The emerging role of the specialist nurse
Promoting the health of looked after children

In the light of recent guidelines from the Department of Health, Catherine Hill, in collaboration with Vanessa Wright, Carolyn Sampeys, Kathy Dunnett, Sue Daniel, Lesley O'Dell and Janet Watkins, discusses the growing contribution that specialist nurses are making in promoting the health of looked after children. To illustrate this trend two projects, in Southampton and Cardiff, are examined, followed by a review of the current professional status of looked after children's nurses in England and Wales. All the evidence presented points to better outcomes and additional quality through nurse-led assessments.

In the past the statutory annual medical examination was often viewed as the principle safeguard for the health of looked after children. Formerly known as the ‘Freedom from infection’ examination, this emphasised the need to protect the health of foster care families rather than promote the health of the child, and neglected to take a broad view of health. In England and Wales the 1991 regulations of the Children Act 1989 ensured that this health contact was medicalised by stipulating that an examination should be undertaken by a ‘registered medical practitioner’. A medical approach was further encouraged by the format of the widely used BAAF medical assessment forms C, D and Y P, where relatively little space was given to functional assessment and lifestyle issues compared to physical examination findings. (This has been greatly improved by the new initial health assessment [IHA] form, although this is not yet universally adopted.) Landmark studies suggested that statutory medicals were poorly attended, with uptake rates of 25 per cent and less (Butler and Payne, 1997; Mather et al, 1997). Furthermore, when reasons for poor uptake were explored young people expressed negative views of the process:

Having to take your clothes off for a strange doctor, when you don’t feel ill is yet one more abuse of the system. (Mather and Batty, 2000, p 10)

The introduction of the Department of Health’s Looking After Children Action and Assessment Records from 1995 onwards, with a substantial focus on health, offered the opportunity to promote health and health care. Too often, however, these records have become another step in a great paper chase.

The burgeoning evidence of health neglect and disadvantage in the population of looked after children was highlighted by a UK Parliamentary review (House of Commons Health Committee, 1998), which prompted a fresh approach to promoting the health of looked after children, subsequently outlined in Department of Health guidelines (2002). These guidelines recognise the place of health assessment (rather than medical examination) in the context of a healthy care environment. They encourage a move away from a clinical diagnostic model to a more flexible and holistic approach, where physical examination is discretionary. The role of health professionals other than doctors is promoted and formalised in the concept of a designated nurse for looked after children.

In April 2002 amendments to the Arrangement of Placements of Children Regulations (see Figure 1) permitted registered nurses and midwives, under the supervision of a doctor, to undertake review health assessments. These significant shifts in policy have created an opportunity for many health and local authorities to employ nurses, in both clinical and strategic capacities, to enhance the health of looked after children. This trend reflects the changing climate of primary care nursing and health visiting (Department of Health, 1999) as universal screening of all children has been discredited (Audit Commission, 1994) and new

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recommendations emphasise the need to focus on vulnerable and disadvantaged children (Hall and Elliman, 2002). Other government initiatives such as ‘Sure Start’ and ‘On Track’ have also exploited the skills of nurses and health visitors working with other professional partners across a range of organisations, delivering more flexible health care to some of the most disadvantaged children in society.

Services have begun to adapt and change, focusing increasingly on children in need, partly in response to these policy demands but also for pragmatic reasons due to vacancy rates in primary care nursing and health visiting. As a result, an evolving pool of nurses with specialist expertise and experience has developed, with the ability and desire to use their skills with some of the more vulnerable children, such as those ‘looked after’. As professional boundaries merge and nursing professionals begin to undertake roles more traditionally viewed as medical, it is crucial that evidence of effectiveness is gathered. This article will review two projects in England and Wales, which provide evidence to support the argument for expanding the role of the nurse in health assessment and health promotion of looked after children and will conclude with a review of the current professional status of looked after children’s nurses in these two countries.

Nurse-led health assessment for looked after children: what is the evidence for improved quality?

A fundamental difference between medical and nursing training is the emphasis in medical training on diagnostic method – the art and science of integrating the patient’s story and examination findings to reach a likely diagnosis. Diagnostic method is the backbone of clinical training for a doctor but does not form a part of standard nursing training. Generally speaking therefore, a health assessment which requires diagnostic skills, further investigation and the prescription of medication would require the input of a doctor. So it is important to know whether the skills of diagnosis are used in statutory health assessments of looked after children. There is little evidence for this in the research literature.

The Southampton study

Hill and Watkins (in press) undertook a retrospective case-note analysis of 49 Southampton children who had attended for at least two statutory medicals. The primary aims of the study were to describe the spectrum of health difficulties presented by the children and assess the efficiency of the healthcare planning process. A secondary aim was to make a judgement about the professional skill-base required to address the children’s problems. This latter aim was achieved in two ways.

Firstly, the researcher documented at each assessment whether:

- the child, carer or social worker expressed concerns about the child’s physical health;
- new visual or hearing impairments were found at assessment;
- there was a positive yield of clinical findings from general physical examination.

Secondly, two experienced school nurses (one of whom, Sue Daniel, is also a specialist nurse for looked after children)
The content of a health assessment*

The needs of the very young
For under-fives, the focus should be on:

- attachment behaviour
- physical health
- growth
- diet
- immunisations
- teeth
- 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 and self-help skills.

The middle years
For primary-age children:

- physical health and management of specific health conditions, eg asthma
- communication skills
- ability to make relationships and to relate to peers
- 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
- where appropriate, to recognise and cope with the physical and emotional changes associated with puberty
- access to accurate simple information about sexual activity
- immunisation
- dental health
- attachment behaviour
- emotional health including depression and conduct disorders.

Adolescence and leaving care
For secondary-age children and young people:

- ability to take appropriate responsibility for own health, including management of specific health conditions, eg asthma, diabetes
- communication and interpersonal skills
- educational and social progress
- lifestyle including diet and physical activity
- understanding of issues relating to sexuality and sexual activity, including its role in relationships, 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
- to ensure that immunisations are up to date
- for care leavers to have a full copy of all social care health records (including genetic background and details of illness and treatments) and be equipped to manage their own health needs
- mental health, eg depression, conduct disorders.

Source: Department of Health, Promoting the Health of Looked After Children, Appendix 4, pp 68–9, 2002
independently reviewed each case-file and scrutinised the assessment records. They were asked to judge whether they would have felt competent to undertake the assessment independently and whether they would have made additional healthcare plan recommendations, in other words provided added value to the assessment.

**History of physical health concerns**
The initial documentary analysis showed that physical health concerns, and specifically physical symptoms, were more likely to be presented at follow-up review than at the initial assessment (Figure 5). This was perhaps curious as it could be assumed that children’s physical problems might have been addressed one year into placement. However, it may reflect the fact that carers had better knowledge of the child at the review assessment. Alternatively, problems that would otherwise have been taken to a general practitioner (GP) may have been ‘saved up’ in anticipation of the health assessment.

**Positive yield of vision and hearing screening**
Testing for visual impairment was undertaken for 43 out of 49 children at initial assessment and at 56/66 follow-up assessments for the same cohort (16 children had second and one child third reviews) using a standard Snellen chart. While the positive yield for abnormality (defined as visual acuity <6/9 in either eye) was 6/43 at first assessment and 5/56 for follow-up assessment, only three out of six (50 per cent) and one in five (20 per cent) of cases respectively were new findings at the health assessment not previously documented, eg at school screening programmes.

Testing for hearing impairment was undertaken for 45 out of 49 children at initial assessment and at 59 out of 66 follow-up assessments for the same cohort using standard audiometric SWEEP testing. While the positive yield for abnormality (defined as hearing loss >40dB in either ear) was 5/45 at first assessment and 7/59 for follow-up assessment, four out of five (80 per cent) and seven out of seven (100 per cent) of cases respectively were new findings at the health assessment.

This suggests that there should be a low threshold for vision and hearing testing of children at both initial and follow-up assessment.

**Physical examination**
Complete systemic physical examination (not including height, weight, vision and hearing assessment), as documented in the BAAF assessment forms, was undertaken for 43 out of 49 cases at initial assessment and 52 out of 66 follow-up assessments. The study did not record reasons for incomplete examination. Positive physical findings suggesting an underlying medical problem were documented for 18 out of 43 (42 per cent) initial and 26 out of 52 (50 per cent) review examinations. Once again there appears to be a relatively high yield of positive findings at review assessment. The original case-notes analysis did not discriminate physical findings that were simply indicative of an established and treated condition from those that were new findings at the assessment. However, there is evidence from previous studies that looked after children suffer recognised or neglected chronic health problems (Williams et al, 2001) and certainly this appeared to be the case with respect to undetected hearing problems in the study cohort.

**Nurse- or doctor-led review?**
For the first review assessments 46 out of 49 available records were analysed independently by two experienced nurses to determine which professional would have most appropriately conducted the review. Their conclusions are presented in age categories in Figure 3. The nurses were in full agreement with each other as to when a nurse-led review was appropriate – this was the case for 30 out of 46 children. They disagreed as to whether three school-aged children should have been seen by a doctor alone or by a nurse with support from a doctor. These cases are displayed graphically as ‘doctor’ reviews. For example, one child required a haemoglobinopathy screen and one nurse felt
confident to undertake the assessment and request medical support while the other felt the assessment would have been better undertaken by a doctor. For the remaining 13 children the two nurses agreed that the review assessment should be conducted by a doctor. The reasons were varied but included the need for developmental assessment in the five pre-school children (the nurses were school nurse trained and unlike health visitors do not have these skills), the need for further investigation of genetic risk and lack of knowledge of pre-existing complex health problems (see Figure 4). On the other hand, the nurses made additional recommendations for 17 out of 46 assessments. These tended to relate to the need for follow-up support around issues such as diet and exercise or the involvement of other professionals, eg education welfare officers or sexual health nurses. The extra recommendations demonstrated the potential for additional health promotion in the context of a nurse-led assessment.

The professional backgrounds of the nurses undertaking the documentary analysis will have determined their perceptions of appropriate professional roles. However, their experiences and qualifications mirror those of many looked after children’s nurses in the UK and their conclusions are likely to be transferable.

**Implications for the study**

The findings of this study highlight both the heterogeneity of health needs of looked after children and the range of skills required to offer the holistic health assessment (Figure 2) as recommended by the Department of Health guidance.

It would be naïve to assume that one professional could address all of these matters, not least because of the age spectrum of children and young people involved. Clearly very different skills are required to assess the health needs of a teenage asylum seeker who speaks limited English compared to a behaviourally disturbed pre-school child who has experienced abuse and neglect in this country. While the study did suggest that traditional diagnostic skills may be required in review assessments, to some

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**Figure 3**

‘Best professional’ to conduct health reviews by child’s age and number of cases where additional health recommendations suggested by nurses

<table>
<thead>
<tr>
<th>Age category</th>
<th>Nurse led</th>
<th>Doctor led</th>
<th>Additional recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5s</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6–11s</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>&gt;11s</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

**Figure 4**

Nature of physical problems judged by nurses to require medical review

- child with ear infection – no equipment to examine ears
- examination of skin lump (2)
- ordering of haemoglobinopathy screen
- splinting of finger
- first diagnosis of eczema
- no training for developmental assessment (5)
- inadequate knowledge of genetic conditions (3)
- investigation of moderate learning disability
- orthopaedic referral
- management of newly disclosed pregnancy

**Figure 5**

Percentage of children presenting with physical health concerns or symptoms at initial compared to review assessments

- First assessment
- Follow-up assessment

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**Figure 5**

Percentage of children presenting with physical health concerns or symptoms at initial compared to review assessments

- Physical concerns
- Physical symptoms

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extent these were predictable (e.g. the child had a pre-existing condition) and in no case did these relate to urgent problems that could not have been addressed by subsequent professional discussion or referral. Crucially it was clear that the nurses would have deployed their skills to advise on lifestyle issues that could have added quality to assessment. These skills are important if children’s health is to be truly promoted rather than simply monitored.

The conclusions of this work led to the implementation of nurse-led health reviews for school-aged children within the City of Southampton. Evaluation is ongoing but initial experience has been overwhelmingly positive. The benefits of working closely in a team have resulted in only two of 148 young people seen for nurse-led assessment requiring a follow-up medical opinion. One child with morbid obesity was referred to exclude an underlying organic cause and another with a proximal myopathy was also referred. Furthermore, feedback from children and young people has suggested that they perceive nurses as more accessible and approachable than doctors. There have been additional networking advantages – for example, the existing medical team had strong links with hospital services and child and adolescent mental health, which have been supplemented with improved links with primary care. Problems have been few. There remains at times a naïve faith in the laying on of hands in the form of a traditional medical examination, and carers and social workers have occasionally felt that a child has not had a ‘proper medical’ if they have not been physically examined. The terminology of ‘health assessment’ has been slow to be accepted in social services where children are still told they will be having a ‘medical’. The other obstacle has been liaison with other medical professionals. One GP was not happy to take the advice of the designated nurse and required further supportive correspondence from the paediatrician. Similarly, a clinically justified physiotherapy referral was turned down.

**The Cardiff study**

Further positive evidence of improved health outcomes in looked after children through nurse-led health assessments is available from the Cardiff Children First health project (Rivron, 2001) which offers nurse-led holistic health assessments to children in residential units and placed with Band 3 foster carers (special carers for the most difficult youngsters). Prior to the inception of the project in November 2000, there were 33 children in residential units and 87 children with Band 3 foster carers. Baseline data on key health performance indicators were collected for the 12 months prior to the project and for the 12 months up to 31 March 2002 (Figure 6). These demonstrate positive improvements in all areas assessed, a considerable achievement considering that the young people who are in these categories of care are often the most likely to be excluded from school and disenfranchised from conventional services.

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**Figure 6**

Outcomes of Cardiff Children First health project

1Note GP and dental registration data refer to the 33 children in residential care prior to the project but all 101 children in residential and Band 3 foster care after the project. However, as children in residential care made up more than 50 per cent of the total in the second stage of data collection, the improvements are likely to be genuine.
The health promotion element of the health assessment has greatly increased (Figure 7). There has been opportunity to discuss a number of health and lifestyle issues with young people and make referrals to other services as appropriate. The nurses have been able to accompany some young people to health appointments at their request; they can then interpret and reinforce information.

Young people and their carers now have a named nurse available at the end of a telephone to offer information and advice almost whenever they need it. It is these quality developments – improving accessibility and presentation of services – that may offer real encouragement to children to access the necessarily ‘special’ services many of them require to protect their health.

Given the evidence just outlined about the success of nurses for looked after children, it is valuable to review the extent and nature of their work in England and Wales.

**Looked after children’s nurses in England and Wales**

There is no central registry for looked after children nurses, but conservative estimates suggest that 90 such posts exist in England and Wales.1 In 2001 Kathy Dunnett (also a member of the BAAF Medical Advisory Group) set up the organisation ‘Champions for Children and Young People in Care’, a national multidisciplinary group to provide professional support to anyone working with looked after children, and to forge links with related agencies to push forward the health agenda. At the 2002 annual conference 45 members were surveyed regarding the nature of their professional roles and employment contracts. A number of patterns emerged.

The commonest professional titles given by the respondents were ‘specialist nurse/clinical nurse specialist’ for looked after children. A minority were described as lead nurse (6) or designated nurse (3) for looked after children in anticipation of the Department of Health guidance. A diverse range of other titles were given, such as ‘health liaison nurse’, ‘health co-ordinator’, ‘nurse advisor’, ‘health project worker’, ‘nurse co-ordinator for Quality Protects’, and perhaps more enigmatically, ‘life chances co-ordinator (health)’.

The nurses were both mature (with average post-qualification work experience of 21 years) and well qualified. The commonest specialist qualification was health visiting (23), followed by school nursing (12). The remainder had community nursing (8) or mental health specialist qualifications (2). A diverse range of additional qualifications of relevance to the health promotion ethos of the role were documented, including family planning (7), nurse prescribing (6) and public health/health promotion certificates (4).

Despite the experienced professional backgrounds of these nurses, over half (25) were supported by short-term funding. The minority of posts that were fully health funded (7) were all tenured except one, whereas this was true for only ten out of 20 jointly funded and three out of 17 fully local authority funded posts. This suggests that local authorities are less likely to commit to long-term funding than their health partners. Recruitment and retention is a major national issue for the nursing profession. The present government has attempted to address this by recognising the advancement of practice with more emphasis on specialist nursing roles, in the hope and expectation

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1Personal correspondence, Kathy Dunnett.

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**Figure 7** percentage of consultations where topic was discussed with young person

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>20%</td>
</tr>
<tr>
<td>STDs</td>
<td>40%</td>
</tr>
<tr>
<td>Contraception</td>
<td>60%</td>
</tr>
<tr>
<td>Drugs</td>
<td>50%</td>
</tr>
<tr>
<td>Solvent abuse</td>
<td>40%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>60%</td>
</tr>
<tr>
<td>Smoking</td>
<td>80%</td>
</tr>
</tbody>
</table>

0 20 40 60 80
of retaining clinical nursing expertise (Department of Health, 1999). The evidence presented here suggests that not all organisations are heeding this policy advice.

The variability of caseload and job content described was striking. While some nurses worked with populations of only 50 children, others had responsibilities for 4,800. However, the median population with whom the nurses worked was 300 and those working with very large populations tended to be employed in a more strategic capacity. Nonetheless the job descriptions of the majority appeared to combine a strategic role with a caseload. On average 25 per cent of time was allocated each to strategy, client contact and liaison, and the remainder divided between training, administration and panel work. All but two respondents had some element of client contact within their job description and all but nine undertook health assessments.

Of concern was the professional isolation of some respondents. Over one-third of the nurses (16) worked without the benefit of a multi-disciplinary team. The lack of a team did not correlate with the size of the population served; indeed eight of these ‘lone’ nurses, who also undertook health assessments, had an average caseload of 390 children each. This is contrary to the 2002 regulatory amendments, which suggest that nurse-led health assessments should be supervised by a registered medical practitioner. For those working within teams it was clear that there was enormous variation in the levels of provision, again with little apparent relationship to the size of the looked after population served. Of the professional colleagues mentioned, 25 per cent were paediatricians, 24 per cent were nursing colleagues, 19 per cent were psychologists or other mental health workers, 23 per cent were social services staff and nine per cent were from education, such as advisory teachers and education officers. A number of respondents alluded to the critical importance of clerical and administrative staff working in a co-ordinating role.

Professional roles and responsibilities of nurses for looked after children appear to have developed to meet local need in response to the strategic drivers of performance monitoring and the need to undertake holistic health assessment. The impetus for the employment of the nurse may well have been to improve access to health care and health outcomes, but organisations may also have been prompted by less altruistic requirements, such as poor returns on the government’s Quality Protects outcome indicators for local authorities, the increasing demands made on pressured medical staff in NHS trusts and on GPs, or the relative economy of nursing rather than medical salaries. These motives may seem less relevant than the importance of the outcome for the vulnerable child, but the motivation for the employment of a professional can influence the demands made upon him/her, and the level or grade of post assigned (grade G up to nurse consultant). This can in turn affect the individual’s authority and power to make the changes necessary to create real and lasting improvements in service delivery. Difficulties can be particularly apparent for nurses working in a local authority, where they may be the only health professional, sometimes with little support or access to good-quality supervision. Knowledge accrued over many years by an experienced nurse is often accepted and acknowledged within an employing health environment, but a lone worker in a new environment may have considerable difficulty negotiating changes in entrenched practice. As one graduate nurse of 28 years experience poignantly noted when asked about continued funding of her post: ‘I have to prove my worth to social services.’

This nurse is working with a population of 375 children, undertaking health assessments, and does not have the benefit of a team of colleagues. It would seem a very tall order to single-handedly reverse years of healthcare failure and simultaneously generate the necessary audit statistics to prove effectiveness.

Conclusion
This article has presented evidence to demonstrate better outcomes and additional quality through nurse-led health
assessments. Nurses nationwide are embracing challenging new strategic roles, developing imaginative health projects and taking on significant caseloads to advocate for and promote health in these vulnerable children. They are a highly skilled professional group and many appear to be working in very demanding roles in the face of insecure funding for their future employment, and sometimes in isolation. There is an urgent need to collate and support the emerging evidence for the effectiveness of these new posts if they are not to fade into history once the dedicated funding available through the government’s Quality Protects and Children First programmes becomes absorbed into mainstream health and social services budgets.

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Rivron M, ‘A health promotion project for young people who are looked after’, Medical Notes, *Adoption & Fostering* 25: 2, pp 70–71, 2001

Note
Champions for Children and Young People in Care can be contacted via the Community Practitioners and Health Visitors Association in London. Tel 020 7939 7000.

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