Four years on: lessons learnt from the implementation of an Integrated Care Pathway to address Promoting Health of LAC guidance (2002) in an English local authority

Background
In 2002, Department of Health guidance entitled Promoting the Health of Looked After Children suggested standards of both content and timeliness of health assessment for children newly looked after. As a result of the consultation a working group was established to look at ways to improve the health situation for looked after children (LAC) in East Berkshire.

Baseline audit
Prior to the publication of the guidance, the three Primary Care Trusts in East Berkshire, with support from the conterminous social services department, undertook an audit looking at the assessment content and a range of indicators. This demonstrated low rates of completed health assessments (62% of those eligible had had a review health assessment), ineffective follow-up of health plans and inadequate basic information on routine health input such as immunisations, where only 32 per cent were recorded as completed, developmental checks (19%) and dental checks in those over two years (54%).

An Integrated Care Pathway (ICP) was developed and featured as an example of good practice in the guidance as Appendix 5. The ICP was based around the guidance premise that all children coming into the care of the local authority should have a holistic comprehensive health assessment by an appropriately trained medical practitioner, and that a health report should be available for the first social services review at one month; also that any actions, and particularly referrals, should be addressed in a timely fashion and that children should not be disadvantaged if they moved out of area.

Most importantly, it incorporated the following timescales for completion of Initial Health Assessments (IHA) and reports based on the guidance consultation and local discussions:

1. notification by social worker to health of admission to care within five days;
2. IHA to be completed within 14 days;
3. report to be sent to the social worker with a health care plan prepared by the LAC nurse in time for the first review at one month.

A team of health professionals was established to develop a better service, including a medical adviser, 1.5 nurse specialists, a mental health nurse and, crucially, an administrator who provides the focus for operations, receiving notifications, arranging the assessments and fielding the paperwork, a task which had previously been managed by social workers, with carers arranging appointments directly with the child’s GP.

The variances from the ICP were reviewed in 2002 and 2004 and demonstrated ongoing problems, not least as our first standard depended on the social workers who had, and still have, great difficulty completing this first task. In 2004, only five per cent of notifications had been received within the five days.

Particular difficulties were identified in arranging timely health assessments and reports from GP practices and achieving complete information. (Only 14 per cent of IHAs in 2004 had been completed within 14 days.) As a consequence, much additional administrative and nursing time were wasted in addressing these issues in an inefficient system.

Response to an inefficient system: specialist clinic for LAC
The team was committed to the idea of a multidisciplinary health assessment involving nurses to provide health promotion and a basic screen for mental health...
issues and a medical practitioner to meet the guidance recommendation for a full medical examination. Although most children will have had some routine input, this is not always guaranteed and examinations still identify unexpected health problems.

Further discussion in the steering group and Slough GP forum established that a dedicated clinic for LAC health assessments would be an acceptable way forward. The resultant clinic, which runs three times a month, is staffed by a rota of medical practitioners with appropriate skills. They include two paediatricians (the medical adviser for LAC and a consultant paediatrician with an interest in child protection) and two named GPs for child protection who alternate in the third clinic. Each clinic is also staffed by one of the LAC specialist nurses, a mental health worker and the administrator as receptionist.

The funding of the doctor’s time has changed from £58.12 per case (BMA recommended fee within Collaborative Arrangements for completion of individual Form IHA, in use prior to publication of new BAAF forms in September 2004) to a sessional rate of £160 per month. (The BMA recommended fee for completion of the new IHA-C or IHA-YP is now £215 per case.) The two paediatricians have reorganised time commitments to the LAC service to incorporate the clinic as part of their work, so that there is no funding issue.

On average, each clinic provides four appointments/sessions lasting three to four hours. The nurses meet the ‘client’, carer and social worker initially, provide health promotion information and weigh and measure them. The mental health nurse attends the appointment with the doctor so that a mental and health history can be explored prior to the actual examination. The clients are asked who they wish to be present at the examination, but chaperonage is an issue when clients decline carers’ attendance and requires further discussion.

Outcomes

The immediate effect of creating this clinic has been the ease with which the administrator can arrange appointments for those placed locally, sometimes within days of notification.

The forms are completed fully and health recommendations are dealt with as soon as possible after the appointment. A health care plan is completed by the nurses and the reports are sent to social workers within 21 days of notification. This meets our own internal timescales, but notifications are still delayed and reports are therefore not always available for the first review. Out-of-county IHAs are still problematic and usually carried out by GPs.

The main issues that have arisen as a result of these clinics are listed below.

Mental health

Not surprisingly, mental health and appropriate support for the children is a major issue. The 2004 audit showed that 43 per cent of our looked after children are over 15 years old (62% over 10) and that only 21 per cent were referred to CAMHS. This was a fall from 38 per cent in 2001 and is lower than the anticipated number given national figures.

Many of the issues we identify at clinic would not meet the threshold for CAMHS support and there are often long delays in providing a service for those who do. Consequently the local authorities have been developing their own mental health provision, of which our mental health nurse is an example. These services would not be considered as CAMHS referrals and may account for the low referral figures. However, this may not be the case and may be a true service deficiency warranting further exploration.

Unaccompanied asylum-seeking minors

The difficulties experienced by asylum seekers generally has been much in the news and the clinic has highlighted those of unaccompanied asylum-seeking minors whose health assessments had not previously been managed by our team. Their needs are much more complex than the clinic anticipated and complicated by age and language issues.
Discussions have centred on the best way to meet the health needs, especially of the over-16s who present as adults in a children’s clinic. There is a real need to promote a specialist service in East Berkshire for all asylum seekers, with a ‘one-stop shop’ approach that includes mental and sexual health.

Data management
The ICP assumed the use of a database to monitor the variances from it. A stand-alone Access programme was established and came into use once the administrator took up the post. As with any system, the data produced are only as good as the input and this has been hampered by changes and gaps in staff, by the complexity of the programme and the formulae used, which calculated all following timescales from admission into care. Thus time variances from the ICP are inevitable because of the delay in notification.

However, and most importantly, every child now has a file in the administrator’s office. It contains all the health assessments reports and is available for review assessments including those for pre-adoption/long-term fostering. The latter paperwork is also now filed in the LAC file.

Prior to the audit in 2001, the reports used were an outdated Berkshire version and one of the recommendations was to use the BAAF forms and health plan, which was implemented. However, the old BAAF forms did not fulfil the team’s expectations and an East Berkshire form was developed and used.

Since BAAF (2004) has developed the new set of forms, the recommendations of Practice Note 47 (consent, parent health history forms and obstetric and neonatal forms to be completed when a child comes into care and to be available for the IHA) have been incorporated into the ICP. It remains to be seen whether the current health and social services systems will be able to cope. To be more realistic, the timescale for completion of assessments has been changed to 21 days.

Summary
The East Berkshire health team for looked after children has provided a focus for meeting the health needs of LAC in East Berkshire. Initially, health assessments were based around a GP assessment but this has not been very successful in terms of timescales and ensuring children’s needs are met, not least because of their frequent moves. In addition, the health needs in this group are better met by a paediatrician or doctor who regularly provides such a service, rather than a GP who may only carry out one such assessment a year.

The team considered that setting up a specialist clinic would better address these issues and has found that the clinic has improved the service provision. It is still in its infancy and should evolve to accommodate review assessments and further opportunities for health promotion.

The development of the clinic has highlighted some issues which had not previously been obvious, not least the plight of young asylum seekers and the need for a holistic service for these young people and adult asylum seekers in East Berkshire. Discussions are ongoing.

The Integrated Care Pathway is being adjusted to reflect these changes, new guidance on adoption and fostering and the new BAAF forms. As with any ICP, variances will continue to be monitored and will shape future service provision.

References
BAAF, Using the BAAF Health Assessment Forms, Practice Note 47, London: BAAF, September 2004

Department of Health, Promoting the Health of Looked After Children, Guidance, London: DH, 2002