Implementation of health recommendations after initial statutory health assessment

The Department of Health guidance document, *Promoting the Health of Looked After Children* (2002), acknowledges the importance of a multi-agency approach in ensuring that the health needs of this vulnerable group of children are met. The statutory health assessment forms the basis for identifying health problems. Current requirements are for an initial health assessment within four weeks of entering the care system, followed by a bi-annual health assessment for all looked after children (LAC) under age five years and annually for those over five.

Our service is based in a health centre in an ethnically diverse area of inner London. Initial health assessments (IHA) are usually undertaken by a consultant paediatrician, staff grade doctor or paediatric specialist registrar. Where a child has been placed outwith travelling distance of our clinic, the GP is asked to undertake the health assessment and return to us. We use the BAAF Form IHA for the assessment and to formulate a summary, health care plan and recommendations for action. This is then sent to the social worker and copies sent to the carer or young person, GP and health visitor or school nurse. It is ultimately the social worker’s responsibility (as the corporate parent) to ensure that the recommendations are carried out.

The number of LAC in our borough has fallen significantly in the last three years and currently stands at 272 (approx 68 per 10,000 children and young people < age 18), with 392 being the total number of children looked after in the year 2008–09. Of these, 75% are in foster placements and up to 70% are in placement outside our borough boundaries. Approximately 10% are unaccompanied minors.

The percentage of LAC undergoing statutory health assessment has risen steadily from 79% in 2003 and now regularly exceeds 90% on a month-by-month basis. Our study was prompted by concern that the high uptake rate identified by the local authority performance monitoring system was providing false assurance that the children in our care system were receiving the health care they need. At the time of the review health assessment (RHA), it is often unclear whether a particular health recommendation has been implemented. This occurs especially when the child has attended his or her GP for the RHA and no mention of previous recommendations is made on the RHA form, or when there has been a change in carer. Furthermore, the reported performance figures relate only to children who have been looked after for a year or more. Many children in our area undergo initial health assessment and then return home or are placed with family members.

**Aim of the study**

1. To ascertain whether the recommendations in the health care plan for children undergoing initial health assessment had been implemented within a six-month timescale.

2. To identify whether there were difficulties in implementing specific types of recommendation and possible reasons for these.

3. To suggest ways in which the implementation rate could be improved.

**Methods**

A retrospective review was undertaken of individual case files of all LAC undergoing initial health assessment between January and June 2007. Fifty-one children and young people were
identified. The health care plan arising from the IHA was reviewed and information pertaining to each health recommendation was obtained from the case file where documented, and otherwise from the social worker, carer, health visitor, GP, young person, etc.

Exclusions:
- Recommendations which were primarily the remit of other agencies, e.g. education services.
- Recommendations that were ongoing and non-specific, e.g. ongoing routine developmental review of a normally developing child.

Health care plan recommendations were categorised as follows:
- Immunisations: obtaining history and/or administering outstanding immunisations.
- Referrals for eye/hearing checks.
- Request for information on birth or past medical history from GP/health visitor/school nurse.
- Request for information from social worker on parental history.
- Miscellaneous, e.g. referrals to therapy or hospital services.

Results
Of a total of 101 specific health recommendations, only 54 were carried out (53.5%) (see Table 1).

We identified obtaining immunisation details and parental health histories as the main problem areas.

Immunisation data
At the time of the IHA, 38/51 children had outstanding immunisations. After a six-month period, 16 of these 51 had documented evidence of receiving the immunisations recommended. Eight children had definitely not received them, and in three of these cases we had written to the wrong GP, as the contact details we had were incorrect. In a further 14 children, it was not possible to obtain updated information despite repeated written and telephone requests to health visitors, GP surgeries and social workers, i.e. recommendations may have been followed but confirmation was elusive. There was particular difficulty in obtaining information regarding unaccompanied minors (see below).

Past medical history
A total of 3/51 children were not registered with a GP. Past medical history (PMH) details were available at the time of the IHA for most children or were obtained shortly thereafter. In the three cases where the PMH was not obtained, we had written to the wrong GP surgery

Table 1
Total results

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Total recommendations/ requests/referrals (N = 51)</th>
<th>Yes: action carried out and/or information obtained</th>
<th>No: action not carried out or information unobtainable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisations outstanding</td>
<td>38</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>Past medical history obtained from GP when requested</td>
<td>13</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Parental medical histories obtained after request</td>
<td>18</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Vision referrals</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Hearing referrals</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>19</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>54</td>
<td>47</td>
</tr>
</tbody>
</table>
because the details we had were incorrect.

**Parental history (PH) forms**

Only two out of 13 requested forms were received. In the cases of nine children, the PH form for at least one parent was available at the time of the IHA. In a further 24 cases, it was not pursued because the child/young person was returning home, or because it had been obtained previously (sibling already in care) or because it was not applicable (unaccompanied minors). Often, blank forms were received from the social worker, indicating a misunderstanding of the procedure.

**Referrals for further audiological or ophthalmology assessments and attendance at appointment**

Nine children were referred to an eye or hearing clinic and six of these successfully attended. The appointments for two children were sent to the wrong address and wrong GP (due to placement moves). One refused to attend.

**Miscellaneous items**

Of 11 direct referrals by the medical adviser for further investigations or to a clinic, nine were successfully completed, one appointment had been sent to the wrong address and one refused to attend. Four children were to have GP follow-up for health problems: two attended, the others had changed GP and the outcome is not known. Information on parental heights was requested for two children with short stature (one obtained). One recommendation was for the health visitor to monitor weight and growth – no feedback was obtained and the child moved.

**Referrals to Child & Adolescent Mental Health Services (CAMHS)**

Although a recommendation for counselling or other mental health services input is frequently made on the health care plan, we did not include this in the audit because we know that many children are referred directly by the social worker. However, we were rarely informed of individual referrals or outcome.

**Unaccompanied minors (UM)**

Of the study population, 13 were unaccompanied minors from Afghanistan, Eritrea and Ethiopia. The following table provides a summary of results for this group.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Total</th>
<th>Yes: action carried out</th>
<th>No: action not carried out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisations</td>
<td>13</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>GP review</td>
<td>11</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Other/referral (e.g. x-ray, blood tests, eye clinic, counselling)</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Unaccompanied minors (almost) invariably have no immunisation record. They therefore require a ‘catch-up’ course of immunisations, as stated in World Health Organisation guidelines for the vaccination of individuals with uncertain immunisation status. We identified an unacceptably high failure rate in the uptake of immunisations amongst this group.

Particular difficulty was encountered in obtaining follow-up information from this group of young people. Few were registered with a GP at the time of the IHA. When GP details were obtained, the young person was rarely known to the GP or had changed GP since the IHA. The social worker rarely had the required information and it was very difficult to contact the young person directly.

**Discussion**

Our finding that only 51% of specific health recommendations had been implemented is similar to that of a previous study by Hill and Watkins (2003) in which 51% of health recommendations were acted upon. The main problem areas that we identified were:

- GP records in transit;
- incorrect GP details;
• obtaining family health histories;
• ensuring immunisations are up to date;
• information not passed on to health team where recommendations had in fact been actioned.

When a child moves placement, he or she may be registered with a new GP on either a temporary or a permanent basis. Social workers and carers are strongly advised to ensure that children are registered permanently, but there remains a reluctance to do this when the placement is thought to be short term. A child’s previous records will be forwarded to the new GP only if they are registered permanently and this can take up to three months. The procedure for temporary records is for these to be returned to the local health authority and then forwarded to the permanent GP record, but a significant delay will inevitably be incurred. We routinely send a request to the GP for past health history but delay in obtaining information arises during the period when records are in transit.

Furthermore, GP details held by the LAC health administrator were frequently incorrect because changes of GP address were not routinely passed on. A copy of each health care plan is sent routinely to the child’s GP and a separate letter is sent to inform the GP of any recommendations that he or she will be responsible for. Sending these to the wrong GP practice will clearly result in missed hospital referrals, missed immunisations and difficulty in obtaining past medical histories. In addition, hospital or other health appointments will be missed if appointments staff are not made aware of changes in placement address.

Parental physical or mental health problems, a family history of genetic disorder or a history of developmental/learning problems can all have implications for the child’s present or future health. Obtaining the family health and educational history is particularly important for children who are going to be placed permanently outside their birth family and provides vital information towards understanding a child’s subsequent emotional, developmental or physical health problems. It is important for social workers and birth parents to note that negative information (i.e. that there is no family history of note) is equally valuable. The difficulty in obtaining this information from birth parents who are not engaging with services is frequently cited by social workers and is acknowledged. However, it must be noted that up to 75% of adopters in an Adoption UK study in 2008 (Hill and Edwards, 2009) felt that lack of information about their child’s birth family history had been an issue.

In addition to the practical aspects noted above, the study highlighted the importance of family history as forming part of a child’s identity.

Of those recommendations that were carried out, many had not been recorded in the LAC health file as the information had not been forwarded to the health team. For example, immunisation updates had to be obtained in each case by telephoning and writing to carers, social workers, GPs or health visitors. Furthermore, a number of recommendations had only been actioned after reminder emails and letters were sent by the LAC health team.

Following up health recommendations is a particular problem in our area as two-thirds of looked after children are placed outside the borough boundaries, and responsibility for provision of health care services therefore transfers to a different health authority.

**Recommendations and service developments**

The results of this audit were discussed with Looked After Children team managers and a number of recommendations were made. Changes within the local authority since this audit have also facilitated information sharing and liaison with our social work colleagues, including the formation of specialist Looked After Children’s teams and co-location of both teams on one site, adjacent to our service base.
Access to the local authority database
This has been in place for LAC health staff since 2008 and has been extremely helpful. It means we have up to date information on placements, GP details and other services involved with the family (for example, CAMHS), avoiding duplication of referrals. We are also able to view minutes of the local authority statutory LAC reviews, which include a section on health. Consideration of the LAC review health section is a particularly useful method of corroborating and complementing the information received on out-of-borough children whose health assessments are undertaken by a GP and, in some instances, identifying information that is misleading or incorrect.

Improving uptake of immunisations
The social worker retains responsibility for ensuring that the child attends his or her GP surgery or health visitor for outstanding immunisations and should forward the updated details to our team, as well as entering them on the local authority database. Because of the appallingly low uptake of ‘catch-up’ immunisations among unaccompanied minors, we now refer these young people to our LAC nurse adviser, who ensures that the necessary course of immunisations is completed.

Parental health histories
• Parents are encouraged to attend the initial health assessment, which we find to be the best way to obtain past medical and family health histories. In addition, it gives the parents an opportunity to understand the process and answer queries they may have about their child.
• We have met with the LAC teams to raise awareness among social workers of the importance of family health histories and to explain the procedure for completion of the parental health (PH) form.
• The permanency panel agenda is sent to the medical adviser four to six weeks in advance of each panel so that outstanding PH forms can be chased up.

Improving clinic attendance and sharing information on outcome
All clinic referrals made by our team are copied to the social worker. Clear responsibility and the timescale for each health recommendation should be stated on the health care plan. In the event of a placement move, the social worker should inform the LAC health team of any outstanding clinic appointments where a further referral is required. Where our team has not been involved in making a referral, details of health appointments and their outcomes should be forwarded to us by the social worker, as soon as received from the carer or hospital clinic.

Other initiatives instituted to improve liaison and health outcomes
• A monthly list of children discharged from the care system is sent to the LAC health team. The case files are reviewed and a discharge form is returned to the social worker which lists any outstanding health issues.
• Quarterly meetings take place with the social services Disabled Children’s Team to review the health needs of individual looked after children who have disabilities and to advise on problems that have arisen.
• A monthly multi-agency meeting to discuss individual pre-school looked after children is being set up from June 2009. This will include the medical and nurse advisers and representatives from education, the early years intervention team, child psychiatry and social work. The aim is to ensure the recognition at an early stage of complex developmental and behavioural issues in young children, so that appropriate interventions can be put in place in a timely manner.
• The Independent Reviewing Officer should ensure that a copy of the child’s most recent health assessment is
available at each LAC review. Sending copies of all health assessments directly to the reviewing officer has also been proposed.

**Summary**
The responsibilities of all agencies to work together to improve the health outcomes for looked after children are clearly documented. In our area we use the BAAF health assessment form IHA as a framework for identifying health problems and making recommendations for action. However, we found that almost half of these recommendations had not been implemented. This audit highlights the danger of relying on process measures rather than focusing on outcome. We have identified some particular areas of difficulty and have worked closely with our colleagues in social care to make improvements. We plan to undertake a re-audit in 2010.

**References**

Hill CM and Edwards M, ‘Birth family health history: adopters’ perspectives on learning about their child’s health inheritance’, *Adoption and Fostering* 33:2, pp 45–53, 2009


**Acknowledgements**
Data collection for audit and analysis of results by Dr G Ikegwu, staff grade doctor; Dr B Klepacka, senior house officer; Dr O Hayes, specialist paediatric registrar; and Dr G Croft