be child-centred and age-appropriate (further information about the content of age-appropriate assessments is at Annex A) and carried out with sensitivity to the child's wishes and feelings and fears, so that the child feels comfortable. Health assessments, including reviews, should also be carried out as far as possible at a time and venue convenient to the child, their carers and parents. They should take account of any particular needs, including attention to issues of disability, race, culture and gender and if they are unaccompanied asylum seekers.<sup>21</sup>
- give the child clear expectations about any further consultations, support or treatment needed. Explanations should include the reasons for this and the choices available, and the appropriateness of plans kept under review as necessary
- pay particular attention to health conditions that may be more prevalent in looked-after children (such as foetal alcohol syndrome or attachment difficulties) and which may otherwise have been misdiagnosed.

45. To ensure the child's health plan is of high quality, the health assessment should use relevant information drawn together beforehand and fast-tracked by all involved to the health professional undertaking the assessment. This will include information in the GP-held record<sup>22</sup> and also, if not in that, the additional information held:

- by children's social services and derived from an assessment undertaken in accordance with [Working Together to Safeguard Children](#). This includes the child's personal and family history if known
- by community dental services and family dentists

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section 20 of the Children Act 1989 the child's parents should also be notified by the child's social worker.

<sup>20</sup> [NSPCC factsheet on Gillick competency and Fraser Guidelines](#). For further information on consent, see Annex C.

<sup>21</sup> Expert paper: [The health needs of unaccompanied asylum seeking children and young people](#).

<sup>22</sup> In the case of GP-held records, a summary report should be requested from the GP holding them. Steps should be taken to fast-track the records to any GP with whom the child is known to have subsequently become registered.

- on the Child Health Information System (CHIS), especially immunisation status to date
- on any parent-held or child-held record, or school health record
- within any database in local hospital emergency departments or within other local hospital record systems, especially where the child is known to have been in contact with services
- on any contact with child and adolescent mental health services (CAMHS)
- on any contact with a Youth Offending Team (YOT) where appropriate.

46. The health assessment should:

- be integrated with any other assessments and plans such as the child's Core Assessment or an Education, Health and Care Plan where the child has special educational needs
- involve birth families as far as possible, so that an accurate picture of the child's physical, emotional and mental health can be built up
- involve a named health professional to coordinate the health assessment and the actions set out in the health plan developed from that assessment.

47. Local authorities should ensure that, as a minimum, the child's main carer completes the carer's two-page version of the SDQ for the child in time to inform his or her health assessment. Further information about the requirement to use the SDQ can be found at Annex B.

48. The health practitioner carrying out the assessment has a duty of clinical care to the child. That includes making the necessary referrals for investigation and treatment of conditions identified at the assessment. Even if the placement is brief, the practitioner should follow up concerns and if the child returns home, every effort should be made to continue to implement the health plan.

## **Who should carry out the health assessment?**

49. It is the responsibility of the local authority that looks after a child to arrange their health assessment in partnership with health professionals. The responsible CCG and, if different, the CCG in the area where the child is placed should reach agreement without delay as to which CCG's service will carry out the health assessment.

50. Factors that should determine any decision about which CCG's commissioned service undertakes the health assessment are:

- the distance at which the child is placed. If a child is placed far from home, the responsible CCG should consider if it is more practicable, and will lead to

the child receiving a better healthcare experience, to commission health professionals in the area of the receiving CCG

- the need to ensure they are satisfied with the quality of health assessment and follow-up to the actions that are identified
- knowledge about the availability of local services that can meet the child's needs.

51. The Department of Health, with NHS England, Monitor, the Royal Colleges and other partners, has developed a mandatory national currency and tariff for statutory health assessments for looked-after children placed out of area. Details are set out in the current National Tariff Payment System.<sup>23</sup>

## Reviews of the health plan

52. The local authority that looks after the child must make arrangements for a registered medical practitioner or a registered nurse or registered midwife to review a looked-after child's health needs and provide a written report for each review addressing the matters specified in section 1 of Schedule 1 of the Care Planning, Placement and Case Review (England) Regulations 2010 (see pages 16-17 of this guidance).<sup>24</sup>

53. The review of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months after the child's fifth birthday. The child's social worker and IRO have a role to play in monitoring the implementation of the health plan, as part of the child's wider care plan.

54. The local authority that looks after a child must take all reasonable steps to ensure that the child receives the health care services he or she requires as set out in their health plan. Those services include mental health services, medical and dental care treatment and immunisations, as well as advice and guidance on personal health care and health promotion issues.

## Mental health services

55. Child and adolescent mental health services (CAMHS) play a crucial role in assessing and meeting any needs identified as part of the SDQ screening process.

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<sup>23</sup> [National Tariff Payment System 2014/15](#) (see sections 4.4.4 and 5.6.5 of the main document, along with the checklist tool at pp95-97 of Annex 4A).

<sup>24</sup> Regulation 7 of the Care Planning, Placement and Case Review (England) Regulations 2010.

56. CCGs, local authorities and NHS England should ensure that CAMHS and other services provide targeted and dedicated support to looked-after children according to need. This could include a dedicated team or seconding a CAMHS professional into a looked-after children multi-agency team. Professionals need to work together with the child to assess and meet their mental health needs in a tailored way.

## Special educational needs (SEN)

57. Two-thirds of looked-after children have special educational needs (SEN)<sup>25</sup>. Of those, a significant proportion will have a statement or a learning difficulties assessment. From 1 September 2014 statements were replaced by Education, Health and Care (EHC) plans, with the transition process to be complete by 2016.

58. To support children and young people with SEN or disabilities, including those who are looked after or leaving care, local authorities and CCGs must commission services jointly. This SEN provision applies to children and young people from birth to age 25.

59. Local authorities are also placed under a duty to publish a Local Offer, which sets out in one place all information about provision across education, health and social care, for children and young people with SEN or disabilities. Local authorities which place looked-after children in another authority need to be aware of that authority's Local Offer if the child has SEN or disabilities.

60. Local authorities and health professionals should ensure that:

- they follow the requirements set out in the [Special educational needs and disability code of practice: 0 to 25 years](#)<sup>26</sup>
- the looked-after child's EHC plan works in harmony with their care plan to tell a coherent and comprehensive story about how the child's health needs in relation to accessing education are being met. Health and education professionals should consider how to co-ordinate assessments and reviews of the child's care plan and EHC plan to ensure that, taken together, they meet the child's needs without duplicating information unnecessarily.

61. Further information can be found in the Code itself and in the [Guide for health professionals on the support system for children and young people with special educational needs and disabilities](#).

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<sup>25</sup> [Outcomes of children looked after by local authorities in England as at 31 March 2014](#) (page 11).

<sup>26</sup> Information about looked-after children who have SEN is included in chapter 10.

## The role of social workers in promoting health

62. Social workers have an important role in promoting the health and welfare of looked-after children. In particular they should:

- work in partnership with carers, looked-after children, their birth parents where appropriate and health professionals to contribute to the formulation of the health plan
- ensure that all the necessary consents and delegated authority permissions have been obtained so that decisions are not delayed
- take action to liaise with relevant health professionals if actions identified in the health plan are not being followed up. Given the impact that poor physical, emotional and mental health can have on learning, they should also ensure the child's virtual school head is involved in resolving any health care needs that impact on the child's education
- ensure the child has a copy of the care plan and the health plan
- support foster carers, or the appropriate person in the children's home where a child is placed, to promote the child's physical and emotional health on a day-to-day basis. That should include providing them with information on the child's state of health, including a copy of the child's latest health plan<sup>27</sup>
- ensure that there is clarity for carers, GPs and dentists, and for the child, about what health care decisions have been delegated to carers.

63. Social workers and health professionals should give carers information on how to contact designated and named health professionals for looked-after children and the looked-after children team, and on how to access services, including CAMHS consultations, that the child needs. Supervising social workers should also support and give information to carers about managing their own health.

64. Social workers and carers require regular training to understand their roles in identifying and responding to the emotional and mental health needs of looked-after children.

65. Social workers should also ensure:

- that foster carers and residential care staff know it is their responsibility to make sure a child attends their health assessment and all other medical, dental and optical appointments, and facilitate any required treatment regimes

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<sup>27</sup> Where the child is 'competent' in line with Fraser Guidelines, their consent should be obtained. [NSPCC factsheet on Gillick competency and Fraser Guidelines](#). For further information on consent, see annex C.

- that the children their authority looks after, including teenage parents, have access to available positive activities such as arts, sport and culture, in order to promote their sense of well-being.

66. Social workers and other local authority professionals should ensure that information about any health needs or behaviours which could pose a risk of harm to the child, the carer or members of his or her family or household is passed to the carer (or residential care worker) at the time of the placement. At the same time, the carer should receive information about the support that will be available to the child and carer to address or manage these difficulties.

## **The roles of Virtual School Heads (VSHs) and designated teachers**

67. Every local authority in England is required to appoint an officer (called a Virtual School Head) to discharge the local authority's duty to promote the educational achievement of the children it looks after, regardless of where they are placed. Maintained schools and academies are required to have a designated teacher for looked-after children. Given the interrelationship between health and education outcomes, social workers should ensure that the authority's VSH and the designated teacher for looked-after children are aware of information about the child's physical, emotional or mental health that may have an impact on his or her learning and educational progress.

## **The role of Independent Reviewing Officers (IROs)**

68. The IRO should, as part of the child's case review, note any actions and updates to ensure that the health plan continues to meet the child's needs. The IRO should be proactive in bringing any deficiencies in the quality of the health plan or its delivery to the attention of the appropriate level of management within the local authority, using the local dispute resolution process if necessary. The local authority should, in turn, discuss any concerns with the designated nurse, so that outstanding issues are addressed without unnecessary delay. IROs should always ensure that looked-after children are involved in the review of their care plan and its component parts, and have their wishes and feelings heard and respected. Further information relating to the statutory requirements of the IRO's role can be found in the [\*Independent reviewing officers' handbook\*](#).

## The contribution of primary care teams

69. Primary care teams have a vital role in identifying the individual health care needs of looked-after children. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions. They may also have continuing responsibility for the child when he or she returns home.

70. From 1 April 2015, all patients (including children) should have a named GP at the practice with which they are registered, who is responsible for the coordination of services provided under the GP contract.

71. GP practices should:

- ensure timely access to a GP or other appropriate health professional when a looked-after child requires a consultation
- 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 this information is passed promptly to health professionals undertaking health assessments
- maintain a record of the health assessment and contribute to any necessary action within the health plan
- make sure the GP-held clinical record for a looked-after child is maintained and updated and that health records are transferred quickly if the child registers with a new GP practice, such as when he or she moves into another CCG area, leaves care or is adopted.

72. Treating a patient as a temporary resident should be avoided if possible, as the medical record is not available to the treating medical practitioner. If it cannot be avoided, the treating practitioner will normally wish to talk to the child's named GP to avoid treating the patient "blind". Temporary registration is for those who intend to be in an area for more than 24 hours but less than three months, and where there is any doubt over the potential length of stay the GP practice should opt for full registration.

## Health professionals and the role of named health professionals for looked-after children

73. All healthcare staff who come into contact with looked-after children should work within the Royal Colleges' intercollegiate framework. This framework identifies the competences that enable healthcare staff to promote the health and well-being of

looked-after children. They are a combination of the skills, knowledge, values and attitudes that are required for safe and effective practice.

74. All staff should have access to appropriate continuing professional development opportunities, clinical supervision and support to facilitate their understanding of the clinical aspects of child welfare and information sharing in relation to looked-after children.

75. Named nurses and doctors for looked-after children have an important role in promoting good professional practice within their organisation and providing advice and expertise for fellow professionals. The named health professional will work in (and usually be employed by) a health provider organisation. He or she will act as a principal health contact for children's social care and should have up-to-date specialist knowledge of the health needs of looked-after children or know how to access it.<sup>28</sup>

76. Working with the designated professionals for looked-after children, named health professionals should:

- coordinate the provision of local health services for individual looked-after children and the input into health assessments and their reviews for individual looked-after children
- ensure the timeliness and quality of health assessments for looked-after children and ensure actions taken to implement the health care plan are tracked
- act as a key conduit and contact point for the child and their carer, where they have difficulties accessing health services.

## Placement out of authority

77. Social workers must notify the relevant CCG, in accordance with Regulations, when a child is placed out of authority.<sup>29</sup> They should ensure that arrangements are made to secure health provision for the child.

78. In making a judgement about the suitability of an out of authority placement for a child, the responsible authority should assess, with input from health services,

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<sup>28</sup> A model job description and person specifications for specialist looked-after children health professionals can be found in the Royal Colleges' intercollegiate framework.

<sup>29</sup> Regulation 13, The Care Planning, Placement and Case Review (England) Regulations 2010.<sup>30</sup> The following must also be consulted: the child's IRO, the child's relatives and parents where appropriate, the CCG (or local health board in Wales) that commissions secondary health care if the child requires secondary health services, and the Virtual School Head.

the arrangements which it will need to put in place to enable the child to access services such as primary and secondary health care.

79. Where the child will require specialist health services such as child and adolescent mental health services (CAMHS), the CCG (or local health board in Wales) that commissions secondary healthcare in the area authority should be consulted, so that the responsible authority can establish whether the placement is appropriate and able to meet the child's needs. The designated nurse and doctor for looked-after children in the area authority will also be a valuable source of advice and information.

80. When a looked-after child or child leaving care is moved out of a CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing healthcare and new providers to ensure continuity of healthcare. CCGs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care. The needs of the child should be the first consideration.

81. [\*The Care Planning, Placement and Case Review \(England\) Regulations 2010\*](#) require local authorities making distant placements to consult with children's services in the area of placement. They also require the Director of Children's Services of the responsible authority to approve these placements.<sup>30</sup> The process for making distant placements and who should be consulted is described in [\*Statutory guidance on out of authority placements of looked-after children\*](#).

## **Supporting foster carers and children's homes to promote health**

82. Fostering service and children's homes providers should work respectively with foster carers and residential care staff to promote a child's health and well-being. Carers should be given information about the child's health needs as they have day-to-day responsibility for making sure those needs are met.

83. Standard 12 of the National Minimum Standards for fostering services and the Fostering Services Regulations 2002 must be adhered to at all times.

84. The Children's Homes Regulations 2015 set out the Quality Standards that must be met by children's homes providers. They describe the outcomes that

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<sup>30</sup> The following must also be consulted: the child's IRO, the child's relatives and parents where appropriate, the CCG (or local health board in Wales) that commissions secondary health care if the child requires secondary health services, and the Virtual School Head.

children must be supported to achieve. One of the Quality Standards is about health and well-being.

85. Where a local authority commissions a children's home or, via the home, a practitioner or non-NHS service to deliver care to meet a specific health or developmental outcome outlined in the child's care plan, they should be confident that the professional care provided will meet the assessed health needs of the individual child. The local authority must give agreement for such care and be involved in its ongoing review.

86. The local authority, as a corporate parent, the child's social worker and health professionals should work with children's home staff to secure and facilitate access to the health services that each child needs. In particular, social workers and other relevant officers in the authority responsible for a looked-after child should ensure the necessary health outcomes are clear in the child's relevant plan and then work with the home to:

- agree the specific responsibilities of the home towards supporting the health needs of each child at the time the placement is made
- ensure that these responsibilities are recorded in the child's placement plan. This must include recording permission from a person with parental responsibility for the child for staff to administer first aid and non-prescription medication, and clearly agreed responsibilities for the administration of prescription medication
- be confident that staff in the home have sufficient understanding of relevant local health provision, including the functions of the designated doctor and nurse for looked-after children in their area, and can support children to navigate these services, advocating on their behalf where necessary and appropriate.

## **Children detained under the Mental Health Act or in custody**

87. The legal status of children who are the subject of a care order is not affected by detention under the Mental Health Act or in custody. The responsibility of the local authority to promote the welfare of looked-after children who are so detained remains. That includes its responsibilities to maintain and review the child's health plan as part of his or her care plan.<sup>31</sup>

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<sup>31</sup> Children remanded to youth detention accommodation under section 104(1) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 become looked-after children. The requirements

88. Every effort should be made, working in partnership with CCGs, NHS England and the institutions in which the children are detained, to ensure these children's health needs are identified and met, wherever they are living. To support the assessment process, the National Child and Maternal Health Intelligence Network (which is part of Public Health England) has developed a standardised and validated Comprehensive Health Assessment Tool (CHAT) for young people in the youth justice system.

## **Transitions from care**

89. Some children who cease to be looked after – whether returning home, adopted or with a Special Guardianship Order or making the transition to adulthood – will have continuing health needs that require ongoing treatment. Health professionals and social workers should ensure that there are suitable transition arrangements in place so that the child's health needs continue to be met. In particular, they should ensure that prospective adopters and care leavers have, or know how to obtain, the information they require about what health services, advice and support are available locally to meet their needs.

## **Children placed for adoption**

90. Children placed for adoption remain looked after until the adoption order is made. Research shows that their needs do not change overnight once they are adopted. Local authorities should ensure there is consistent and sustained health care in place to support each child during the transition from care to a permanent home. This will help inform post-adoption support for the child and the child's new parents and enable continuity of services.

91. At a strategic level:

- local authorities should have robust arrangements in place for the commissioning of timely health assessments so that prospective adopters have the information they need to support the child placed with them
- local authorities and CCGs should cooperate to make sure adoption agencies and panels secure access to timely medical advice and comprehensive information about a child's health so as to avoid unnecessary delays

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in the Care Planning, Placement and Case Review (England) Regulations 2010 for them to have a health assessment and plan are disapplied.

- local authorities and health service providers should work together to ensure that information in health records is not lost once the child ceases to be looked after.

92. At an operational level, at an early stage where adoption is the planned permanence option for a looked-after child, social workers should:

- comply with the requirements for health assessments and reviews set out in the [Adoption Agencies Regulations 2005](#)
- build on the health assessments and information already included in the child's health plan.
- request adoption medicals that include the requirements for any further medical reports necessary for the purposes of placement order proceedings, for example, in relation to any on-going mental health needs and therapeutic services that need consideration to support bonding and attachment with the child's prospective new parents.

93. The local authority should be ready to file the medical (and other) reports required under Rule 29 of the Family Procedure (Adoption) Rules 2005 and [Annex B of the Practice Direction which supplements Rule 29\(3\)](#).

## Care leavers

94. Local authorities, CCGs and NHS England should ensure that there are effective plans in place to enable looked-after children aged 16 or 17 to make a smooth transition to adulthood, and that they are able to continue to obtain the health advice and services they need. In particular:

- there should be an emphasis on partnership working between the young person and their personal adviser, and the doctors and nurses involved in their health assessments<sup>32</sup>
- personal advisers should have access to information and training about how to promote physical and mental health
- transitions should be planned as early as possible, and certainly at least six months in advance of a transition to adult services, so that social workers, personal advisers, commissioners and providers of children's and adult services can manage transitions smoothly and ensure that young people are clear about expectations.

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<sup>32</sup> From their 16<sup>th</sup> birthday, the authority responsible for looking after the child must appoint a personal adviser for eligible children to work with them and prepare a pathway plan.

95. Care leavers should be equipped to manage their own health needs wherever possible. They should have a summary of all health records (including genetic background and details of illness and treatments), which suggests how they can access a full copy if required. Information needs to be given to care leavers sensitively and with support, with an opportunity to discuss it with health professionals. Young people leaving care should be able to continue to obtain health advice and services, and know how to do so.

96. Personal advisers should work closely with looked-after children's health teams involved in health assessments. Leaving care services should ensure that health and access to positive activities are included as part of the young person's pathway planning. They should also ensure that care leavers have the information they need to be able to manage their health when living independently.

97. Care leavers with complex needs, including those with disabilities, may transfer direct to adult services and the pathway plan will need to ensure that this transition is seamless and supported. For care leavers who do not meet the criteria for support by adult services, their personal adviser should ensure that all possible forms of support, including that offered by the voluntary sector, are identified and facilitated as appropriate.

# Annex A: Age-appropriate health assessments

## Recommended content

The content of the health assessment should be age-sensitive and developmentally appropriate. The recommended content for the different stages of childhood is outlined below. There may be other aspects of health care that are also relevant. This will depend on the individual child. Practitioners should not, therefore, confine themselves to assessing only the areas identified below if there are other matters that are relevant.

### Under-5s

For under-fives, the focus will be on:

- attachment behaviour and emotional health
- physical health
- growth
- diet and nutrition
- screening and immunisations
- dental health
- considering the impact on the child of parental substance misuse
- monitoring developmental milestones, in particular the development of speech and language, gross and fine motor function, vision and hearing, play and pre-literacy skills, social skills.

### Ages 5-10

For primary school age children, the focus will be on:

- physical health and management of specific health conditions eg asthma
- communication skills
- ability to make relationships and to relate to peers
- mental and emotional health, including depression and conduct disorders
- progress at school
- exercise and diet and understanding of a healthy lifestyle
- maintenance of personal hygiene
- awareness of basic safety issues, including road safety
- provision of a healthy balanced diet
- ability to recognise and cope with the physical and emotional changes associated with puberty

- access to accurate simple information about sexual activity
- considering the impact on the child of parental substance misuse
- screening and immunisation
- dental health
- attachment behaviour
- social and self-help skills
- assessment of the risks of child sexual exploitation, antisocial or youth offending behaviour, bullying, domestic abuse or sexually harmful behaviour.

## **Adolescents and those leaving care (11-18)**

For secondary school age children, the focus will be on:

- ability to take appropriate responsibility for their own health, including the management of specific health conditions, e.g. asthma, diabetes
- communication and interpersonal skills
- educational and social progress
- lifestyle, including diet and physical activity
- ensuring that immunisations are up to date
- dental and skin health
- mental and emotional health, including depression and conduct disorders
- understanding of issues relating to healthy relationships, including sexuality and sexual activity, contraception, sexually transmitted infection and the particular risks of early sexual activity
- access to sources of information and advice about a range of health issues, including the risks of alcohol, tobacco and other substance use, and access to sources of advice on modifying health risk behaviours. Assessment should be made of whether referral to specialist treatment for substance misuse is appropriate
- assessment of the risks of child sexual exploitation, antisocial or youth offending behaviour, bullying, domestic abuse or sexually harmful behaviour.

## Annex B: Strengths and Difficulties Questionnaire (SDQ)

It is important to have some means of measuring on a regular basis the emotional and behavioural difficulties experienced by looked-after children at a national level. The way in which that is currently done is through the Strengths and Difficulties Questionnaire (SDQ). This was introduced into the Department for Education's data collection for children looked after at 31 March in 2008 and is the outcome measure used for tracking the emotional and behavioural difficulties of looked-after children at a national level.

The SDQ is a clinically validated brief behavioural screening questionnaire for use with 4-17 year olds or 2-4 year olds. It is internationally validated and simple to administer. It exists in three versions: for parents or carers, teachers and children aged 4-17, and can be used to screen for any problems related to a child's emotional well-being. The SDQ comprises a series of statements that require a judgement on how well it describes the child by ticking one or three or four boxes for each question.<sup>33</sup>

The SDQ provides information to help social workers form a view about the emotional well-being of individual looked-after children.

For the purpose of the Department for Education's SSSDA903 data collection, the requirement is that local authorities must ensure that the looked-after child's main carer (a foster carer or residential care worker) completes the two-page questionnaire for parents and carers. This is a simple questionnaire that does not require any training to interpret and can be completed in between five and ten minutes.

If the SDQ completed by the carer suggests that the child's total difficulties score is outside the normal range (i.e. a borderline score of 14-16 or a score of 17+, considered as giving cause for concern), the child may benefit from triangulating the scores from the carer's SDQ with those of his or her teacher and (if he or she is aged 4 to 17) the self-evaluation. Social workers and Virtual School Heads should consider arranging for this to be done in order to provide more comprehensive information for the health assessment. If triangulation of those scores confirms the carer's score, consideration should be given to using a diagnostic tool to enable an appropriate intervention to be identified.

Other validated screening tools may be used in addition to the SDQ.

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<sup>33</sup> [Further information on the SDQ.](#)

The questionnaire can be completed at any point during the year, but to reduce the administration required it is recommended that it is completed around the time of a child's health assessment. Local authorities, usually through the child's social worker, should ensure that:

- SDQ questionnaires are given to carers to complete. This should be done well ahead of the child's health assessment so that the completed SDQ informs the health assessment. Ideally, it should be completed one month before the health check is due. For those young people who have recently come into care, the carer will need to establish a relationship with the child before they are in a position to carry out the assessment. If the child has recently moved to a new placement, social workers will need to judge if the child's previous carer is better placed to complete the questionnaire
- carers are given an explanation of how it should be completed and that they understand why it is important to complete the SDQ (and that it is about the child and not a reflection on their ability to care for him or her). Carers should know to whom the completed SDQ should be returned and by when
- information in the completed questionnaires is collected by the local authority and the child's total difficulties score is worked out and available to inform the child's health assessment. This should help the social worker and health professionals to decide whether to triangulate the scores with an SDQ completed by the child's teacher and (if the child is in the relevant age bracket) the child, and whether the child needs to be referred for further diagnostic assessment of their mental health
- if the child's SDQ scores suggest there are underlying problems, this should trigger consideration of a fuller diagnostic assessment. The SDQ should be used as evidence to support a referral to local targeted or specialist mental health services, where appropriate.

When decisions about placement choices are being made and where changes of placement occur, social workers, working in partnership with health professionals, should consider referral for specialist mental health assessment and treatment where it is appropriate. The SDQ should help inform these decisions. Professionals should ensure this information is shared securely and appropriately where changes of placements, including from care to adoption, occur.

The data return for the Department for Education relates only to the part completed by the carer.<sup>34</sup>

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<sup>34</sup> [Further information on the SSD903 Data Collection.](#)

## Annex C: Principles of confidentiality and consent

NHS organisations and local authorities should have in place protocols which establish the framework for information sharing at an intra- and inter-agency level. These should reflect the [HM Government guidance on information sharing](#).

Children who become looked after may not return to their birth families but will become permanently part of new foster or adoptive families, or may move into independence without retaining links with birth families. The transfer of information about a child's health status and history becomes very important. Accurate information about health history, and any current/ongoing medical conditions, may be vital to securing the right placement for a looked-after child.

For this reason, obtaining consent to information sharing is a vital first principle to promoting the health of looked-after children. The person or third party will need to understand the reasons why particular information needs to be shared, so that they can give **informed** consent.

Where disclosure of a child's information might reveal information about other individuals (e.g. parents, family), consent should be sought from these individuals as well. Where it is not practicable to seek consent or where the individual is not competent to give consent, it is important to consider whether disclosure would be justified in the 'public interest' (e.g. to protect others from a risk so serious that it outweighs the individual's right to privacy). Decisions to disclose information in the public interest must be taken on a case by case basis, and should always be fully documented.

In obtaining consent to seek information from other parties or to disclose information about the child, a key consideration will be determining whether the child is competent to give consent or whether consent should be sought from a person with parental responsibility.

The same issues arise in relation to consent to information sharing as in consent to treatment, namely:

*'Young people aged 16 or 17 are regarded as adults for the purposes of consent to treatment and are therefore entitled to the same duty of confidence as adults. Children under 16 who have the capacity and understanding to take decisions about their own treatment are entitled also to decide whether personal information may be passed on and generally to have their confidentiality respected... In other instances, decisions to pass on personal information may be taken by a person with parental responsibility in consultation with the health professionals involved.'*

## Children aged 16 and 17

Once young people reach the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care. This means that in many respects they should be treated as adults – for example if a signature on a consent form is necessary, they can sign for themselves.

However, it is still good practice to encourage competent children to involve their families in decision making. Where a competent child does ask for their confidence to be kept, it must be respected unless disclosure can be justified on the grounds of 'public interest' e.g. that there is reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm.

Efforts should be made to persuade the child to involve their family, unless it is believed that it is not in their best interest to do so. If a decision is taken to disclose, the justification should be noted in the child's records.

## Children aged 15 and under

Unlike 16 or 17 year olds, children under 16 are not automatically presumed to be legally competent to make decisions about their healthcare. However, the courts have stated that under 16s will be competent to give valid consent to a particular intervention if they have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (sometimes known as "Gillick competence"). In other words, there is no specific age when a child becomes competent to consent to treatment: it depends both on the child and on the seriousness and complexity of the treatment being proposed.<sup>35</sup>

'Competence' is not a simple attribute that a child either possesses or does not possess: much will depend on their relationship and trust between doctors, other health professionals and the child and their family or carer. Children can be helped to develop competence by being involved from an early age in decisions about their care.

If a child under 16 is competent to consent for himself or herself to a particular intervention, it is still good practice to involve the family in decision making, unless the child specifically requests that this should not happen and cannot be persuaded

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<sup>35</sup> [Gillick competency and Fraser Guidelines.](#)

otherwise. As with older children, a request for confidentiality must be respected unless the child is suffering or likely to suffer significant harm without disclosure.

## Annex D: Some terms used in this guidance

*Designated professional:* CCGs are required to have access to the expertise of a designated doctor and nurse for looked-after children, whose role is to assist commissioners in fulfilling their responsibilities to improve the health of looked-after children. The [Royal Colleges' intercollegiate framework](#) includes model job descriptions.

*Designated teacher:* all maintained schools and academies are required to have a designated teacher for looked-after children. Their role is to act as a source of advice and expertise and to champion the needs of looked-after children within the school as well as work with the local authority that looks after the child to ensure his or her personal education plan (PEP) is developed and implemented.

*Distant placement:* Regulation 11(5) of the Care Planning, Placement and Case Review Regulations (England) 2010 as amended defines a distant placement as meaning 'a placement outside the area of the responsible authority and not within the area of any adjoining local authority'. Distant placements must be approved by the responsible authority's Director of Children's Services (DCS).

*Eligible child:* a looked-after child who is aged 16 or 17 and has been looked after by a local authority for a period of 13 weeks, or periods of 13 weeks, which began after he or she reached 14 and ended after he or she reached 16.

*Former relevant child:* a former relevant child is a young person aged 18 or above who either has been a relevant child and would be one if under the age of 18 or who, immediately before he or she stopped being looked after at the age of 18, was an eligible child.

*Looked-after child:* a child who is looked after by a local authority (referred to as a looked-after child) is defined in section 22 of the Children Act 1989 and means a child who is subject to a care order (or an interim care order) or who is accommodated by a local authority.

*Named health professional:* providers of health services are expected to identify a named doctor and nurse for looked-after children. As well as coordinating the provision of services for individual children, named professionals provide advice and expertise for fellow professionals. The [Royal Colleges' intercollegiate framework](#) includes model job descriptions for this and other specialist health professional roles.

*Originating authority (sometimes called the responsible or placing authority):* the local authority that looks after the child.

*Originating CCG (sometimes called the home or responsible CCG):* when a looked-after child is placed out of authority, the originating CCG is the CCG in whose area the child is placed before that move. The originating CCG remains the *responsible commissioner* for CCG-commissioned services.

*Placement out of area (sometimes referred to as an out of authority placement):* a placement out of the local authority's area is one that is a placement in foster care, a residential children's home or in 'other arrangements' located outside the boundary of the responsible authority. An out of authority placement could be in an adjoining local authority or in a more distant area

*Primary care team:* typically includes GPs, practice nurses, community nurses, midwives, health visitors, the GP practice manager and support staff

*Receiving authority:* the local authority area in which the local authority that looks after a child places him or her.

*Receiving CCG:* in the case of a placement out of authority, the receiving CCG is the CCG to whose area the looked-after child is moved.

*Registered medical practitioner:* any doctor who treats patients in NHS or private practice must be registered with the General Medical Council and hold a licence to practise.

*Relevant child:* a child who is not looked after, is aged 16 or 17 and was an eligible child before he or she stopped being looked after.

*Virtual School Head (VSH):* an officer employed by a local authority in England whose job is to ensure that the authority's duty to promote the educational achievement of the children it looks after is properly discharged.

## Further information

### Useful resources and external organisations

The following list, though not comprehensive, is intended to highlight some of the main resources that local authorities, CCGs, NHS England and health providers should find useful.

- [Attachment Aware Schools project](#)
- [British Association for Adoption and Fostering Resources](#)
- [Comprehensive Health Assessment Tool \(CHAT\)](#)
- [Inspecting local authority children's services: the framework](#)
- [Intercollegiate role framework. Looked-after children: Knowledge, skills and competences of health care staff](#)
- [National Tariff Payment System](#)
- [NSPCC Face to Face service](#)
- [Strengths and Difficulties Questionnaires](#)
- [NICE pathways: looked-after babies, children and young people: an overview](#)
- [NICE local government briefings: Looked-after children and young people \(June 2014\)](#)
- [NICE Quality Standard for the health and well-being of looked-after children](#)
- [NICE public health guidance 28: Looked-after children and young people](#)
- [Research in practice: Fostering and adoption learning resources](#)
- [The Children's Food Trust Learning Network website](#)
- [The United Nations Convention on the Rights of the Child \(UNCRC\): Articles 12, 13, 24, 39](#)
- [Young Minds](#)
- [What works in preventing and treating poor mental health in looked-after children? \(August 2014\). This is part of NSPCC's Impact and Evidence series co-produced with the Rees Centre, University of Oxford](#)
- [Who Pays? Determining responsibility for payments to providers](#)

### Other relevant departmental advice and statutory guidance

- [Adoption statutory guidance](#)
- [Gov.UK: looked-after children's services](#)
- [Gov.UK: safeguarding children](#)
- [Care Leaver Strategy: a cross departmental strategy for young people leaving care](#)
- [Children's Homes Guide and Quality Standards](#)
- [Fostering Services \(England\) Regulations 2011](#)
- [Fostering Services: national minimum standards](#)
- [Mental health and behaviour in schools: departmental advice](#)

- [Out of authority placement of looked-after children – statutory guidance](#)
- [Outcomes of looked-after children: statistical first release](#)
- [Promoting the education of looked-after children: statutory guidance for local authorities](#)
- [Public Health Outcomes Framework](#)
- [Special educational needs and disability code of practice: 0 to 25 years](#)
- [Safeguarding children and young people from sexual exploitation](#)
- [Working Together to Safeguard Children](#)



Department  
for Education



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of Health

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