

Improving access to services for Looked After and Accommodated Children (LAAC): An ‘unmet needs’ pilot study in Renfrewshire, West Dunbartonshire and Argyll & Bute.

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1. Abstract

Aim

To investigate the change in access to health services for looked after and accommodated children (LAAC) in residential care through the establishment of a specialised nursing service.

Design

The study was a service evaluation involving data collection before and after introduction of the nursing service.

Setting

All residential care units in Renfrewshire, West Dunbartonshire and Argyll & Bute.

Participants

168 LAAC children domiciled in residential units between August 2006 and March 2007.

Interventions

A LAAC nursing service was created to: provide health promotion and support to children and carers; provide liaison with the health service; ensure correct documentation procedures; pro-actively engage with residential care units around the health agenda; respond to health-related requests; map existing service provision and highlight locality-specific health issues.

Outcome measures

The main outcome measures were the proportion of LAAC: with completed health records; pre-admission and comprehensive medicals; with up-to-date immunisations; with outstanding medical or dental issues; registered with a dentist and the proportion whose medical needs had been communicated to their key worker. These were supplemented by a thematically analysed LAAC nurse journal, a service evaluation questionnaire, a participant feedback exercise and a qualitative study into the views of residential care workers embedded in the pilot study.

Results

The proportion of LAAC with completed health records increased from 3% to 77%; the percentage who had a documented 'pre-admission medical' increased from 39% to 48%; the proportion with all age appropriate immunisations documented increased from 9% to 56%; the proportion with at least one outstanding medical referral decreased by at least 4%; the number registered with a dentist increased from 14% to 62.5%; the proportion with an up-to-date comprehensive medical increased from 23% to 58.5% over the course of the intervention. Thematic analysis of the LAAC nurse journals suggested that universal services were much more accessible for LAAC in Argyll due to well developed interagency working and low staff turnover rates. In the more urban areas the advantage of the LAAC nursing team was felt to be in the facilitation of this interagency working. Several of the nurses felt that the procedures relating to the documentation of health information were particularly lax. The service evaluation questionnaire provided positive feedback on the service from residential care workers. The participant feedback suggested that some health promotion sessions were more useful than others, but that most of the sessions were positively received. The qualitative study provided a series of suggestions as to why LAAC are unable to access health services easily. These focussed around issues of culture; staff training; health documentation and the systems in operation in residential care units (including staffing and resources).

Conclusions

LAAC suffer from health inequalities and barriers in accessing health services. The provision of the LAAC nurse service in Renfrewshire, West Dunbartonshire and Argyll & Bute improved the access of LAAC children in these areas to health services and this input was welcomed by care staff and the children. Numerous barriers remain in place to resolving access issues.

2. Introduction

In 2005 NHS Argyll & Clyde made a successful bid for 'Unmet Health Needs Fund' monies from the Scottish Executive to conduct a pilot study into the unmet health needs of looked after and accommodated children (LAAC). This was used to create and evaluate a LAAC nursing service for children domiciled in residential units in Argyll & Bute, Renfrewshire and West Dunbartonshire.

It is recognised that LAAC suffer from poor health outcomes both in absolute terms and health inequalities relative to others (Bundle 2000, Saunders & Broad 1997, Philpot 2004, Hill & Watkins 2002, Scottish Executive, 2002). Although the circumstances that have resulted in these children being cared for by local authorities are likely to be the main driver of these inequalities, it is also realised that they access services disproportionately less than the level of need that they have (Williams et al 2001, Bundle, 2000, Holland, Faulkner & Perez-del-Aguila et al, 2005, Philpot, 2004, Hill & Watkins, 2003). Therefore one of the potential routes to improve the health outcomes of this group is to enhance the accessibility and quality of services provided for them (Meltzer, 2000, Holland, Faulkner & Perez-del-Aguila et al, 2005, Hill & Watkins 2003).

This pilot study was an attempt to investigate if a LAAC nursing service could meet the unmet health needs of looked after and accommodated children.

It had been initially intended to carry out a comparison study of the introduction of the nursing service with intervention and control areas. This was to be based on three basic outcome measures (dental registration, immunisation uptake and uptake of routine health visiting appointments). A number of issues occurring during the course of the study such as: the disbanding of NHS Argyll & Clyde; the introduction of Hall 4; changes to the immunisation schedule; delays in achieving research ethics approval; problems with staff recruitment/retention and withdrawal of Inverclyde as a control area for the study. This meant that this type of study became impossible. Furthermore the initial data collection indicated that the proposed research outcomes were inappropriate as they were either unavailable or did not offer scope for improvement. The research protocol was therefore altered to investigate the impact of the introduction of a looked-after nursing service for LAAC in residential care settings in West Dunbartonshire, Renfrewshire and Argyll.

The project manager (Donna Hunter) had conducted a concurrent qualitative piece of work during the study in part fulfilment of a Master's degree. This research is synergistic to this project and its results are therefore also presented here.

3. Aims and Objectives

The aim of the pilot study was to:

“Investigate the change in access to health services for looked after and accommodated children in residential care as a result of the establishment of a specialised nursing service”.

The objectives were as follows:

- 1) To set up a sustainable protected database containing health information about LAAC that would be accessible to health professionals in the field. This should ensure that health information about children that are looked after and accommodated is easily accessible to health professionals.
- 2) Ensure that all LAAC have an up-to-date health assessment using the BAAF (British Association for Adoption and Fostering) health assessment forms within 6-8 weeks of entering the care system.
- 3) Provide health education and promotion to foster carers, LAAC and residential care unit staff with respect to the health care needs of LAAC.
- 4) Ensure that all LAAC receive a pre-admission medical.
- 5) Produce a mapping directory that contains a list and contact details of relevant health and social services/agencies for LAAC. This directory will have chapters devoted to each project locality.
- 6) Ensure that all LAAC have a BAAF health record and that the information contained therein is both up-to-date and complete.
- 7) Ensure that all medical referrals made for LAAC are followed up.
- 8) Ensure that all LAAC medical needs have been reported to the appropriate key (social) worker.
- 9) Improve immunisation uptake in residential units.
- 10) Ensure that each LAAC is registered with a dentist, improve the uptake of the 6 monthly dental check-up and improve the uptake of recommended dental procedures.

4. Methods

Design

This was a service evaluation of the impact of the introduction of a LAAC nursing service.

Setting

The study took place in all residential care units in Renfrewshire, West Dunbartonshire and Argyll & Bute. These local authorities have a combined population of 352,220 (based on GROS 2006 MYE). Renfrewshire has a number of specialised residential centres (the Kibble school and the Good Shepherd Centre) which provide a service for a much wider and needy population.

The LAAC nurses also worked with foster carers domiciled in these local authority areas.

Participants

168 LAAC children domiciled in residential units between August 2006 and March 2007 and an unspecified number of foster carers.

Intervention

A LAAC nursing service was created comprising of a Project Manager, 3 WTE LAAC nurses (Grade G) and a clerical support officer. An existing LAAC nurse who already worked within Renfrewshire worked alongside the project staff.

The intervention period ran from August 2006 until March 2007.

Each LAAC nurse was responsible for:

- Promoting the existence of the LAAC nursing service within their locality through the distribution of promotional leaflets (via social work departments) and visiting the children's units 'on their patch' for both carers and children
- Mapping existing service provision for children that were looked after and accommodated within their locality
- Responding to health-related requests from service users within their locality.
- Providing health education/promotion to LAAC, foster carers and residential care unit staff
- Liaising with allied health professionals and social care providers to ensure the health needs of the looked after and accommodated children within their area were being met
- Highlighting locality specific issues relating to the healthcare needs of LAAC
- Ensuring that the appropriate health related procedures/recommendations were adhered to and that relevant documentation was complete and up-to-date
- Gathering pre and post intervention evaluation data

Main outcome measures

The main outcome measures of the project were collected before and after the provision of the LAAC nursing service. The outcomes were as follows:

- 1) Number of LAAC children with health records (BAAF books).
- 2) Number of LAAC with complete and up-to-date BAAF books.
- 3) Number of LAAC receiving 'reception into care'/pre-admission medicals.
- 4) Number of children in residential units that had up-to-date immunisations.
- 5) Number of LAAC that had an outstanding medical referral that they had NOT taken up.
- 6) Number of LAAC registered with a dentist

- 7) Number of LAAC attending for 6 monthly dental check ups.
- 8) Number of LAAC with untreated dental problems.
- 9) Number of LAAC with up-to-date health assessments/comprehensive medicals using BAAF forms.
- 10) Number of LAAC whose medical needs had been reported to the appropriate key/social worker.

Supplementary outcome measures

In addition to the main outcome measures there were a number of adjuncts used to assist with the evaluation of the service. These were as follows:

1. *LAAC nurse journal*
Each LAAC nurse kept a journal and made note of unexpected issues and concerns they encountered within their locality over the course of the pilot project (see Appendix 2). The journals were thematically analysed and locality specific issues identified.
2. *Service evaluation questionnaire*
A service evaluation questionnaire was administered to care home staff. Responses were analysed to determine care unit staff's view of the service.
3. *Participant feedback*
Participatory appraisal techniques were employed to ascertain how helpful the accommodated children found the health promotion activities conducted by project staff.

The results of the concurrent qualitative study undertaken by the project manager are also presented with permission of the author (Hunter 2007).

Ethics Approval

Ethics approval was sought and granted by the Local Research Ethics Committee prior to the commencement of the pilot study.

Project Management

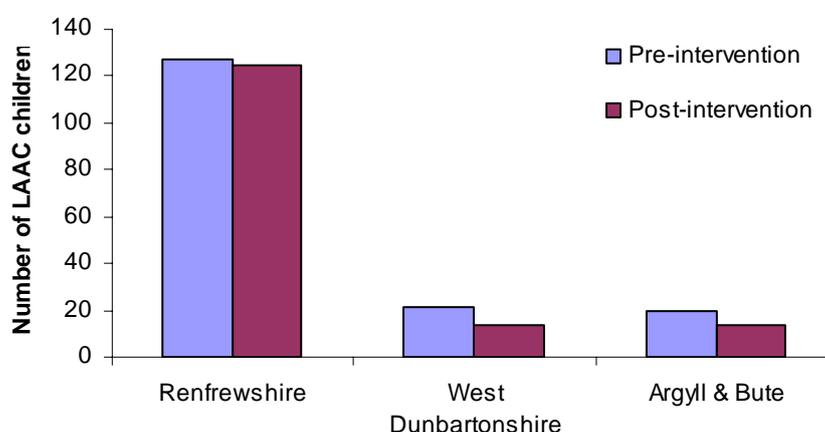
A project steering group was set up on commencement of the pilot project. Members of the steering group included a Children's Services Manager, Staff Grade Paediatrician, LAAC Pilot Project Manager, Specialist Registrar in Public Health, Public Health Researcher and a LAAC Nurse Specialist (Appendix 1).

5. Results

Penetration of LAAC nursing service

Whilst the specialised LAAC nursing service was available to children in foster care (except those on home supervision orders), there was very little uptake of the service from this group of children/foster carers. Dissemination of promotional leaflets (containing contact details for the nursing service) was conducted through social work departments in each of the participating localities. Participating social work departments were reluctant to provide project staff with the contact details of the children in foster care/foster carers within their jurisdiction. Consequently, LAAC nurses were reliant on the fostered child/foster carer contacting them for health-related advice/assistance and were unable to initiate direct contact with this category of eligible users. As a result, it was only children in residential care units that featured in the data collection procedure (pre-intervention n = 168; post-intervention n = 152). Shellach View Children's Unit in Oban was not included in post-intervention statistics as a decision was made that mainstream services for LAAC in that area were adequate. The LAAC nurse that served the Oban area left the project to take up another post in October 2006. The distribution of the participating LAAC is shown in Figure 1.

Figure 1 - The distribution of participating LAAC in the pilot study



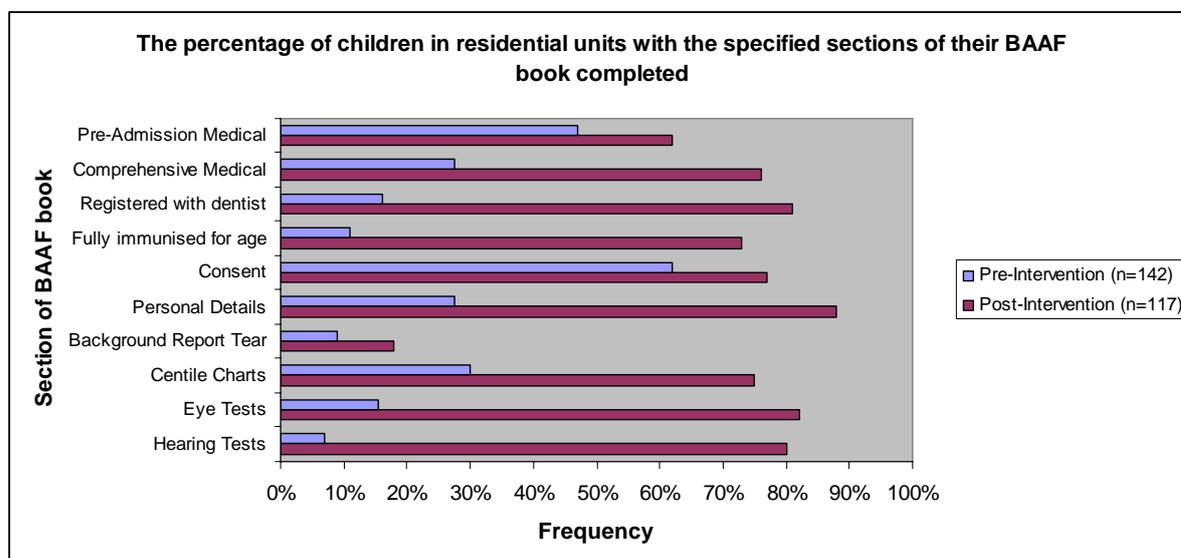
Main outcome measures

Data on the main outcome measures was collected immediately prior to the intervention period and following completion of the active phase of the pilot study (August 2006 and March 2007). During this period, some children had left the care system, entered residential care, moved between units, or left and re-entered children's units. Therefore, these outcomes represent a 'snapshot in time' (Figure 2).

Figure 2 - Main outcome results

Evaluation measure	Pre-intervention		Post-intervention	
	Children in residential units with BAAF books (n= 142)	Percentage of total sample (n=168)	Children in residential units with BAAF books (n= 117)	Percentage of total sample (n= 152)
With BAAF books	100%	84.5%	100%	77%
With up-to-date and complete BAAF books	3.5%	3%	100%	77%
Received a pre-admission medical	47%	39%	62%	48%
With all age-appropriate immunisations	11%	9%	73%	56%
At least one outstanding medical referral that had not been taken up	27%	At least 27% but exact figure unknown	0%	Less than 23% but exact figure unknown
Registered with a dentist	16%	14%	81%	62.5%
Had attended for dental check-up in last 6 months	Data unobtainable	Data unobtainable	Data unobtainable	Data unobtainable
Untreated dental problems	Data unobtainable	Data unobtainable	Data unobtainable	Data unobtainable
With an up-to-date BAAF health assessment /comprehensive medical	27.5%	23%	76%	58.5%
Medical needs reported to key/social worker	unknown	unknown	100%	100%

Figure 3 - Information deficits in BAAF books



Whilst surveying the BAAF books of the children in residential units, it became evident that certain information that should have been documented in the BAAF books was missing (see Fig. 3 above). Specifically,

1. **Results of pre-admission medical:** Prior to the commencement of the project, 47% of children (i.e. 66 children out of the 142 with BAAF books) had the results of their pre-admission medical documented in their BAAF book.

On completion of the pilot project, 62% of children (i.e. 73 children out of the 117 with BAAF books) had the results of their pre-admission medical documented in their BAAF book.

2. **Results of comprehensive medical:** Prior to the commencement of the project, 27.5% of children (i.e. 39 children out of the 142 with BAAF books) had the results of their comprehensive medical documented in their BAAF book.

On completion of the pilot project, 76% of children (i.e. 89 children out of the 117 with BAAF books) had the results of their comprehensive medical documented in their BAAF book.

3. **Dental registration:** Prior to the commencement of the pilot project, 16% of children (i.e. 23 children out of the 142 with BAAF books) had it documented in their BAAF book that they were registered with a dentist.

On completion of the pilot project, 81% (i.e. 95 children out of the 117 with BAAF books) had it documented in their BAAF book that they were registered with a dentist.

4. **Immunisation status:** Prior to the commencement of the pilot project, 11% of children (i.e. 15 children out of the 142 with BAAF books) had their immunisation status documented in their BAAF books.

On completion of the pilot project, 73% (i.e. 85 children out of the 117 with BAAF

Books) had their immunisation status documented in their BAAF books

5. **Consent for medical treatment:** Prior to the commencement of the project, 62% of children (i.e. 88 children out of the 142 with BAAF books) had legal guardian/parental consent for medical treatment documented in their BAAF book.

On completion of the pilot project, 77% of children (i.e. 90 children out of the 117 with BAAF books) had the consent form for medical treatment (contained within their BAAF book) signed by their parent/legal guardian.

6. **Personal details:** Prior to the commencement of the project, 27.5% of children (i.e. 39 children out of the 142 with BAAF books) had all relevant personal details (e.g. date of birth, home address, parents names, details regarding siblings, etc.) documented in their BAAF books.

On completion of the pilot project, 88% of children (i.e. 103 children out of the 117 with BAAF books) had all relevant personal details documented in their BAAF books.

7. **Background report tear off slip:** Prior to the commencement of the project, 9% of children (i.e. 13 children out of the 142 with BAAF books) had the reason(s) why they were in care documented on the background report tear off slip. This must be completed by the Receiving Social Worker to be removed on completion of the Medical Report and can be retained by the child's General Practitioner.

On completion of the pilot project, 18% of children (i.e. 21 children out of the 117 with BAAF books) had the reason(s) why they were in care documented on the background report tear off slip. This must be completed by the Receiving Social Worker to be removed on completion of the Medical Report and can be retained by the child's General Practitioner.

8. **Centile Charts:** Prior to the commencement of the project, 30% of children (i.e. 43 children out of the 142 with BAAF books) had their growth plotted against 'norms' documented in their BAAF books.

On completion of the pilot project, 75% of children (i.e. 87 children out of the 117 with BAAF books) had their growth plotted against 'norms' documented in their BAAF books.

9. **Eye Tests:** Prior to the commencement of the project, 15.5 % of children (i.e. 22 children out of the 142 with BAAF books) had it noted in their BAAF book that they were registered with an optician and had attended for at least one eye test.

On completion of the pilot project, 82% of children (i.e. 96 children out of the 117 with BAAF books) had it noted in their BAAF book that they were registered with an optician and had attended for at least one eye test.

10. **Hearing Tests:** Prior to the commencement of the project, 7% of children (i.e. 10 children out of the 142 with BAAF books) had it noted in their BAAF book that they had undergone standard hearing tests during their comprehensive medical.

On completion of the pilot project, 80% of children (i.e. 94 children out of the 117 with BAAF books) had it noted in their BAAF book that they had undergone standard hearing tests during their comprehensive medical.

Supplementary outcome measure results

LAAC nurse journal: thematic analysis

Each LAAC pilot project nurse completed a journal over the course of the pilot study. The content of these journals was thematically analysed and the following main issues identified:

- Rural areas (in particular Argyll) appeared to offer a very good standard of service to LAAC with universal services. Several factors were identified that contributed to this high quality of care:
 - Small numbers of LAAC
 - A high level of interagency working and cooperation
 - Low staff turnover rates
- The LAAC nursing team felt that their role facilitated a greater degree of interagency working amongst care partners.
- 'Professional boundaries' occasionally prevented effective interagency working.
- BAAF books were rarely complete and up-to-date. Indeed, when some children left the care of the local authority only to re-enter the care system weeks/months later, they were issued with a blank BAAF book while their previous book was filed away.

Service evaluation questionnaire

60 questionnaires were completed by staff in the residential units. Most of these were from staff employed in Renfrewshire (47%), with smaller numbers from West Dunbartonshire (38%) and Argyll & Bute (15%). This response included staff members from 16 different residential units. The main findings of the questionnaire were as follows:

- Feedback on the health promotion activities provided by the LAAC nurses during the project were very positive.
- The most useful aspects of the LAAC nursing service were said to be the availability of medical attention and advice and the building of relationships between the nurses and young people.
- Suggestions for improving the service included the appointment of full-time nurses, creating drop-in opportunities, providing more information about the service and to increase the amount of group work and interactive learning.

Participant feedback using evaluation wheels

At the close of the intervention participatory appraisal techniques were employed to gauge how helpful children found the health promotion activities offered by the LAAC nurses. Evaluation wheels were utilised to ascertain how helpful the children had found the activities they had attended.

Participants were asked to place a dot on each segment that represented an activity that they had attended. Dots in blue represent males and in red represent females. Dots closest to the centre of the evaluation wheel were considered to be the most helpful. All returned evaluation wheels were then mapped onto 2 'master wheels'.

44 children (15 males and 29 females) returned completed evaluation wheels, spread across each of the local authority areas. This demonstrated that at least 29% of the children in participating residential units had attended at least one health promotion/group work event.

Figure 3 shows the feedback on the activities with a relatively high attendance, and Figure 4 the feedback on the activities with a relatively low attendance.

Figure 3 – Evaluation wheel of activities with relatively high attendance

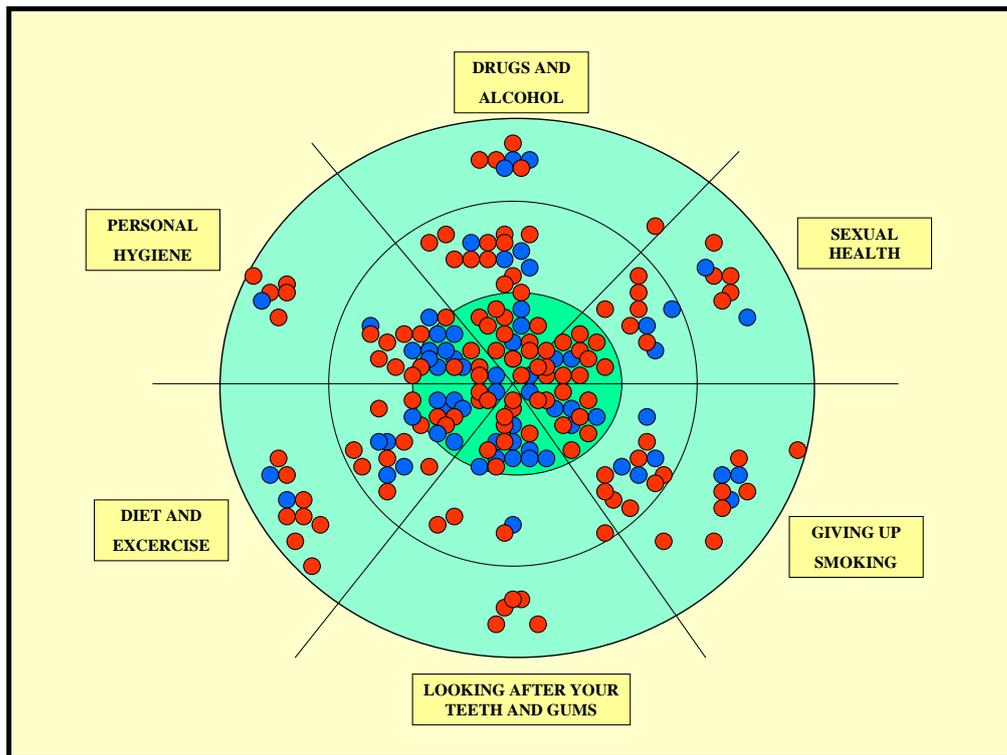
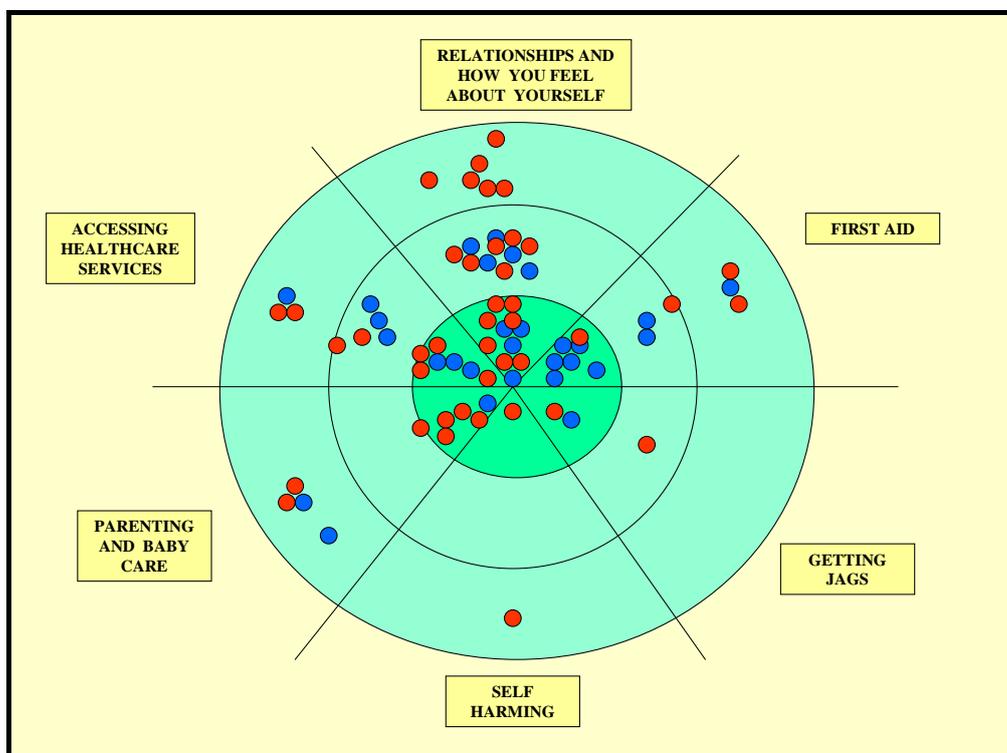


Figure 4 – Evaluation wheel of activities with relatively low attendance



Results of complementary qualitative study

During the pilot study a further piece of research was carried out in part fulfilment of a Masters degree. This was a qualitative piece of research into the views of residential care workers of the health and well-being of LAAC. The results of this study are presented here as they add depth to the findings of the main study.

This qualitative study was based on 12 one-to-one interviews with residential care workers (RCWs) to explore their views and beliefs on the health of LAAC. In particular, residential care workers were asked to describe what barriers and facilitators there are to documenting and accessing health information.

The findings of this qualitative research can be described in four broad areas:

1. Views around how to support the health of LAAC
2. Staff training
3. Documenting health information
4. Systems in residential homes

1. Views around how to support the health of LAAC

The RCWs were asked what they understood by child health and what their role was in the health of LAAC.

The consensus view was that health was never formally discussed with the children. Two of the workers raised concerns regarding the children missing out on health education at school because of poor attendance rates at school, but felt they did not have the knowledge required to hold any sort of health improvement workshops. Health education tended to be on a one to one and ad-hoc basis.

RCW 4: "This is their home and I feel health things should be discussed with their doctor or in health talks at school".

RCW 6: "I suppose our health talks are more kind of reactive, like if someone is caught smoking, we'll talk to them about the danger to their health, but if someone comes in drunk I'd be stressing the dangerous situation they could get into, especially the girls, you know getting raped or pregnant – I wouldn't talk about damaging their liver or anything, they just wouldn't be interested".

Three residential care workers identified protecting children from distress as a reason not to persist with a health appointment or health promoting behaviour.

RCW 7: "I know jags and stuff should be up to date, but when there's other things going on in their lives, you know, like their parents miss a contact visit, or they are in a bad place in their heads aggressive or emotional, medicals don't seem that important. I think it's my job to cancel that appointment and focus on what is important to the young person at the time".

RCW 6: "Food and obese kids are in the media all the time and we do try to give healthy choices, but it's hard. If they haven't eaten healthily at home, eating like chicken nuggets and chips all the time, I think it's cruel to make them eat fruit and vegetables and things they don't like when they are already distressed".

RCW 6: "This isn't a hospital or a school environment, yes we want what is best for the young people, and we try very hard to improve their outcomes across the board but we can't continually push them. I think we sometimes forget it is supposed to be their home".

The RCWs were asked to reflect on two areas that could make the children healthier and how could they support this. Exercise emerged as a common theme.

RCW 12: "I'm really into keep fit and going to the gym and I'd like to see the young people exercise more. We know schools are doing less P.E. and it's up to us to motivate them. I'd be happy to do some keep fit classes in the units if the council allowed it".

RCW 9: "The young people need to exercise more. At my daughter's school they have a walk to school group, which I think is great. None of our young people can walk to school though. We try to keep them in their own schools if possible so most of our young people have to have taxis there and back. There's just no way round it".

RCW 4: "A lot of our young people have low self esteem and they say exercise lifts you mood so I'd like to support more exercise, it's good for their weight too. It's difficult though there's only two carers on each shift so say someone wants to go to karate, it means there's only one adult left in the unit and if someone kicks off it's really difficult".

2. Staff Training

Of the twelve participants interviewed for this study only one felt it was not part of their job description to provide guidance on health issues.

RCW 5: "I would love to know more about health issues. As a parent myself I talk to my own children about healthy eating and keeping away from drugs and things like that, but I get this information from the media not from like a proper source. That's o.k. because I know my kids are getting it at school and I'm just kind of backing it up, but the young people in the unit have usually missed a lot of schooling so I feel I should be giving them information that is definitely right".

RCW 6: "We all have to do this SVQ qualification for working in the units. I did it 2 years ago and most of my colleagues have too. We received no input from health".

RCW 9: "We have one first aider, but that worker obviously isn't always on a shift, so some practical advice would be useful, someone coming into the units would be great as it is hard for staff to get away".

3. Documenting health information

The BAAF Health Record is designed to be an up-to-date health record which can be readily accessed by all health professionals with whom the child has contact. As can be seen from the earlier results, the BAAF Health Record is sometimes absent, and very few are fully documented. The views of the residential care workers give some insight into the reasons for this:

RCW 4: "We tend to write in our own records. I think it's a lot of duplication and we just don't have time. To me a lot of the information isn't relevant, things like immunisations, they should get them when they are babies, so again I think it's a waste of time trying to find out if they are up to date, I mean when they are 14 years old, its way to late, you're not going to do anything about it now".

RCW 6: "Not all the Local Authorities use the BAAF book, we get young people from all over, so we tend to forget about it and write in our own notes instead".

Several of the residential care workers felt the BAAF Health Record could be useful if filled in properly but voiced reasons as to why this was not always possible:

RCW 1: "If the books are filled in I think they probably are good, but quite often we get blank ones or don't get one at all. Really it's up to the social worker and health to sort it out".

RCW 2: "If the book is filled in properly its really useful. The clinic doctors know how to fill them in, but the GPs unless it's the ones we always go to, don't seem to know".

RCW 9: "The book is useful for keeping track of things but I don't push it. A lot of our young people refuse medicals, partly because they don't feel ill and partly because its one of the few things they can say no to when their come into care. If it's taken me a bit of time to persuade the young person to go, I won't take the book because often again it makes them feel different, no other kids their age has one".

RCW 12: "I think in principle the books are a good idea, but in practice it sometimes seems like a waste of time. When the young person leaves the unit we archive the books in the loft. If the young person comes back to this unit we will retrieve it, but if the young person is admitted to another unit, another new blank book will be issued and all the fact finding starts over again (pause). I know it's daft but no-one seems to be able to co-ordinate keeping things together".

Other residential care workers had a different opinion stating the books were of value and described the steps they took to ensure the BAAF Health Record was up to date. Some also added suggestions on how to make the book more user-friendly.

RCW 12: "I think the books are a good thing, if we don't get one we keep phoning the Social Worker until we get one. If the information isn't in it, we phone the Social Worker again and get as much information as we can, then we start phoning around for the health information and that's the tricky bit".

RCW 7: "We always take the book to the health appointments but depending on which GP you get, some fill it in and some don't. Some GP's make you feel they don't have time, so when we get back to the unit we write in ourselves "attended GP". We don't write down why they attended in case we say something wrong".

RCW 9: "In this unit we take the book to every appointment. We have ten children in the unit and there is no way we could remember all their appointments without it. I think a few extra pages for us to write in would be useful. Like if they have a cough and we give them some medicine, we do write it in the medications log, but it would show us better how often the young person had minor problems if it was written in their own book".

RCW 5: "I think the book is a good idea, but a lot of the time you can't read what it says. Something I would change is the front cover, its blue and other kids get a red one (the universal Personal Child Health Record) so it stigmatises our young people straight away, also it's a sort of wipe clean cover so if anyone's hands are greasy all the information is wiped off".

Unhelpful health professionals were also seen as a barrier to accessing and documenting information health information:

RCW 8: "Quite often we go with the Social Worker to get the children's pre- admission medical. It can be no mean feat getting past the receptionist – the children must be seen within 48 hours and though we do try as much as possible to get the children's own GP it is not always possible".

RCW 3: "When you say you're not the parent, some staff won't give you all the information. I know there are confidentiality problems but we are all on the same side".

RCW 8: "Trying to get health information is impossible. As soon as you say you're from Social Work the tone of voice changes, and they say they will phone back, but rarely do".

4. *Systems*

The impact of the systems in place, bureaucracy and waiting times for appointments were seen as a further barrier to accessing health care:

RCW 1: "Sometimes the young people are only with us a relatively short time say two to three months. If there is a health problem found, by the time the appointment comes they would be back home. There should be some sort of fast track system for our young people".

RCW 6: "Sometimes you need an appointment after school and they are like gold dust. The thing is we are trying to get the young people into a good pattern of going to school, so we can't keep taking them out for appointments".

Currently it is the responsibility of the residential care worker to collate the health information in the BAAF health record, however, it is difficult for residential care staff to access health information as due to confidentiality issues only health personnel have this privilege. No workers had received training regarding the book. Only one worker felt it would be of interest.

RCW 3: "I would like information about the immunisations, I don't know what is due and when, we used to get the BCG at school but I think I heard on the news they don't give it any more. See what I mean, I'm not sure and I don't want to give the wrong information. Sometimes when we are waiting for an appointment the young person might ask to see their book which is fine, but I can't explain things like the growth charts. I just feel it gives the young person more confidence if you seem to know what you are doing.

Summary of findings from the qualitative study

It was clear that there are many barriers to achieving good health outcomes for LAAC from the discussions with the RCWs. Some of these barriers were consistently raised by a number of RCWs. These included the difficulties of being the corporate parent (with the conflicting roles that arise from that), the lack of health-based training for staff, the inaccessibility of health services for LAAC and problems with the systems (such as health information recording systems and staffing levels) that operate in residential care.

6. Discussion

Universal and specialised health services for LAAC

This pilot study looked at the impact of the introduction of a specialised LAAC nursing service. The pre-intervention data collection revealed a low rate of use of the appropriate documentation, and low rates of documented follow-up of medical referrals, registration with a dentist and of immunisation. Each of these outcomes was significantly improved by the presence of the specialist nursing team. It is not clear from this data what proportion of this related simply to an improvement in the documentation of events. The qualitative evidence and supplementary outcomes presented here do indicate however that an actual improvement in health service uptake did occur due to the nurses pursuing care pathways to completion and co-ordinating a health response between agencies. It was noted that universal health services created a number of unintentional barriers for LAAC in Renfrewshire and West Dunbartonshire, but that this was not seen in Argyll and Bute. The existence of long-term professional relationships, an approach tailored to the needs of the child and a smaller number of needy children were obvious in this area. The role for LAAC nurses in the urban areas was often to create this environment and to overcome organisational barriers where they arose.

Interagency working

'Getting it Right for Every Child'¹ is a set of guidelines published by the Scottish Executive to assist those working with children in a multi-agency environment. The Scottish Executive are currently reviewing the Children's services (Scotland) bill which will:

- Place a duty on agencies to share information to protect children at risk;
- Place a duty on agencies to be alert to the needs of children and to act to improve a child's situation;
- Place a duty on agencies to co-operate with each other in meeting the needs of children and to establish local co-ordination and monitoring mechanisms;

The pilot study suggests that there is significant work still to be done in the sharing of information between agencies. Confidentiality was frequently cited as a reason for an inability to share information with the nursing service at the start of the study. However, as the nurses became known to the RCWs, they referred more queries to them and were more willing to discuss problems as they arose. Furthermore the practice of recording information in the BAAF books became far more widespread.

Continuity of care and information sharing

Many of the key objectives of the study were attempts to facilitate information sharing between agencies. The BAAF forms are key to this for health information, but this is not the perspective of all of those working with LAAC. It is clear that GPs, RCWs and others are not routinely utilising this common repository for health information, and that there remain numerous cultural and practical barriers to this being resolved. Although 84.5% of LAAC in residential care units had BAAF books on commencement of the pilot project, only 3% of these children had BAAF books that were complete and up-to-date. On completion of the pilot project, a slightly lower percentage of children had BAAF books (77%; n = 117) but of the children who had BAAF books, all were complete and up-to-date. The reduction in the number of children with BAAF books post-intervention can best be explained by 'traffic' through the care system (i.e. 'new' children had not yet been issued with BAAF health records or they may have come from a Local Authority not issuing the books).

The computerised database was another attempt to resolve this problem. Unfortunately a number of practical difficulties were encountered in setting up a shared database for the purposes of information sharing, although a prototype has been developed and tested (Appendix 2 details the current status of the database system).

¹ <http://www.scotland.gov.uk/Topics/People/Young-People/childrenservices/girfec>

LAAC are clearly a group with exceptionally high health care needs, and are often a very mobile population. Breakdown in continuity of care or with information sharing is therefore likely to compound these already existent problems.

7. Conclusions

In the residential units in Renfrewshire and West Dunbartonshire the presence of a single health professional responsible for co-ordinating health care improved the uptake of health services for LAAC. The systematic monitoring of health progress by nursing staff also shows signs of being an effective means to health improvement in this group. This pilot study has demonstrated that there are a range of systematic and cultural barriers to LAAC accessing universal health services which are difficult to overcome.

There appears to be a need for health awareness training for residential care staff and for the creation of 'health promoting residential units'. This would include a removal of the staffing, financial, social and cultural barriers to health creation.

This study indicates that there is a need for a review of the practice of recording and sharing health information between agencies, areas and different parts of the NHS. This is in line with the recommendations contained within 'Getting it right for every child', but it appears that these problems are not yet resolved.

There are difficulties for NHS staff attempting to engage with foster carers through social work departments. It remains to be seen what the impact of the creation of community health partnerships will be on this.

LAAC suffer from significant health inequalities which represent the inequalities in the social determinants of health present in society. In the long-term it will be important to address the underlying problems in society if the health inequalities of groups such as LAAC are to be significantly improved.

Appendix 1 – Contributors to the pilot study

Membership of Steering Group

Annie Hair
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Appendix 2 – Status of the database system

One of the objectives of the pilot study was as follows:

“To set up a sustainable password protected database containing relevant health information about LAAC that would be accessible to health professionals in the field. This should ensure that health information about children that are looked after and accommodated within the former NHS A&C is easily accessible to health professionals”.

At present the current system is live and is capable of recording the following sections relating to the child:

- Registration and Referral details to LAAC
- Health Issues
- Primary Care details
- Residential details
- Associated Persons
- Medical Assessment information
- Medications
- Allergies
- Medical Conditions
- Interaction with healthcare professionals

The system also facilitates a reporting section which incorporates the patient "Review Sheet" which is a full summary of a patient. Also available with the system is a "Word App". This allows the user to print pre-determined letters for a selected patient where any patient information held on the system is automatically pre-populated into the letter. Examples of such letters are "General Appointment", "Social Work Cover Letter" and "Discharge Notification".

The system is effectively split into 3 sections to perform the above. The first section to record Registration, Referral and Activity is held within our existing Community Information System. The second section to record all other sections and allow reporting is held within a custom designed Web application. The third section for printing letters uses an interface into Microsoft MSWord. This section although available is not currently in use as it requires full data within the Web section of the system before it can be fully utilised. Training, although very simple, will also have to be given on this. It is intended that after 6 months of use a review of the system in its entirety will take place. This would be to look at any failings of the system and also to look at furthering any sections that could not be included in the original implementation. Such sections include Immunisation and integration of BAAF forms.

The creation of a database system could solve the problem of BAAF books being lost or restarted in the event of re-entry into care, but could also represent duplication of documentation. This database therefore requires further piloting work.

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Appendix 4 – Contact Details

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