HEALTH NEEDS ASSESSMENT OF CHILDREN IN CARE IN KENT APRIL 2015

This report uses information from work done by Dr Alexis Macherianakis, Consultant in Public Health Medicine and Emily Silcock, Public Health Information analyst in October 2014. Their report was updated by Jill De Paolis and Colin Thompson in March 2015, and finally by Geoff Gurney, Interim Assistant Director for Corporate Parenting in April 2015.

Also in April, Thom Wilson produced Kent County Council's Sufficiency, Placement and Commissioning Strategy 2015 – 2018 and up to date facts and figures for Kent children in care have been transcribed into this document.

Please note, throughout the strategy different data sets are used and the timeframes to which this data refers can vary.

About Kent

Kent is a shire county located in the south east of England. It has a total population of just over 1.48 million (ONS 2012). According to the 2011 census, 322,743 (22%) are aged 0-17 years old. The age profile is similar to that of England. However, Kent has a greater proportion of younger people aged 5-19 years. Kent has the largest population of all English counties and over the last ten years, the population has grown faster than the national average, increasing by 7.8% between 2000 and 2010. This is above the average for both the south east (6.7%) and England (6.1%).

Parts of Kent share the affluence of the south east of England region and, overall, Kent ranks as the 51st least deprived local authority. However, some areas of the county are amongst the most deprived in the country. While almost three-quarters of the county is rural, most people live in the main 26 towns, the largest of which is Maidstone.

Some 17.3% of Kent's children were living in poverty in 2010 (IDACI) , the majority in lone parent households claiming income support and job seekers allowances, although poverty among those in low paid employment is an increasing concern. The districts of Thanet, Swale, Shepway, Gravesham and Dover have the highest percentage of children living in poverty. Kent's population is largely of white ethnic origin. Children and young people from minority ethnic groups account for 9.4% of the total under 18 years old population.

Within the county boundary are 12 district councils and one unitary authority (Medway council). The districts are divided in West, North, East and South Kent areas:

- East Kent districts are Canterbury, Swale and Thanet
- South Kent districts are Ashford, Dover and Shepway
- North Kent districts are Dartford, Gravesham and Sevenoaks
- West Kent districts are Maidstone, Tonbridge and Malling and Tunbridge Wells

INTRODUCTION

Acknowledgments

- All members of the health needs assessment of looked after children steering group for offering their time and advice and helping to shape the draft report
- All those who agreed to be interviewed and share their knowledge and experience from their work with looked after children
- Both UASC service and Catch 22 16+ for organising the focus groups with UASCs and care leavers
- Kent Children in Care Health and Wellbeing Group for acting as a focus group
- Public health team and Director of Public Health for their support and advice
- Emily Silcock and Del Herridge for their significant contribution in the data collection and analysis
- Viki Morgan and Sam Gentry-Marshall for their invaluable support in transcribing the interview recordings
- Helen Buttivant for setting up the steering group and developing the project outline

Methodology

Throughout the report, the terms 'children in care' and 'looked after children' are used interchangeably. The report provides information on the demography, placements, geographical distribution, legal status, about care leavers, education, NEETs, offending, health status and health services and specific groups of looked after children such as those with disability, UASCs, care levers, ceased to be looked after and looked after children placed in Kent from other local authorities (OLAs).

Children placed for adoption was not a focus of this report.

For the most part the report provides the latest available information about children in care that was for Kent the year ending 31st March 2014 (unless otherwise stated) and for England for the year ending 31st March 2013. The latest available Information for trends is provided for the last five years (in most cases 2009/10 to 2013/14) (unless otherwise stated). In some cases, there is variation in the number of years reported due to variation in the number of years data is available. The maximum number of years available is reported.

As a corporate parent, Kent County Council (KCC) is ambitious for the children and young people in its care, and is focused on them achieving the best possible outcomes. The lifting of the Notice to Improve Safeguarding and Children in Care services (in place since early 2011) in November 2013 validated the progress the council has made but it is not enough for our Children's Services to 'require improvement'. The aspiration is for KCC Social Care to continue to improve the service provision offered to all our service users and aim to provide an 'outstanding' quality of care.

Since the requirement for a sufficiency strategy was first introduced by Government in 2011 Kent has undergone significant change: numbers of children in care and care leavers have risen, financial challenges have intensified, the political landscape in Kent has changed and legislative changes have presented additional challenges. This report has been able to use this most recent work to include updated facts and figures when this has been possible.

Interviews and focus groups of interested parties and stakeholders

For the purposes of this health needs assessment for children in care, the following professionals were interviewed:

- KCC UASC service - manager
- KCC commissioning manager for specialist children's services (including CAMHS for LAC and 16+ services)
- KCC county manager for disabled children
- KCC Virtual School Kent service manager
- KCC management information unit – manager
- KCC public health information analyst
- KCC public health specialist
- KCC public health consultant
- Designated doctor for looked after children
- Designated nurse for looked after children
- KCHT nurses for looked after children (three)
- KCHT community services director
- KCHT health coordinator for looked after children
- Catch 22 (Kent care leavers service) – operations manager
- Sussex Mental Health Partnership – CAMHS for looked after children – manager
- Commissioning support unit – associate for vulnerable children
- Medway Council – Consultant in Public Health

The following groups were interviewed:

- UASC focus group. A focus group with UASCs was organised by the Kent UASC service in Millbank reception and assessment centre. Originally, 6-8 UASCs were invited to attend, but only two attended.
- Care leavers focus group. A focus group with care leavers was organised by Catch 22 16+ service in Ashford.
- Kent Children in Care Health and Wellbeing Group – focus group. The participants represented Commissioning Support Unit (CSU), UASC service, nursing team for looked after children, designated nurse for looked after children, KCC LAC team, Virtual School Kent (VSK)

Epidemiology is the science that studies the patterns, causes, and effects of health and disease conditions in defined populations. It is the cornerstone of public health, and informs policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare.

The National Institute for Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) produced guidance on looked after children and young people in October 2010 which has subsequently been updated. This Health Needs Assessment follows the same principles as the guidance in considering the health of this very vulnerable group of children in a holistic way based on consideration of the wider determinants of health.

CONTENTS

SECTION 1: KENT CHILDREN IN CARE

Section 1 starts with a look at some facts and figures about children in care in Kent compared with children in care in statistical neighbour authorities, the South East of England and all England: age; gender; ethnicity; placement; geographical distribution; legal status.

Some groups of children and young people are disproportionately represented in the looked after population or have particular needs; this includes black and ethnic minority groups, unaccompanied asylum seeking children, those who are gay or lesbian, and those who may have been sexually abused or exploited. Services should be sufficiently diverse and sensitive to meet the needs of these groups.

Section 1 continues with a look at: Care Leavers; Offending; Unaccompanied Asylum Seeking Children; Children from Other Local Authorities.

Stable education built on high aspirations is essential to promoting the quality of life for looked-after children and young people. Transition to adulthood for children in care can often be traumatic. Without access to services to support this transition young people can end up unemployed, homeless or in custody, experiencing a downward spiral of rejection.

Section 1 concludes with a look at the Education of Kent children in care.

SECTION 2: HEALTH

The importance of secure attachments and establishing a sense of permanence in a child's life cannot be overestimated when considering their health and well-being. A child's need to be loved and nurtured is fundamental to achieving long-term physical, mental and emotional wellbeing.

Promoting the quality of life for looked-after children and young people depends on how well organisations, professionals and carers work together to ensure children and young people looked after experience high quality care, stable placements and nurturing relationships that reinforce a sense of belonging.

Section 2 starts with a report on the statutory health checks as immunisation, dental checks, and health assessments.

Next there is a report on the **Strengths and Difficulties Questionnaire** expected for all children looked after. The process of delivering **health assessments** is presented together with a review of **patient satisfaction**. There is more information about **health assessments** and a focus on the work of the **Child and Adolescent Mental Health Services (CAMHS)**.

Section 2 concludes with a brief look at Drug and Alcohol issues, and Disability.

SECTION 3: THE FINDINGS

Section 3 reports the main findings, including themes and concerns from the interviews and focus groups, and concludes with recommendations for action.

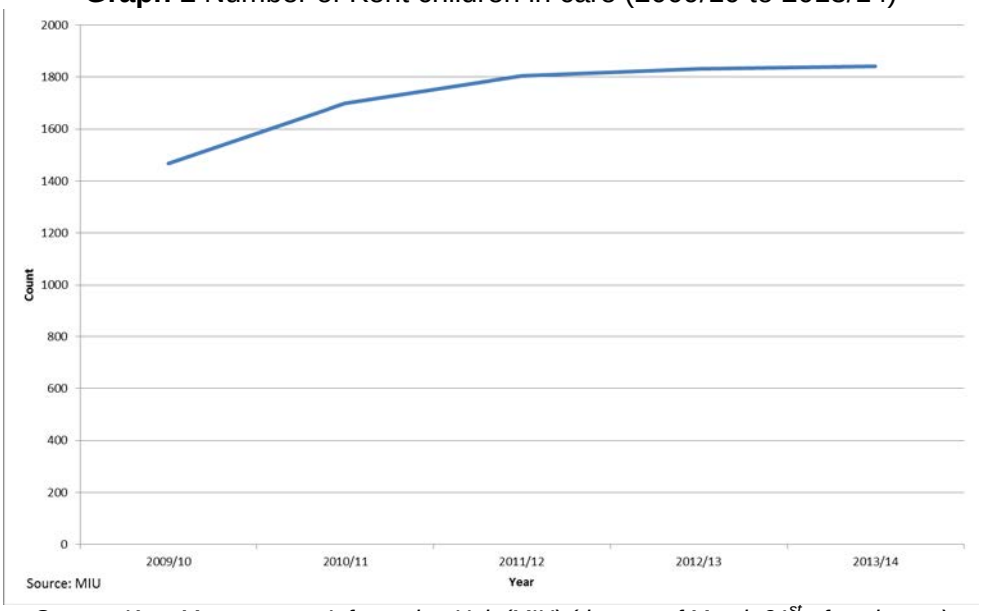
There are 3 Appendices to the report: 1. Supplementary statistics that are referred to throughout Section1; 2. Detailed findings from the interviews; 3. Detailed findings from the focus groups.

1. KENT CHILDREN IN CARE

1.1 Numbers

Kent children in care includes Kent children placed both within and outside of Kent. There was a 25% increase in the number of Kent children in care between 2009/10 and 2013/14. The biggest increases were observed in the first three years of this time period, with numbers stabilising from 2012/13 onwards (Graph 1). In 2012/13, the number of looked after children across England increased by 12% compared to 2008/09. The number across England has increased steadily each year and now is higher than at any point since 1985.

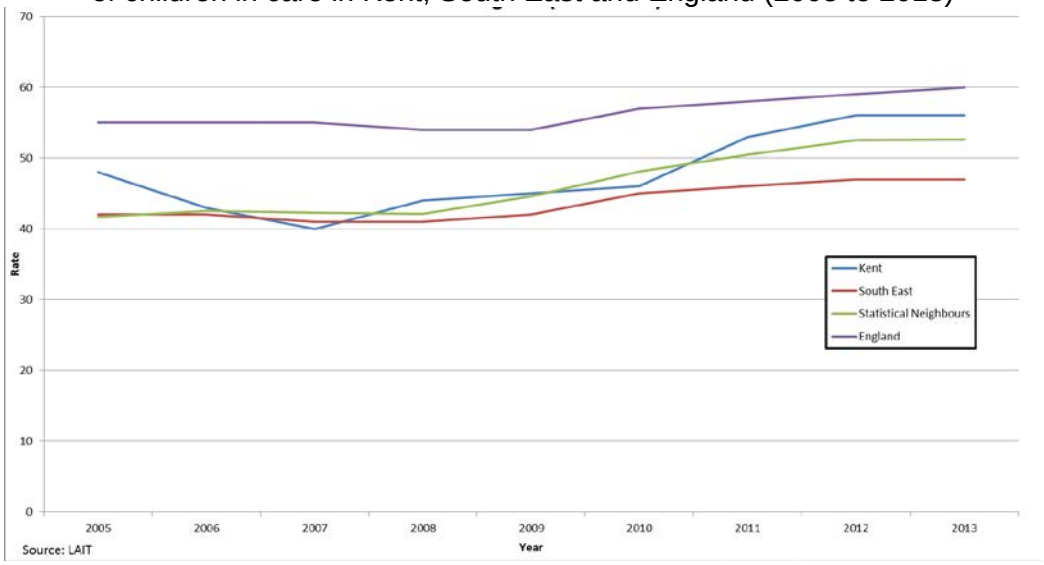
Graph 1 Number of Kent children in care (2009/10 to 2013/14)



Source: Kent Management Information Unit (MIU) (data as of March 31st of each year)

The rate (per 10,000 children aged under 18 years old) of Kent children in care has increased from 2007 to 2013; however it has been consistently lower than the national rate (Graph 2). This difference is not significant

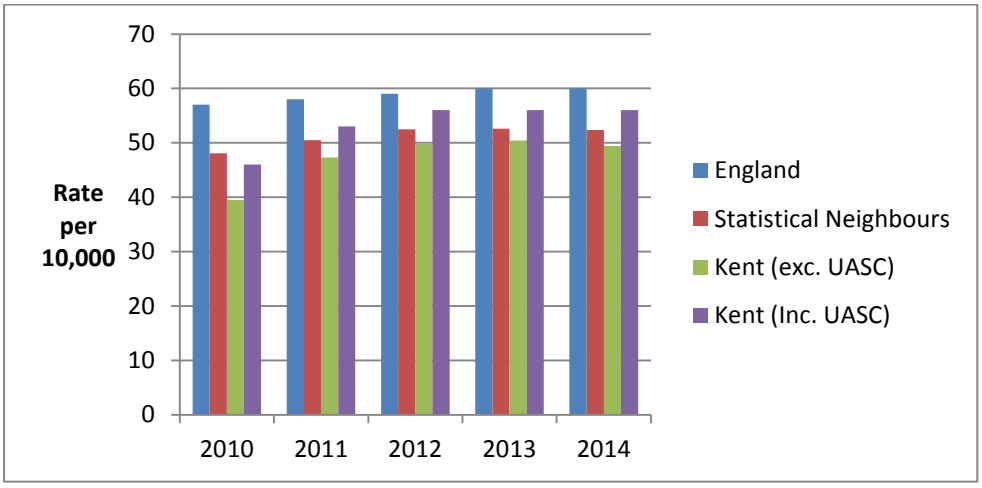
Graph 2a Rates (per 10,000 children aged under 18 years old) of children in care in Kent, South East and England (2005 to 2013)



Source: LAIT = Local Authority Interactive Tool for comparing data about children and young people across all local authorities in England

The latest available data for Kent gives a rate of 56 children in care per 10,000 children including asylum seekers. This drops to 49 per 10,000 (below the rate of our statistical neighbours) if asylum data is not included.

Graph 2b Children in Care rate per 10,000, comparison (2010 – 2014)

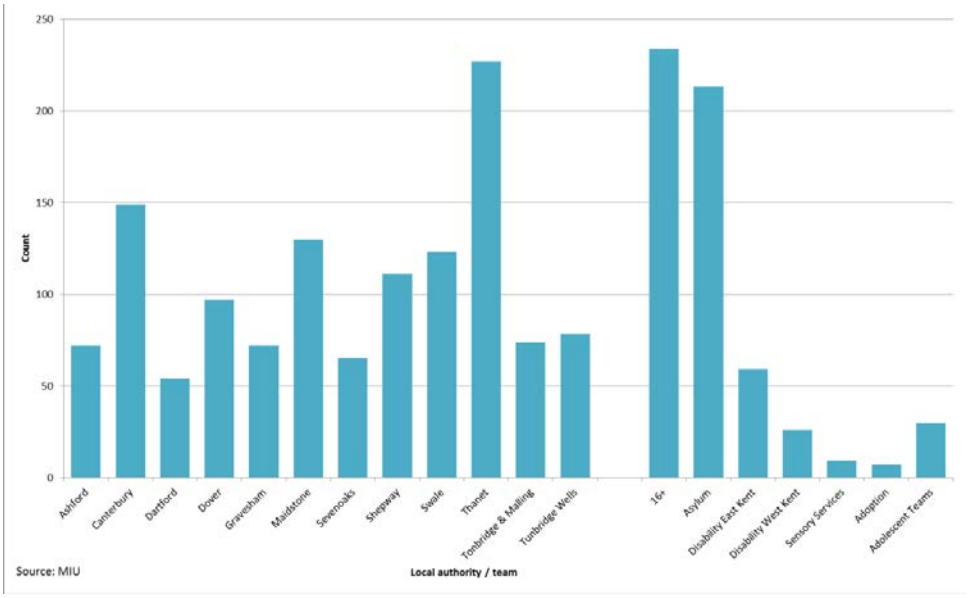


Source: Sufficiency, Placement and Commissioning Strategy 2015 – 2018

At the time this health needs assessment started (October 2014) Kent children in care were supported by district level social care teams or Kent wide teams as Catch 22 16+, the Service for Unaccompanied Asylum Seeking Children (SUASC), Disability, and Adolescent teams. In September 2013, 234 children were supported by the Catch 22 16+ service and Thanet had the highest number (277) of children in care. The SUASC supported 213 children (Graph 3).

Graph 3 Number of Kent children in care by district and local service (Sept 2013)

Source: Kent



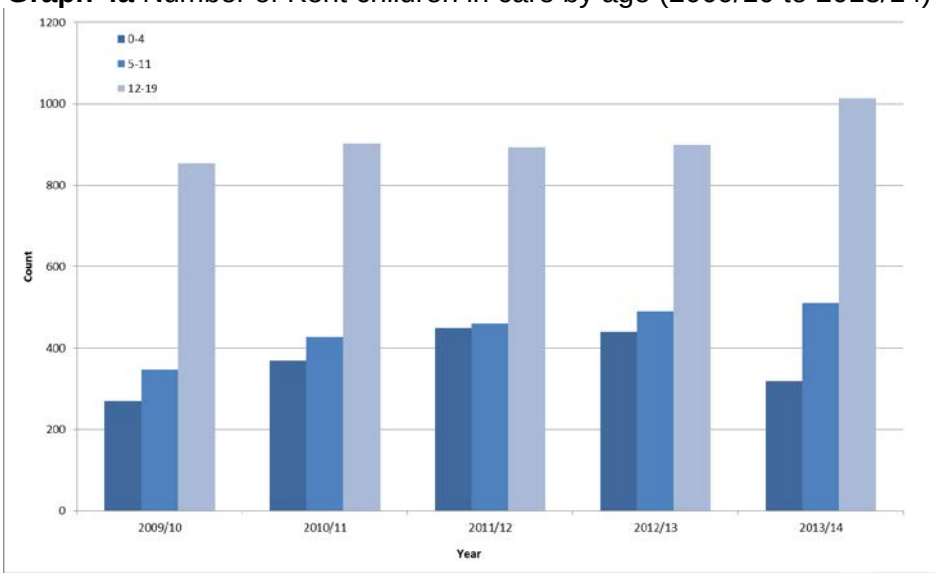
Management Information Unit (MIU)

Kent currently has a children in care population of 1,881 (December 2014), with the population steadily increasing over the last 5 years. Having been below its statistical neighbour levels up until 2010, there was a sharp increase in the rate per 10,000 after this point (see Graph 2a). This may have been as a consequence of the outcome of the 2010 OFSTED inspection, but also an increase in the numbers of Unaccompanied Asylum Seeking Children who arrive in Kent via the port of Dover.

1.2 Age

The number of children aged between 12 and 18 years old, who are in care has increased over the past five years (reflecting the national trend that children increasingly leave care at a later stage), as has the number of 5 to 11 year olds. The number of children aged between 0 and 4 years old increased between 2009/10 and 2011/12; however it has decreased in more recent years (Graph 4a). This is partly explained from the observed increase in the number of children being adopted in this age group.

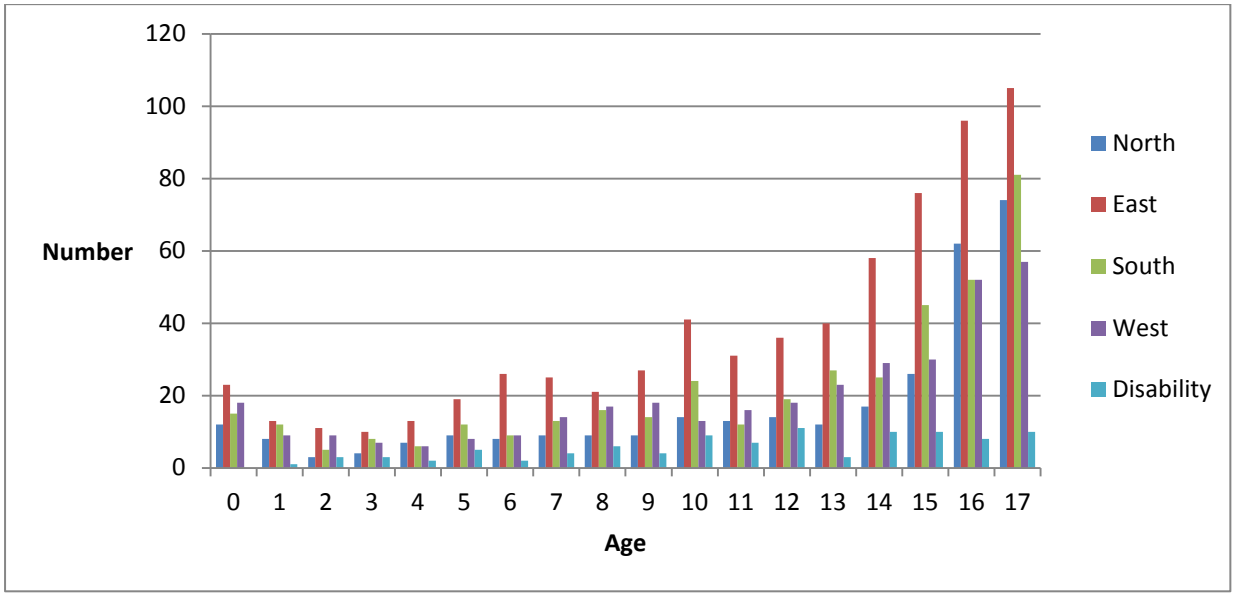
Graph 4a Number of Kent children in care by age (2009/10 to 2013/14)



Source: Kent Management Information Unit (MIU)

The geographical and age profile of children in care in Kent is shown in Graph 4b. It is clear that the highest number of children in care come from the East of the county, where there is most deprivation. It is also clear that the numbers of children in care dramatically increase in the older age ranges.

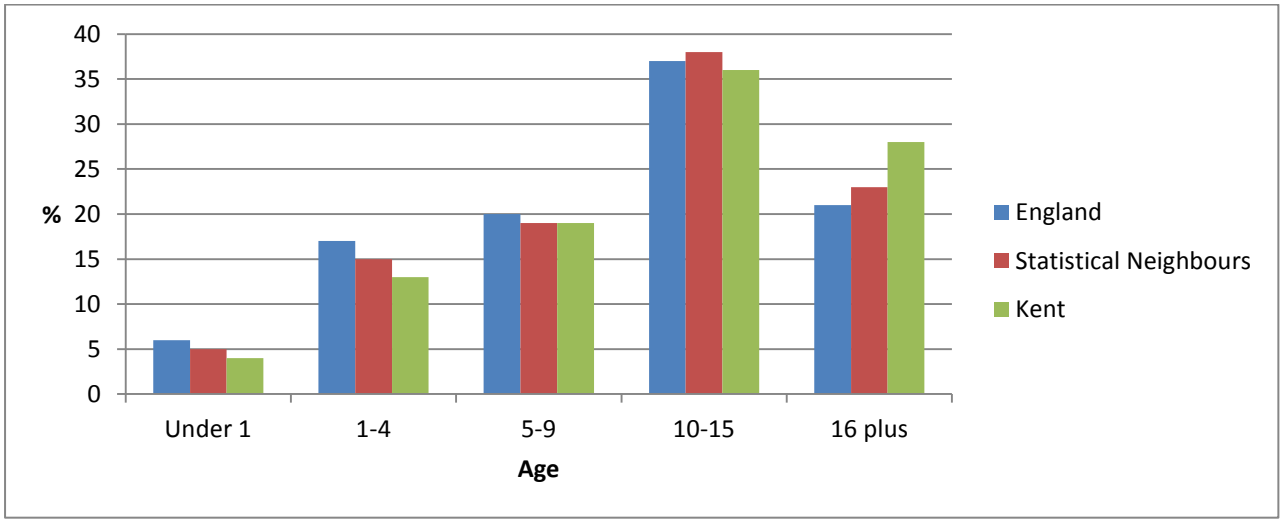
Graph 4b Age profile of Children in Care in Kent, by area (including disability)



Source: Sufficiency, Placement and Commissioning Strategy 2015 – 2018

Kent's children in care population broadly mirrors national and statistical neighbour trends. However Graph 4c shows that Kent has a significantly higher proportion of children in care aged 16 to 18.

Graph 4c. Age range of Children in Care comparison



Source: Sufficiency, Placement and Commissioning Strategy 2015 – 2018

1.3 Gender

Approximately 40% of Kent children in care are female, and this has remained stable over the past five years. The only district or local team with over 50% of children in care being female is Shepway.

The Unaccompanied Asylum Seeking Children (UASC) service supports the lowest percentage of female children in care, with only 14 female children (September 2013) compared to 199 male UASC children in care (see appendix graphs 44 and 45).

1.4 Ethnicity

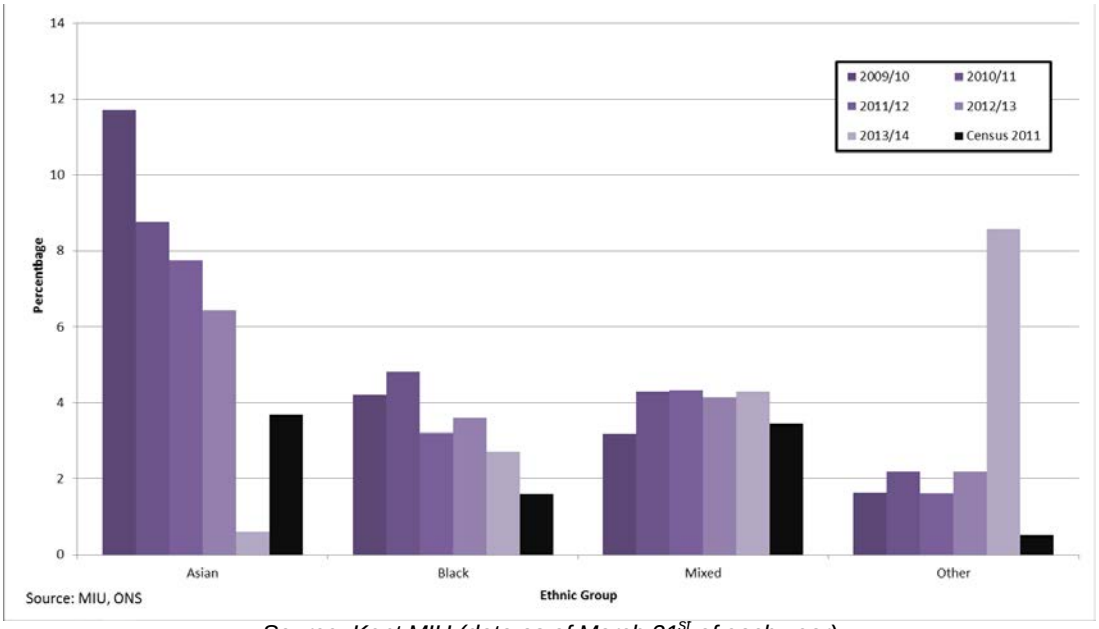
The ethnic profile of Kent's 0-19 population has changed since the 2001 census. Black and minority ethnic communities now account for just over 12% of the population (2011 census), an increase of 6.4% since 2001. This is reflected in the ethnic profile of children in care, with a particular increase in the number of Black, African, Caribbean, Black British and mixed heritage children in care.

The percentage of Kent children in care from a white British background has increased (from 78% in 2009/10 to 84% in 2013/14), and it is lower in comparison to the 2011 census for Kent (91% of 0 to 18 year olds were of white British background). This figure was 74% for looked after children across England (March 2013) where the ethnic breakdown has varied little since 2009.

The percentage of Kent children in care with an Asian ethnic background decreased (from 12% in 2009/10 to 1% in 2013/14), whilst the percentage of children recorded as having 'other' ethnicity has increased (from 2% in 2009/10 to 9% in 2013/14), due to changes in recording ethnicity (Graph 5a).

The percentage of Kent children in care from mixed ethnic background has remained relatively stable over the last five years, and is above this group in the general child population. The percentage of children in care from black ethnic background has decreased, but again is higher than this group in the general child population.

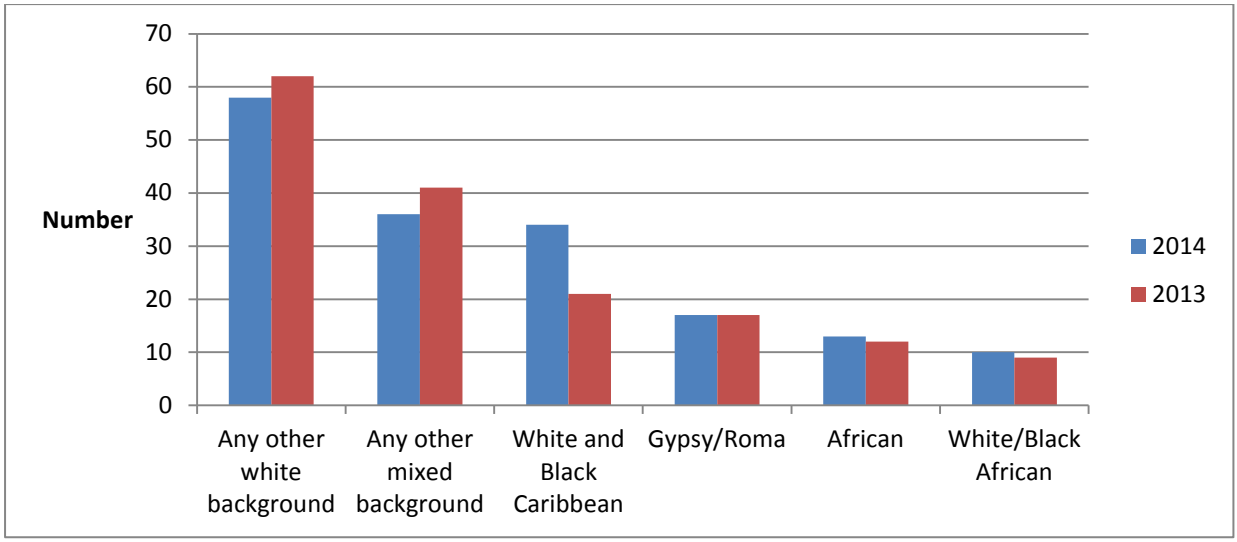
Graph 5 Kent children in care (%) by ethnicity (2009/10 to 2013/14) in comparison to census data for 0-18 years old in Kent (2011).
The percentage of Kent children in care of white British background is not shown.



Source: Kent MIU (data as of March 31st of each year)

Of the 1,530 children in care in Kent in February 2015 (not including UASC), 1335 are white British. The remaining 195 children in care are made up of 17 different ethnic groupings with the 6 largest groups shown in Graph 5b.

Graph 5b Ethnic breakdown of Children in Care population by number



Source: Sufficiency, Placement and Commissioning Strategy 2015 – 2018

Although the ethnic minority children in care population has remained broadly stable over the last 2 years, it should be noted that the reduction in overall numbers (94) in the last year would appear to have come from the 'white British' population which has reduced by 97 in the same period.

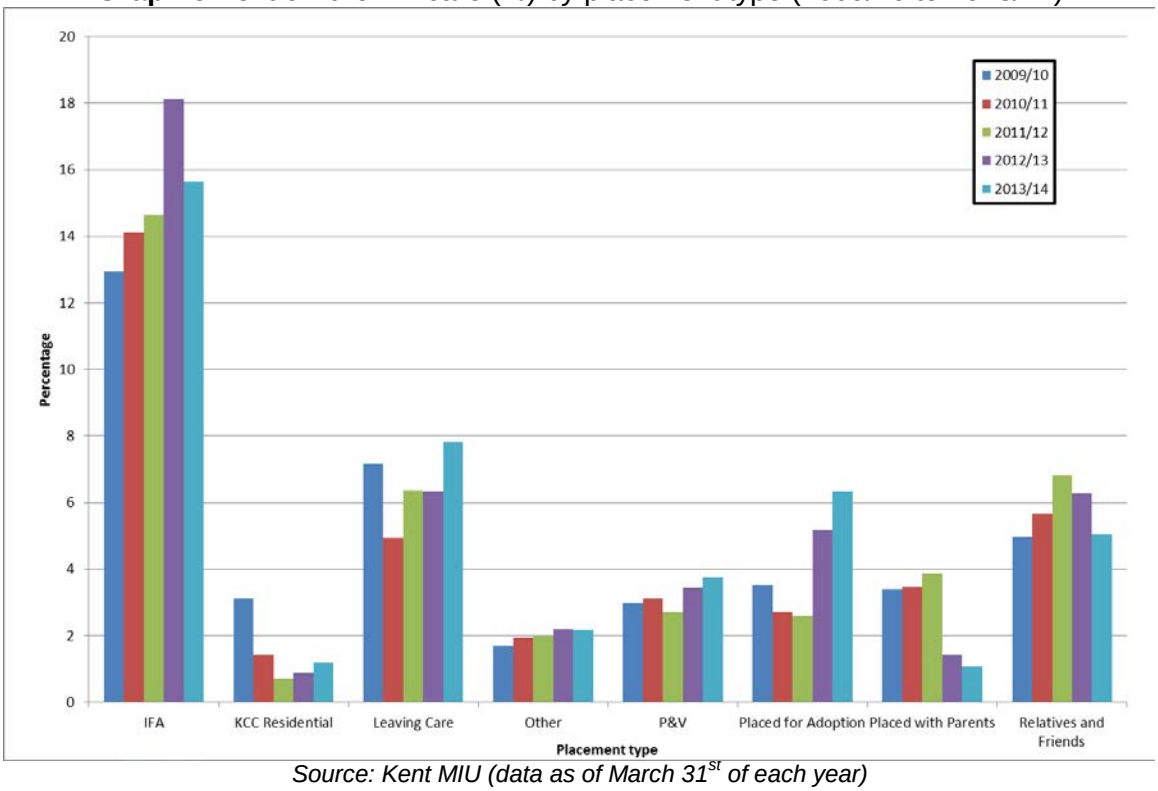
1.5 Placement

The majority of children in care are placed with Kent County Council 'in-house' foster parents (highest in 2010/11 at 63%). 884 children were placed with in house foster carers in 2009/10, increasing to 1049 in 2013/14. An increase of 19%, but a lower rise than that in overall number of looked after children in the same period. Independent Fostering Agencies (IFA) have the second highest percentage of children in care.

Over the last three years, there has been an increase in the number of children placed for Adoption (from 47 in 2011/12 to 117 in 2013/14), whilst the number of children placed with parents has fallen during the same period (from 70 to 20 respectively). Relatively few children are placed in residential care (Graph 6).

As may be expected, given the age distribution of children in care, the age group most represented amongst the two most common placement types (in-house foster parents and IFA placements) was the 11-15 years old (as at September 2013). As older children tend to be harder to place they are more likely to be placed with IFA foster parents, whilst pre-school and primary school children are most often placed with in-house foster parents. Younger children are more likely to be placed for adoption than older children, whilst a similar number of children across all age groups were placed with relatives and friends (see appendix graph 46).

Graph 6 Kent children in care (%) by placement type (2009/10 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

In England, 75% of looked after children were cared in a foster placement (2013), an increase from 72% in 2009. 9% of looked after children were placed in secure units, children's homes and hostels, a decrease from 10% in 2009. 5% were placed with parents, a decrease from 7% in 2009. 5% were placed for adoption; this is a 16% increase from 2012 and a 25% increase from 2009.

In order to compare Kent and the rest of England, ONS data (2013) shows that children in care placements in Kent are (see appendix graph 47):

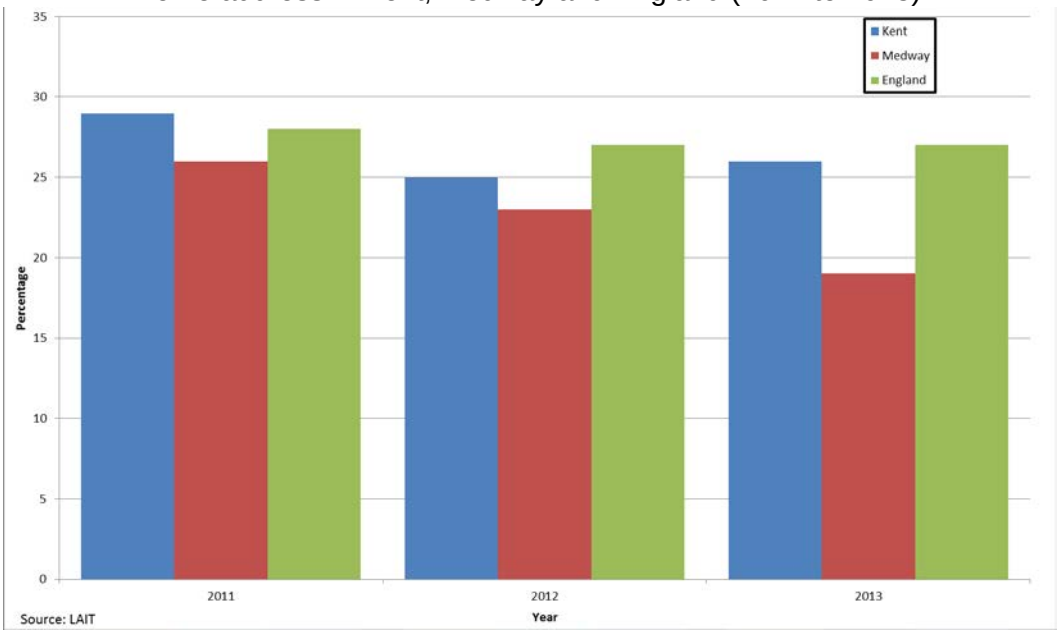
- above national average for foster care and placements in the community, reflecting the relatively high number of UASCs (80% of Kent children in care were with foster placements compared to 75% in England, and 4% were placed in the community in Kent compared to 3% in England)
- are at the same level for adoptions (5% for both Kent and England)
- below national average with parents (2% in Kent and 5% in England) and in secure units, children's homes and hostels (5% in Kent and 9% in England)

1.6 Geographical distribution

The Government expects KCC to place as many children in care as possible within 20 miles of their original home if it is safe to do so. This ensures they suffer less disruption to their schooling and life and help improve the outcomes they achieve. A child being placed in a different District Council area may still be living within 20 miles or less of their original address. The number of Kent children in foster care placed within 10 miles of their home address has increased (from 749 in 2011/12 to 825 in 2013/14); however the percentage remained relatively stable over the past three years, as the number of children in foster care also increased (see appendix graph 11). The percentage of children in foster care placed more than 20 miles from their home address was similar amongst Kent children in care and those across England (Graph 7).

Over the last five years, Thanet had the highest number of children in care amongst East and South Kent districts. In Canterbury, the number of children in care has increased. In the other districts, the number of children has decreased over the past year (see appendix graph 49).

Graph 7 Children in care (%) in foster care placed more than 20 miles from their home address in Kent, Medway and England (2011 to 2013)



Source: LAIT= Local Authority Interactive Tool for comparing data about children and young people across all local authorities in England

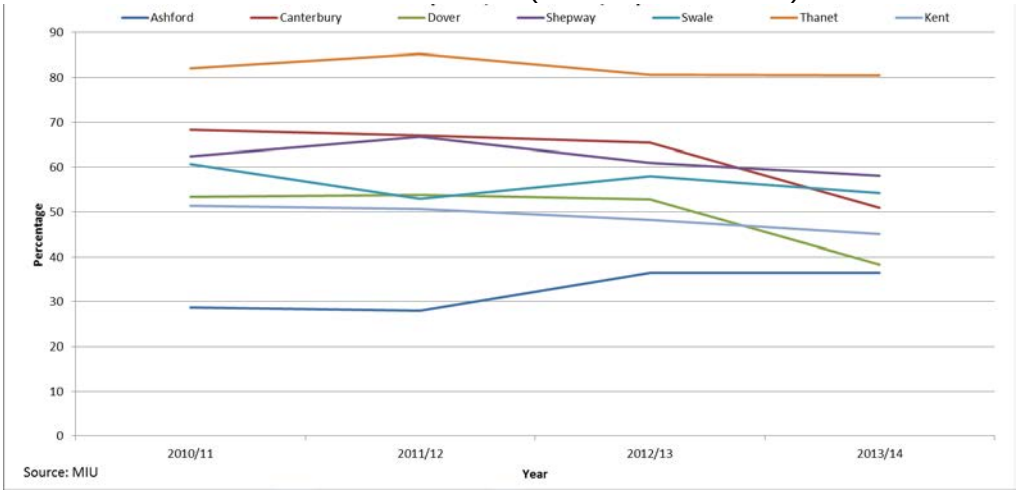
The number of children in care placed in West and North Kent districts is lower than those of East and South Kent. The highest number is in Maidstone and the lowest in Sevenoaks. In most West and North Kent districts, there have been rises in the number of children in care in recent years (see appendix graph 50).

Thanet places over 80% of children who enter care within its district, and had the highest percentage of all Kent districts for the past four years. The percentage of children in care from Ashford placed within this district has risen; however it is still the lowest percentage among the East and South Kent districts (Graph 8).

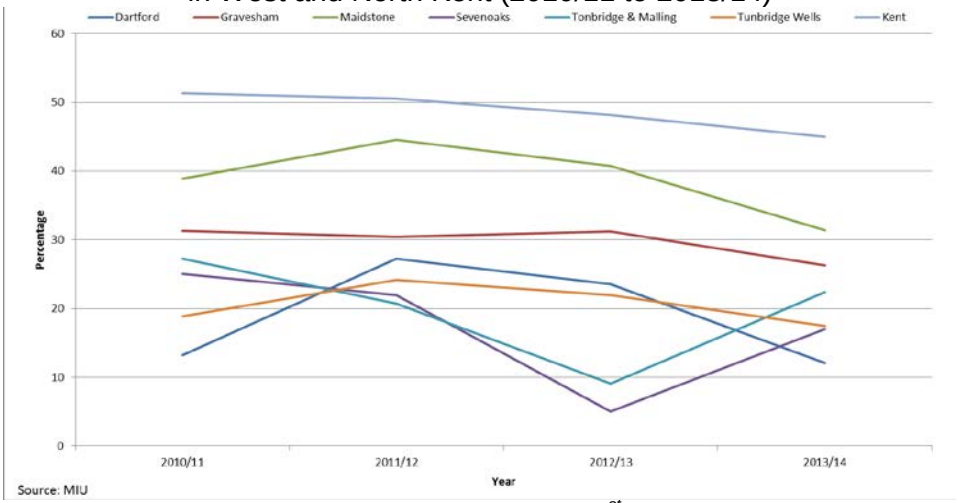
West and North Kent districts have relatively low percentages of children in care being placed within the district of their home address. Maidstone has the highest percentage in West and North Kent; though this has fallen in recent years. In Gravesham, the percentage has remained steady, but has also decreased in the past year. The percentage fluctuates more among the other West and North Kent districts (Graph 9).

In West and North Kent, the number of children in care placed in a different Kent district is higher than those placed within the same district. In East and South Kent, the number of children in care placed within the same district is the highest (with the exception of Ashford). This is particularly evident in Thanet (see appendix graph 51).

Graph 8 Kent children in care (%) placed within the district of their home address, in East and South Kent (2010/11 to 2013/14)



Graph 9 Kent children in care (%) placed within the district of their home address, in West and North Kent (2010/11 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

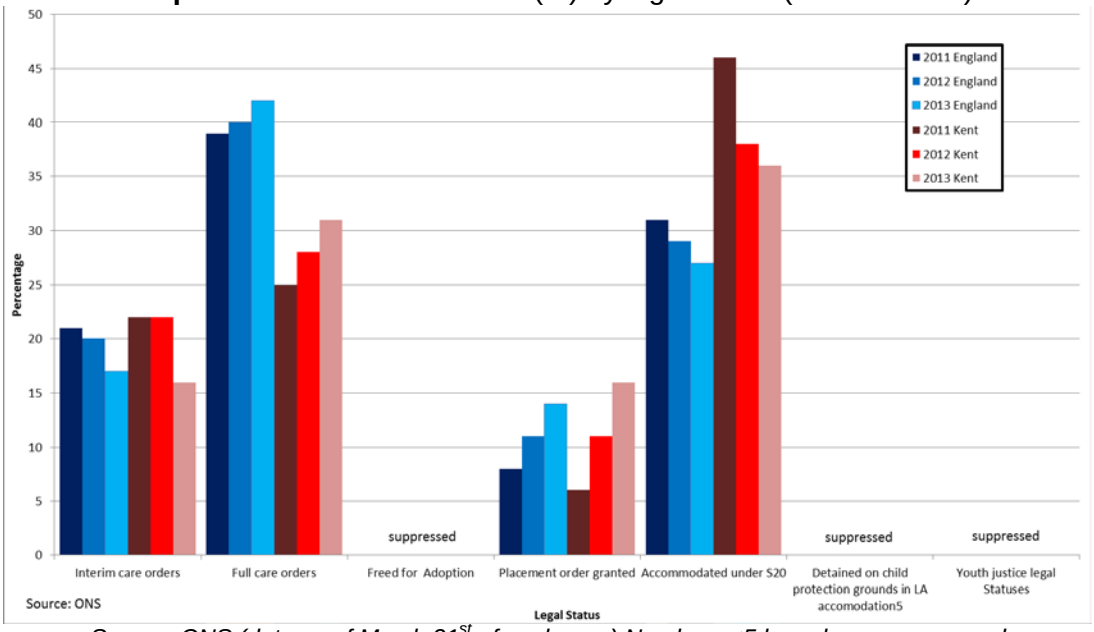
1.7 Legal status

The legal status of the majority of Kent children in care is 42% under a care order (either interim or full care order), with 36% voluntary accommodated under Section 20 of the Children's Act . The least common legal status is on remand and accommodated.

In order to compare Kent and the rest of England, we used ONS data. It shows that the legal status of children in care across England and in Kent is, respectively (Graph 10):

- 59% of looked after children in England (2013) were under a care order (either interim or full care order) and this has remained relatively stable since 2009, although the number of these children has risen by 11% in line with the overall rise in the number of looked after children.
- 27% of looked after children in England (2013) were accommodated under a voluntary agreement under Section 20 of the Children's Act (36% in Kent). This figure was 32% in England (2009).
- Placement orders have been granted to 14% of looked after children in England (2013) (16% in Kent). This figure was 8% in England (2009).
- As a result of changes to legislation children who are on remand or committed for trial and held in the secure estate are now children in care and as a result there has been an increase in the numbers (310 in 2013, more than double the number in 2012). This is due to the implementation of the Legal Aid, Sentencing and Punishment of Offenders Act that came into effect in December 2012. The Act states that all children remanded by the courts will become looked after. We expect to see more children becoming looked after under this legal status as a result of their involvement with the criminal justice system.

Graph 10 Kent children in care (%) by legal status (2011 to 2013)



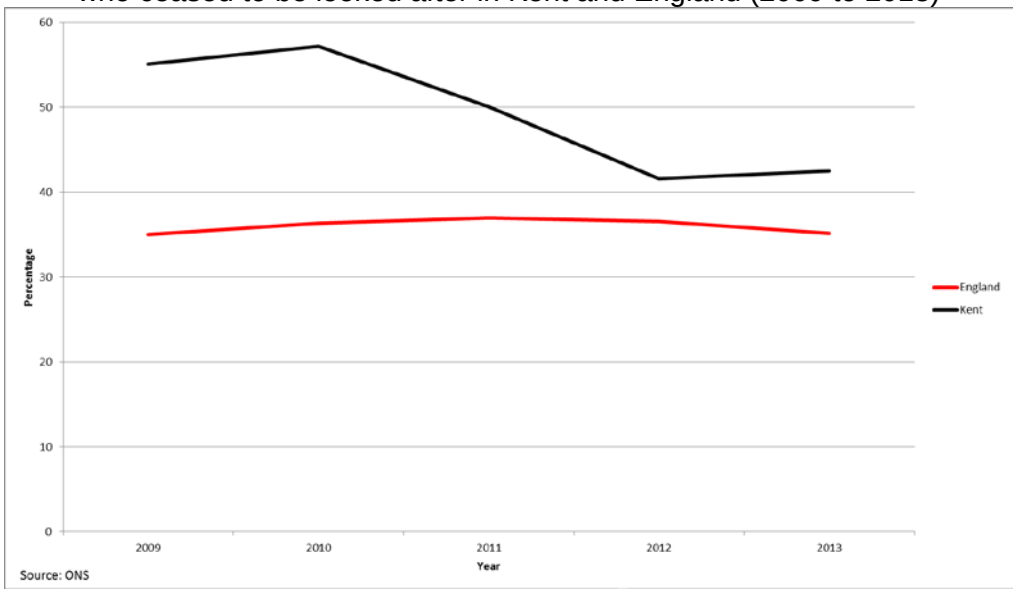
Source: ONS (data as of March 31st of each year) Numbers <5 have been suppressed

1.10 Care leavers

Between 2009 and 2013 the number of Kent children leaving care increased, whilst the number of children aged 16 years old and over leaving care decreased; however it was still the case that the 16+ age group is the largest cohort of children who leave care (365 out of 865 children who ceased to be looked after) (see appendix graph 55).

The percentage of Kent children who ceased to be looked after at the age of 16 years old and over has decreased; whereas the England average remained constant (Graph 11).

Graph 11 Children in care (%) aged 16 years old and over who ceased to be looked after in Kent and England (2009 to 2013)



Source: ONS

In June 2014 KCC had a care leaver population of just over 1,000 with 413 UASC and 589 citizen young people. Of these 807 are currently based in Kent. This compares to our statistical neighbours who have an average of 327 care leavers.

The potential negative impact of leaving care too early and living independently without the right support has been well documented with the Children Right's Director's surveys on care leavers. Children in Care Council (CICC) meetings show that many care leavers feel that they leave care too early and often feel isolated and lonely. Care leavers are over represented in statistics relating to poor outcomes, for example nationally 34% of care leavers are NEET compared to 15.5% of the general population.

Care leavers activity and accommodation

49% of care leavers (aged 19 years old who were looked after when they were aged 16 years old) were engaged in education, employment or training at the age 19 years old. The council were not in contact with 22% of the care leavers (see appendix graph 76). Across England, 34% were classified as NEETs and 58% were in education, training or employment (2013).

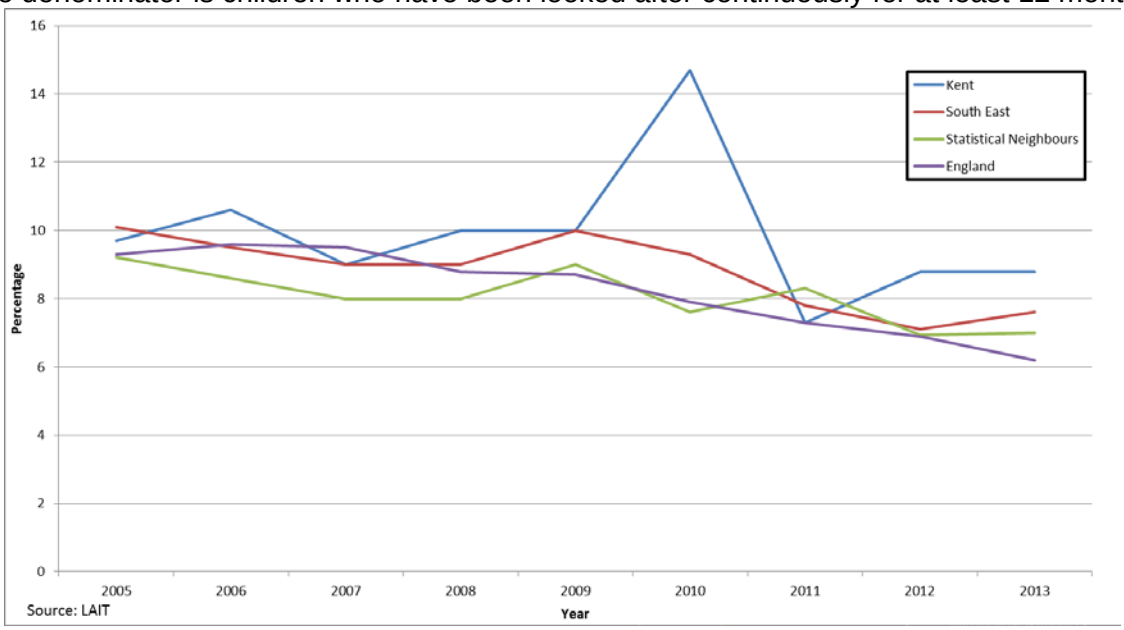
73% of care leavers aged 19 years old who were looked after when they were 16 years old are deemed to be living in suitable accommodation. The majority live in independent living accommodation (see appendix graph 77). Across England, 37% were living independently and 88% were deemed to be living in suitable accommodation (2013).

Regulation 9(2) of the *Care Leavers Regulations* defines what is meant by 'suitable accommodation'. It is accommodation, which, so far as reasonably practicable, is suitable for the child in light of his/her needs, including his/her health needs. The authority should have satisfied itself as to the character and suitability of the landlord or other provider; ensures that the accommodation complies with health and safety requirements related to rented accommodation; and that the authority has so far as reasonably practicable, taken into account the child's wishes and feelings; and education, training or employment needs.

1.11 Offending

8.8% (65) and 6.2% of children in care aged over 10 years old were subject to a conviction, final warning or reprimand in Kent and England respectively (2013). Overall, there has been a gradual decrease in the percentage of children in care who are subject to a conviction, final warning or reprimand over the last eight years (Graph 12).

Graph 12 Children in care subject to a conviction, final warning or reprimand (%) in Kent, South East and England (2005 to 2013).
The denominator is children who have been looked after continuously for at least 12 months.



Source: LAIT= Local Authority Interactive Tool for comparing data about children and young people across all local authorities in England

1.12 Unaccompanied asylum seeking children (UASCs)

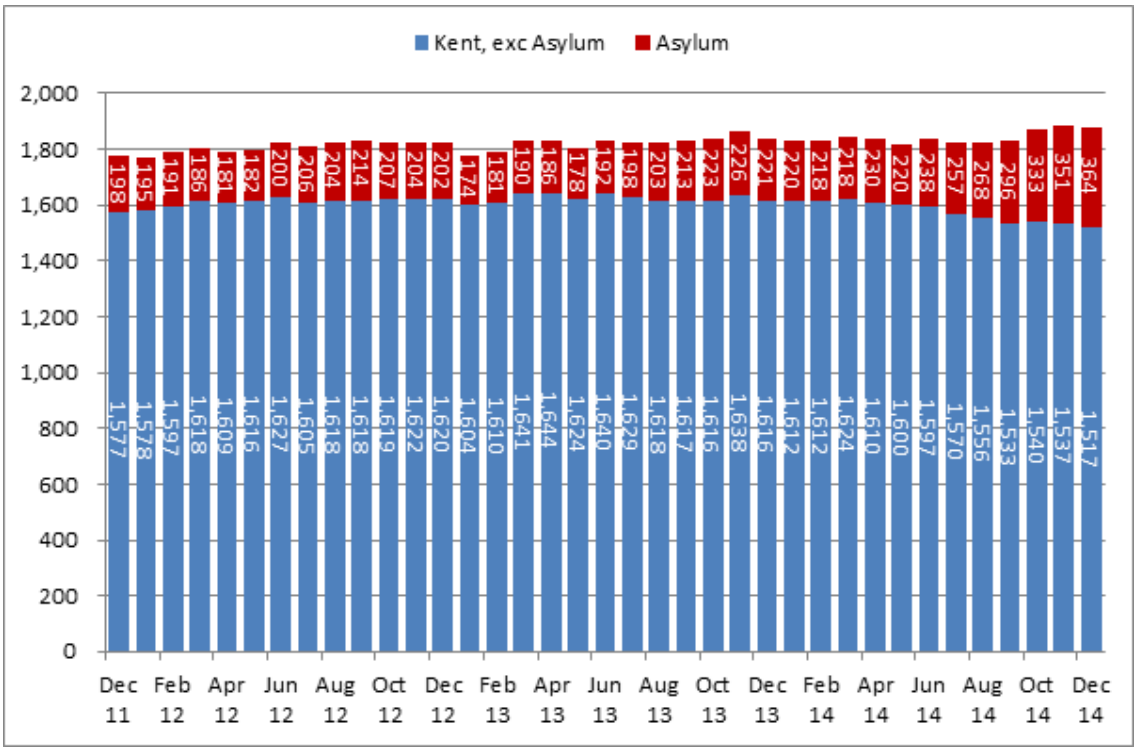
The Kent UASC service supported both UASC who are looked after children and those who are care leavers. The number of new UASC who became looked after peaked in 2009/10 and began to decrease. It has since risen again as a result of conflicts and repression of some minority populations in various parts of the world. In 2012/13 and 2013/14 the number of UASC reached a plateau (Graph 13) although it has subsequently risen again since June 2014. The number of UASC care leavers has followed a similar pattern with peaks over 2009/10 and 2010/11 and a substantial decrease since (see appendix graph 94). The UASC service caseload was an average of 914 in 2008/09, 640 in 2013/14 whilst in December 2014 it had reached 364). Approximately 90% of UASC are male (see appendix graph 45). East Kent had the highest number of UASC placed within the area (see appendix graph 95).

Although UASC from 32 different nationalities entered the Kent care system between April 2008 and March 2014, ten nationalities constituted more than 90% of UASC during this period and half of UASC came from only two nationalities (Afghanis and Eritreans). The arrival of Afghani young people decreased substantially, whilst the number of Eritrean UASC increased over the period. (See table).

Table Nationalities of UASCs entering the care system in Kent (2008/09 to Aug 2014)

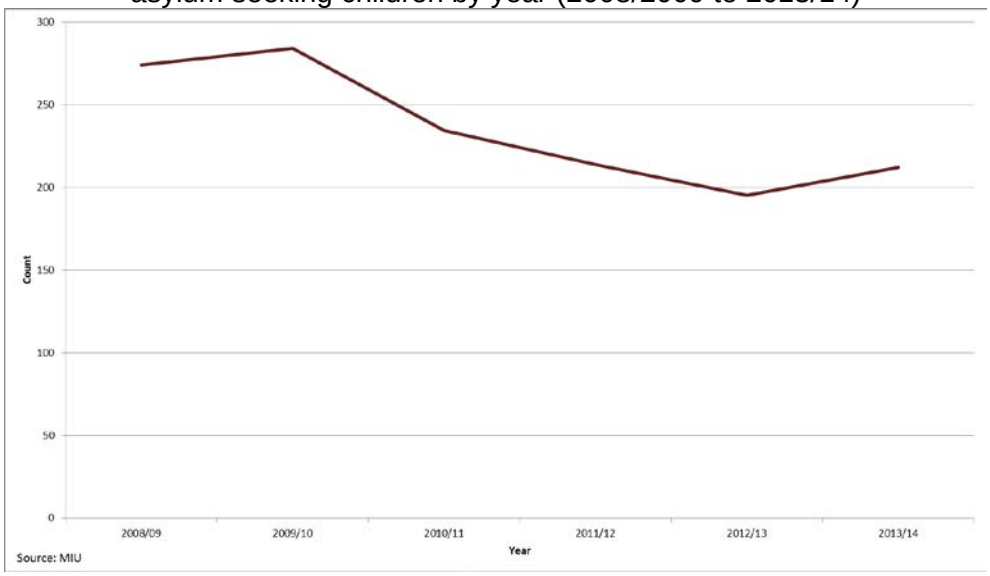
Afghani	382	Albanian	65
Eritrean	183	Syrian	51
Iranian	112	Moroccan	40
Vietnamese	78	Sudanese	39
Algerian	74	Iraqi	23

Graph 13 Number of Children in the care of Kent County Council, including Unaccompanied Asylum Seeking Children



Source: Sufficiency, Placement and Commissioning Strategy 2015 – 2018

Graph 13a Number of children in care in Kent that are unaccompanied asylum seeking children by year (2008/2009 to 2013/14)

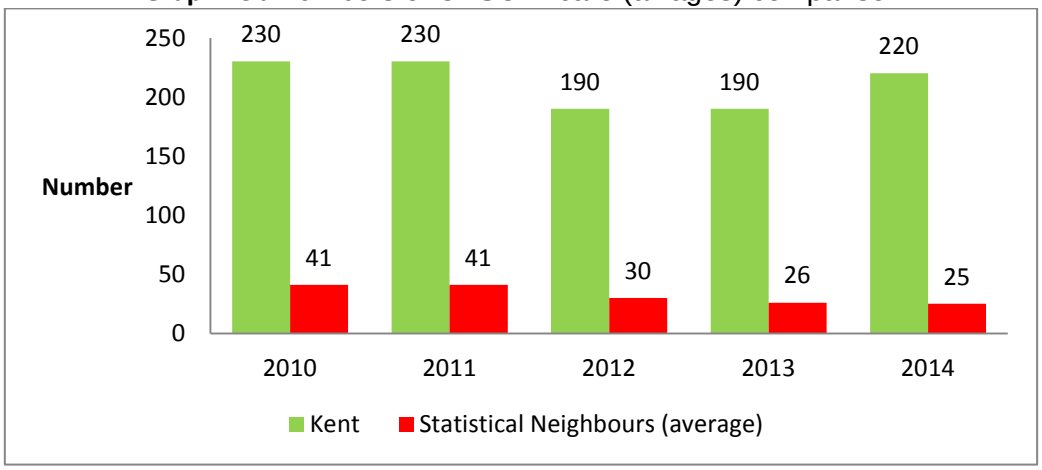


Source: Kent MIU

The proximity to France and the Port of Dover means that Kent receives significantly more UASC than its statistical neighbours. The figure had fallen in 2012 and 2013 but increased significantly in 2014 (see graph 5).

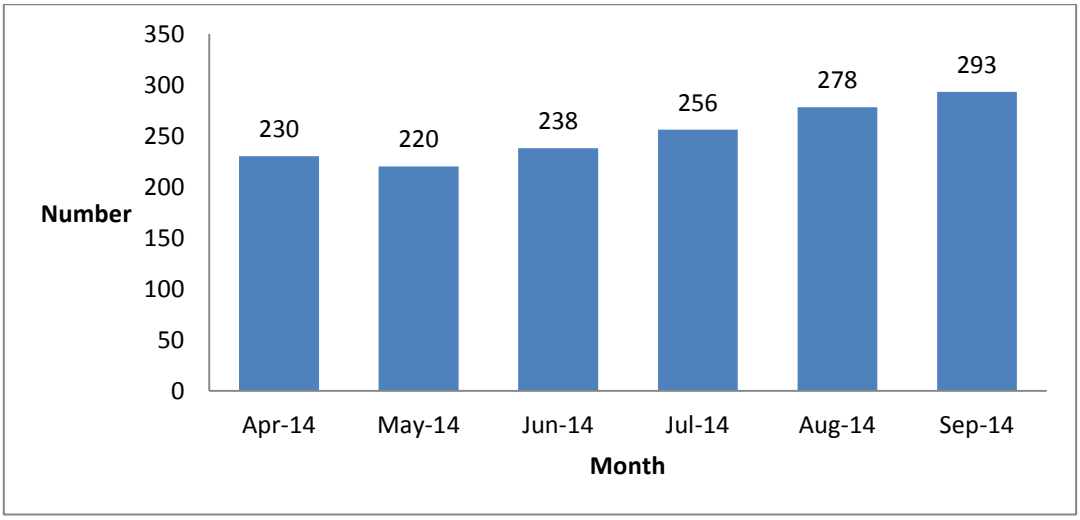
Kent Country Council has no control over the number of UASC who enter the county. The current levels of political unrest in the Middle East and African sub-continent have seen significant increase in the numbers of UASC arriving in Kent during 2014 (see graph 6). Numbers arriving are also directly impacted on by the policies adopted by French authorities in Calais.

Graph 13b Numbers of UASC in care (all ages) comparison



Prior to 2014 there has been a reduction in the number of UASC arriving in Kent during the colder winter months. However data shows that in 2014/15 has not taken place, with numbers much higher than expected for the time of year. Based on advice from national government the council is expecting the numbers to continue to increase, with 2015/16 estimated at 10% higher than in 2014/15.

Graph 13c Numbers of UASC Children in Care (all ages), April to September 2014



In the last 2 years, UASC haves gone from being 10.5% of Kent's children in care population in March 2013 to 20% in February 2015.

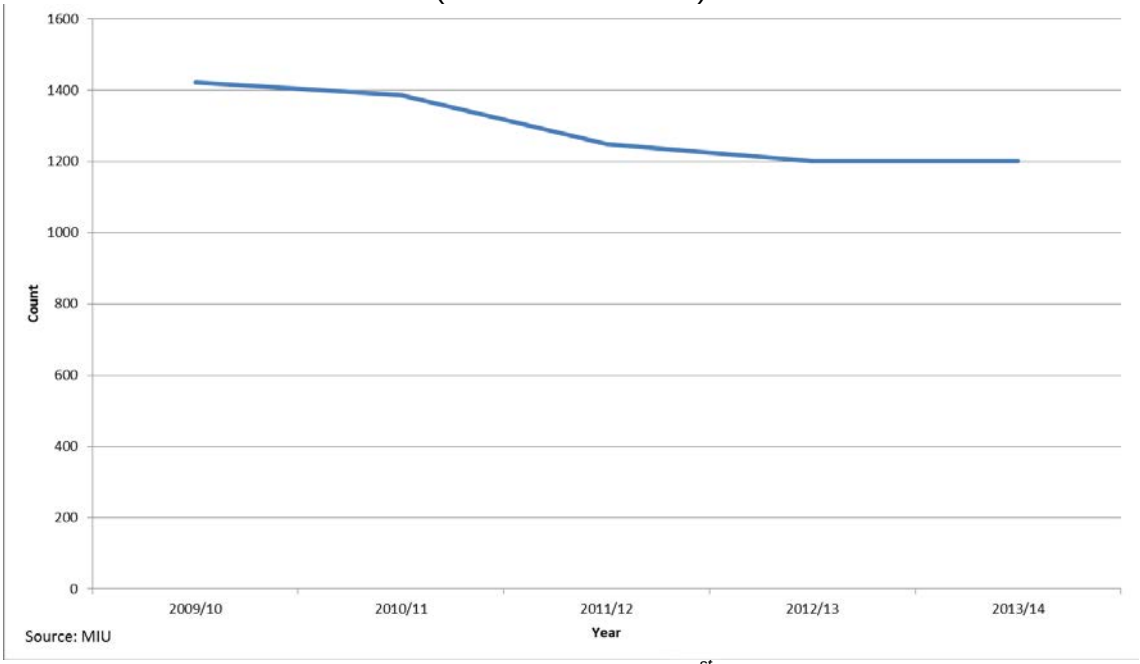
1.13 Children in care placed in Kent by other local authorities (OLA)

The number of OLA children in care placed in Kent decreased by 16% (from 1421 in 2009/10 to 1200 in 2013/14). The decrease in number of OLA children has been observed for most placing OLAs with the exception of Greenwich, Medway, Hammersmith and Fulham, and Southwark (Graph 14).

The number of OLA children in care for the 12 to 18 years old age group decreased (from 951 in 2009/10 to 703 in 2013/14) (see appendix graph 96) in contrast to the number of Kent children in care aged 12 years and over that has increased over the same period (see graph 4). Approximately 60% of children in care from other local authorities placed in Kent are male (see appendix graph 97); this is consistent with the gender breakdown of Kent children in care (see appendix graph 44).

Thanet and Swale have the highest number of children in care from OLAs placed within them. A decrease in OLA children in care has been observed in most East and South Kent districts (see appendix graph 98). Tunbridge Wells had the lowest number of OLA children in care placed within the district (see appendix graph 99). The range of ethnic background of children in care placed in Kent by OLAs is wide (45 ethnic groups).

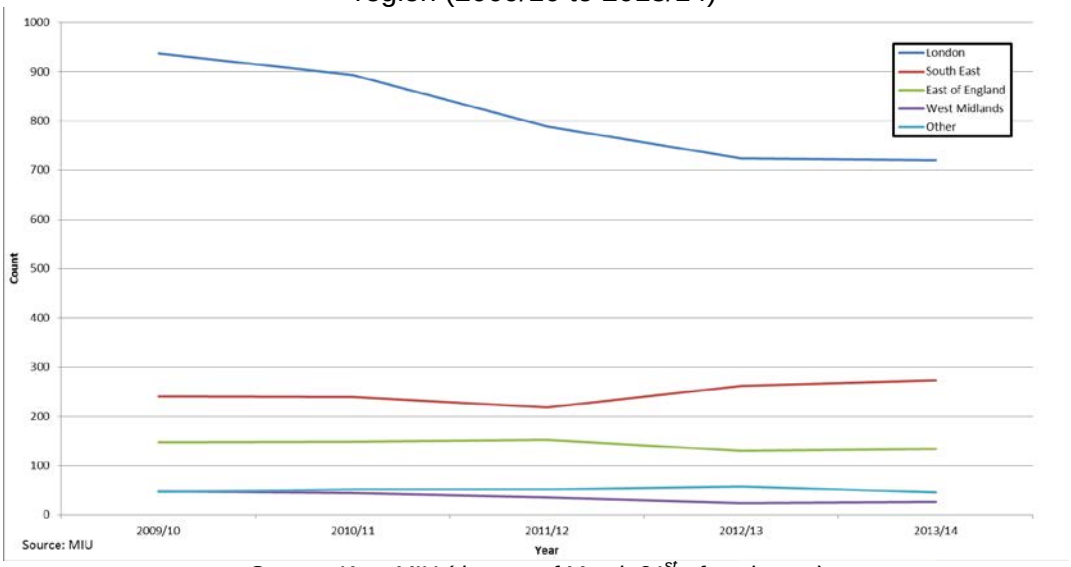
Graph 14 Number of children in care placed in Kent by other local authorities (OLAs) (2009/10 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

The majority of children in care placed in Kent by other local authorities come from London, although this has decreased (graph 14a). Regions with a small number of children from other local authorities (OLAs) have been grouped into a category called 'other'. These include the South West and East Midlands (each with 13 children in 2013/14), the North West (6 children in 2013/14) and Yorkshire and Humber, Scotland, Wales, North East and 'elsewhere', whereby each had less than 5 children placed in Kent in 2013/14.

Graph 14a Number of children in care placed in Kent by other local authorities (OLAs) by region (2009/10 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

Medway children in care placed in Kent

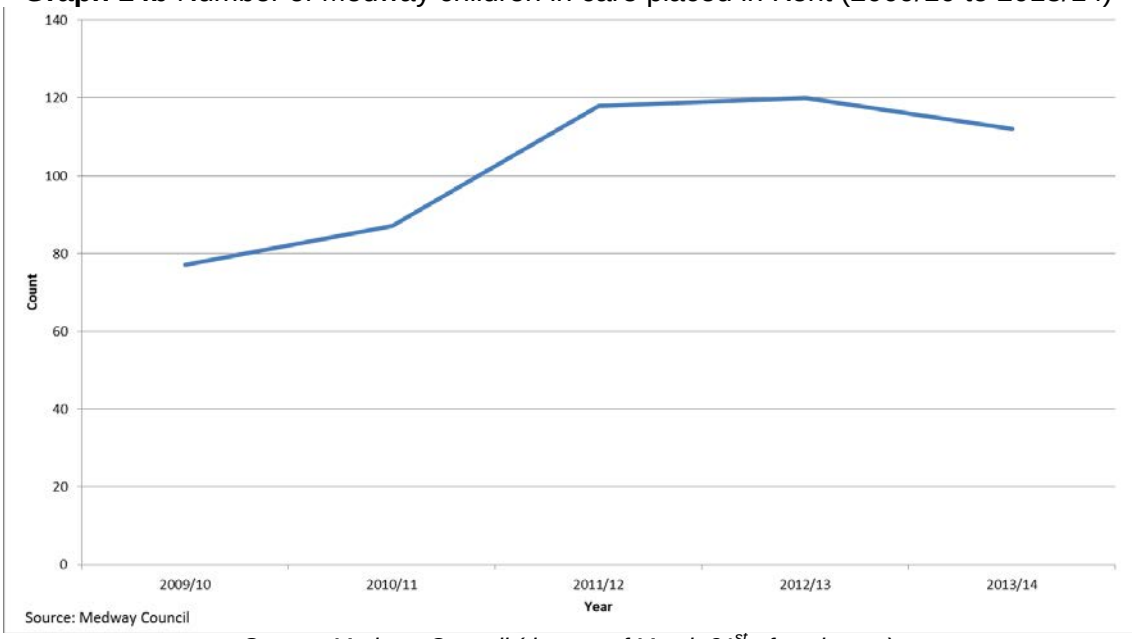
The number of Medway children in care placed in Kent increased by more than 50% (from 77 in 2009/10 to 120 in 2012/13) (graph 41). This is against the general trend of children in care from s placed in Kent (see graph 39). This could be explained by a Medway Council initiative to recruit more foster parents that are based in Swale.

The number of Medway children in care aged between 12 and 18 years old has increased over the past five years. The number of children aged between 5 and 11 years old and 0 and 4 years old increased between 2009/10 and 2012/13, but decreased in the last year (graph 98). The age distribution follows the general trend of children in care from other local authorities placed in Kent (see appendix graph 96). A considerable number of Medway children in care have been in care for a number of years before being placed in Kent, as it is clear from the shift to the left (graph 43 compared to graph 42).

There is a preponderance of males amongst the Medway children in care placed in Kent in line with the picture of Kent children in care (see appendix graphs 44 and 100). Approximately 90% of Medway children in care placed in Kent are of white British background, higher than the percentage observed amongst Kent children in care (see Graphs 14b, 14c, 14d, and appendix graph 101).

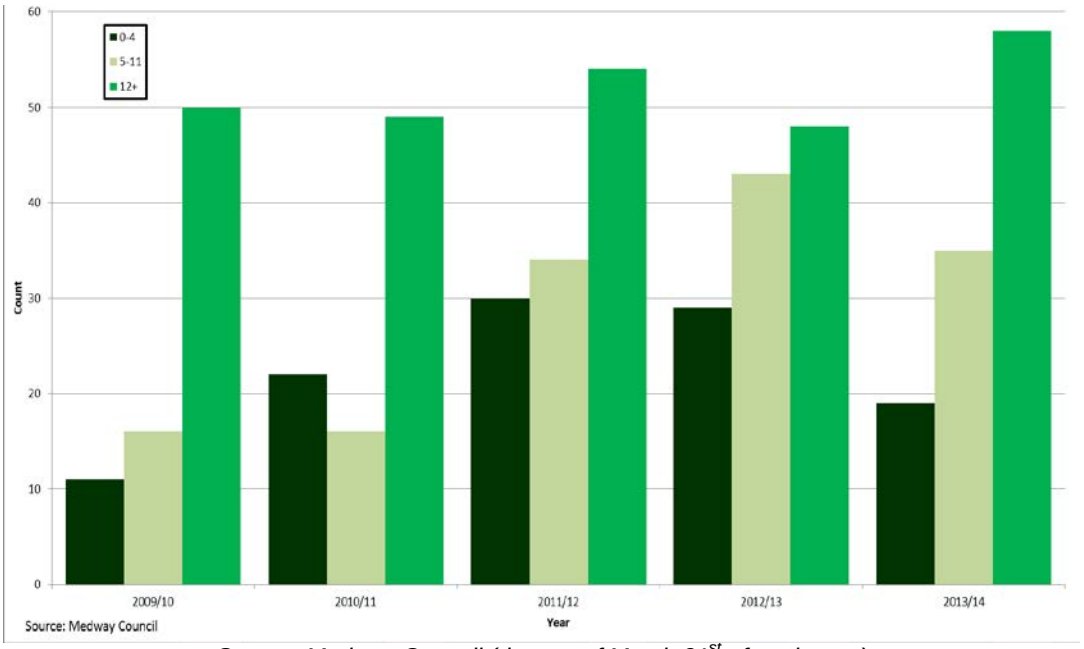
The Medway children in care placed in Kent within 10 miles of their home address has decreased (from 46% in 2009/10 to 37% in 2013/14). It appears that as more Medway children in care are placed in Kent, the distance from their home increases.

Graph 14b Number of Medway children in care placed in Kent (2009/10 to 2013/14)



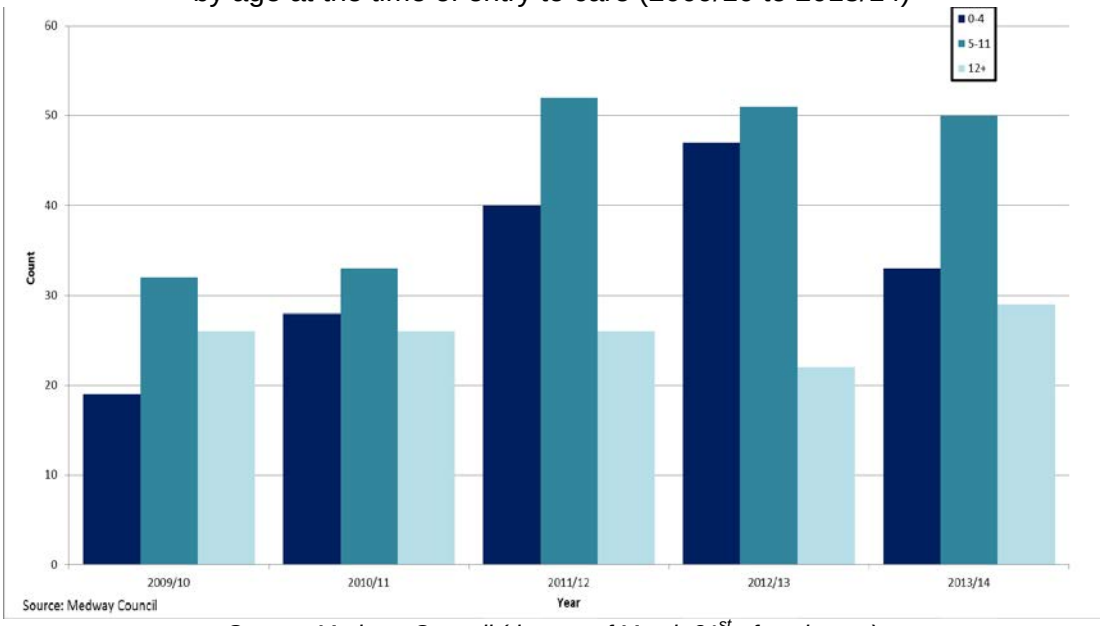
Source: Medway Council (data as of March 31st of each year)

Graph 14c Number of Medway children in care placed in Kent by age (2009/10 to 2013/14)



Source: Medway Council (data as of March 31st of each year)

Graph 14c Number of Medway children in care placed in Kent by age at the time of entry to care (2009/10 to 2013/14)



Source: Medway Council (data as of March 31st of each year)

1.14 Education

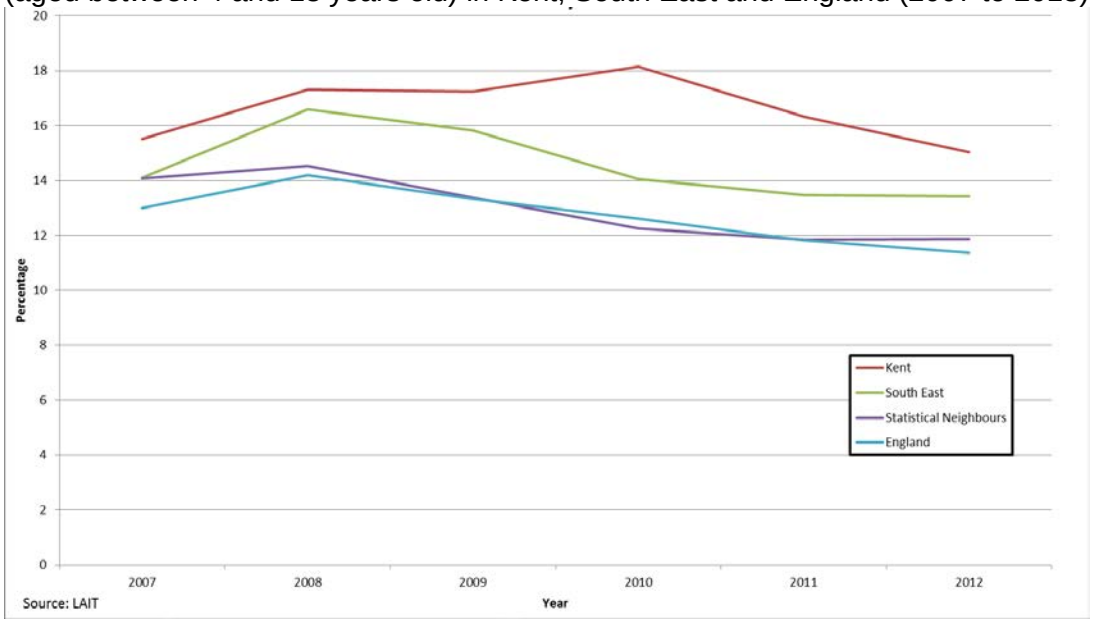
Fixed period school exclusion refers to a pupil who is excluded from a school, but remains on the register of that school because they are expected to return when the exclusion period is completed. The number of fixed term school exclusions of Kent children in care is highest in Swale (113), followed by Ashford (77) and Thanet (76). The numbers are lowest in Tunbridge Wells (5) and Tonbridge and Malling (11) (see appendix graph 58). Children in care have a higher fixed term exclusion rate than the general school child population of Kent in five out of the 12 Kent districts; however overall Kent children in care have a statistically significant higher rate (34.3 per 1000 school children in 2013/14) compared to the general school child population of Kent (29.7 per 1000 school children in 2013/14) see appendix graph 59).

The percentage of fixed school exclusions for children in care is higher in Kent compared with England (Graph 15). The number of fixed term school exclusions for children in care has remained fairly constant in most East and South Kent districts; however it has fallen rapidly in Thanet (from 208 in 2009/10 to 76 in 2013/14) (see appendix graph 60). The numbers of fixed term school exclusions for children in care in West and North Kent districts tend to be lower than those of East and South Kent districts. The numbers have been reduced in Gravesham (from 47 in 2009/10 to 19 in 2013/14) and in Tunbridge Wells (from 30 in 2009/10 to 5 in 2013/14) (see appendix graph 61).

A child can have more than one fixed exclusion per year

Information on exclusions is derived from the school census returns. In January 2006, the school census changed to a termly collection cycle for secondary schools (i.e. there was a census in the autumn, spring, and summer terms). Each census collects information on exclusions that occurred two terms previous to that in which the given census fell, e.g. exclusion data relating to the autumn 2006 term were collected in the summer 2007 school census. Primary and special schools changed to this termly collection in January 2007.
The number of fixed term exclusions for children in care increases with age until 15 years old, and then decreases. This is a similar pattern to fixed term school exclusions in the general children population (see appendix graph 62).

Graph 15 Fixed term school exclusions (%) for children in care (aged between 4 and 18 years old) in Kent, South East and England (2007 to 2013)

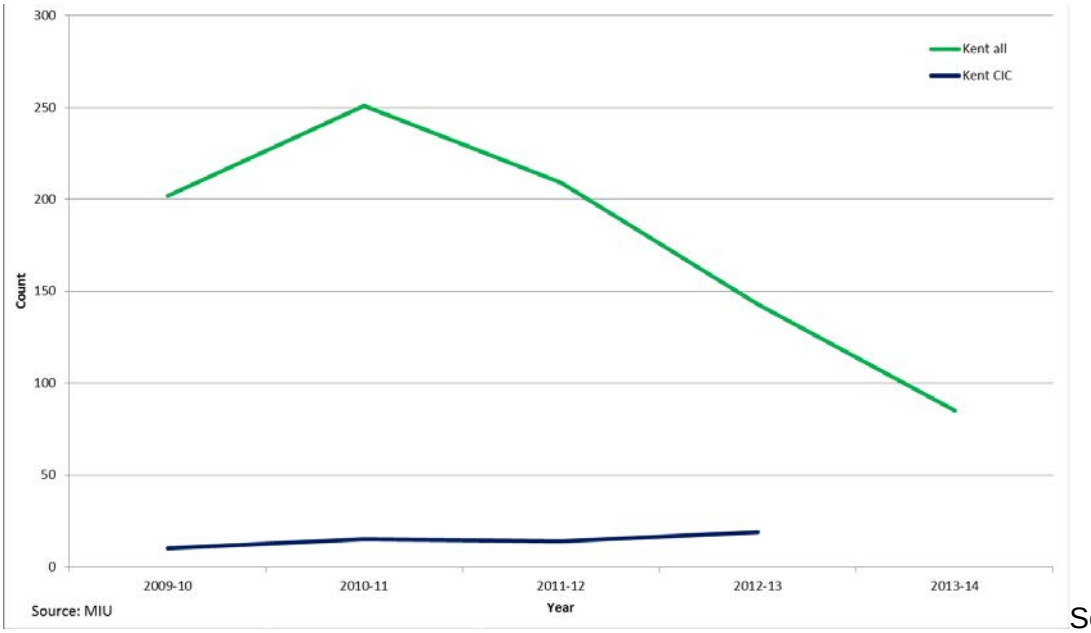


Source: LAIT

Permanent school exclusion refers to a pupil who is excluded and their name removed from the school register. Such a pupil would then be educated at another school or via some other form of provision. Thanet had the highest number of permanent school exclusions for children in care (see appendix graph 63).

The number of permanent school exclusions for general school population in Kent reduced (from 251 in 2010/11 to 85 in 2013/14). Over the past year, the number of permanent exclusions for Kent children in care decreased. It was relatively stable in the preceding four years (Graph 16). A majority of permanent school exclusions were given to children in care aged 14 years (see appendix graph 64).

Graph 16 Number of permanent school exclusions amongst Kent children in care and Kent school children (aged 4 to 18 years old) (2009/10 to 2013/14)



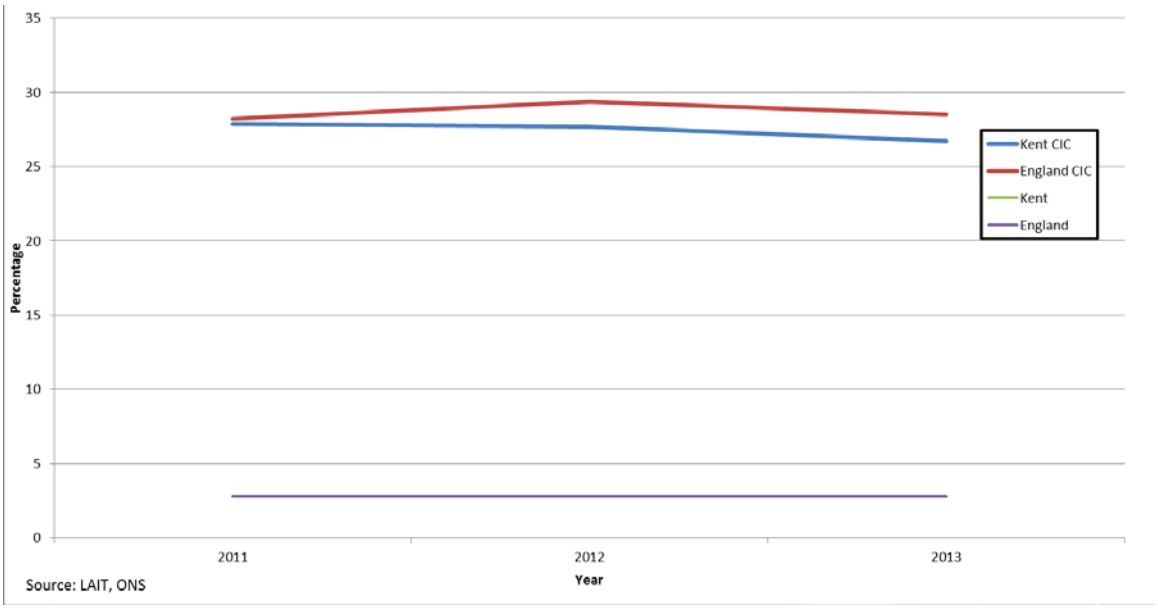
Source:

Source: Kent MIU

The number of Kent children in care with a statement of **special educational needs** (SEN) was the highest in Thanet (133), followed by Swale (103). Numbers are lowest in Tonbridge and Malling (13) and Tunbridge Wells (13) (see appendix graph 65). The rate of SEN statements was significantly higher for Kent children in care at 42.6 per 1,000 compared to 21.8 per 1,000 for the general Kent school children population (2013/14). In nine out of the 12 districts, the SEN statement rate among children in care is higher than in the general child population (see appendix graph 66).

Over the last three years, the percentage of Kent children in care that had a SEN statement is lower than that across England, but it is approximately 10 times higher than the percentage (2.8% for the period 2009 to 2013) of children who had a SEN statement amongst the general school children population for both Kent and England (Graph 15a).

Graph 15a Children in care (%) in comparison with general school children population in both Kent and across England (2011 to 2013)



Source: ONS and LAIT

Children looked after continuously for at least 12 months as at 31 March excluding those children in respite care

The number of children in care with SEN statements has remained stable across East and South Kent districts and is consistently highest in Thanet (see appendix graph 67). In West and North Kent, Sevenoaks consistently has the highest number of children in care with SEN statements; furthermore, the numbers are lower in comparison with East and South Kent (see appendix graph 68). In all Kent districts the number of male children in care with SEN statements is higher than the number of females (see appendix graph 69). The number of Kent children in care with SEN statements increases with age until 15 years old (see appendix graph 70).

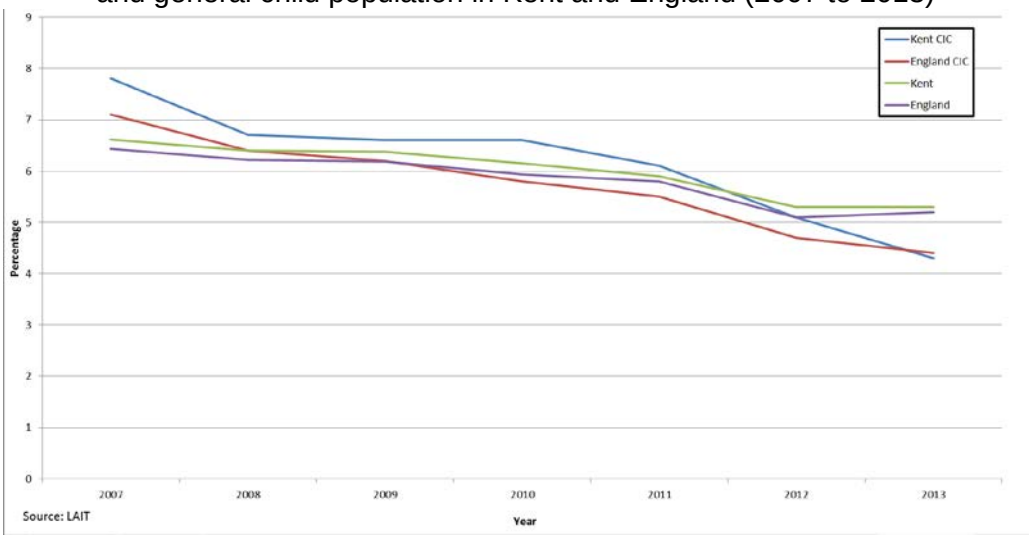
School absences decreased among Kent children in care (from 6.6% of sessions lost in 2009 to 4.3% of sessions lost in 2013). This reduction in absences has comprised of a decrease in both authorised absences (from 5.1% in 2009 to 3.4% in 2013) and unauthorised absences (from 1.6% in 2011 to 0.8% in 2013) (see appendix graph 71).

General children population percentage is expressed as a percentage of the total number of pupils in all schools.

Authorised absences are those for which an acceptable reason has been given, as decided by the school. Persistent absence is defined as the percentage of pupils who have missed over 15% of sessions.

Schools absences (percentage of half days missed) have decreased for children in care and the general child population in Kent and England over the past seven years. There has been a more marked decrease amongst children in care both in Kent and across England and as a result their percentages are lower than those of the general child population in both Kent and England (Graph 15b).

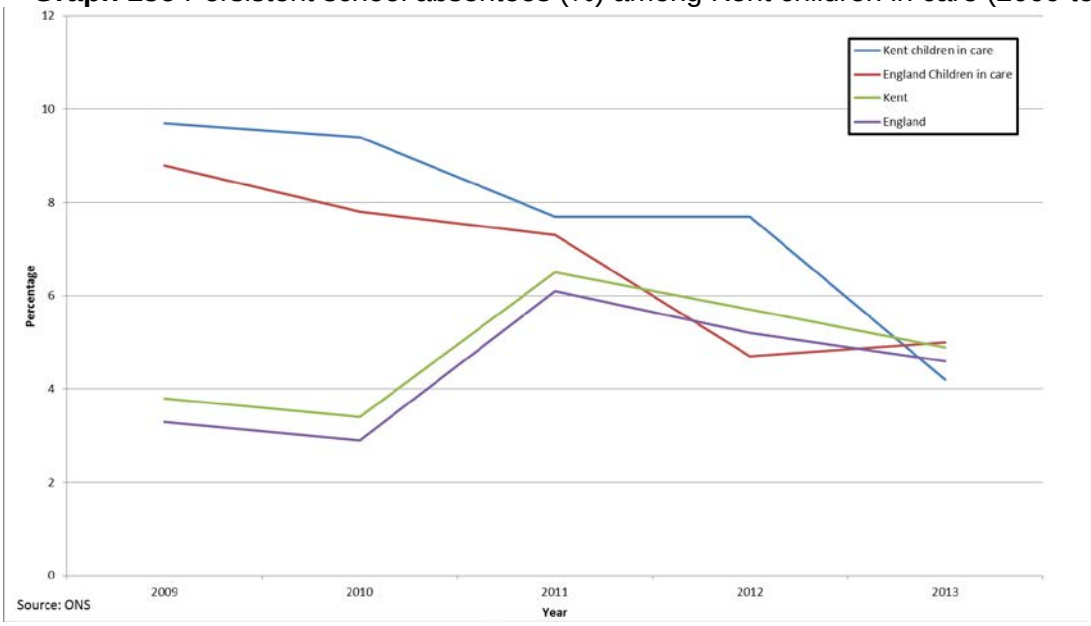
Graph 15b School absences (%) of children in care and general child population in Kent and England (2007 to 2013)



Source: LAIT

The percentage of Kent children in care that were persistent absentees has decreased (from 9.7% in 2009 to 4.2% in 2013). Between 2009 and 2011, the percentage of children who were persistently absent was higher among children in care than the general child population; however in the past two years this difference has reduced (Graph 15c).

Graph 15c Persistent school absentees (%) among Kent children in care (2009 to 2013)



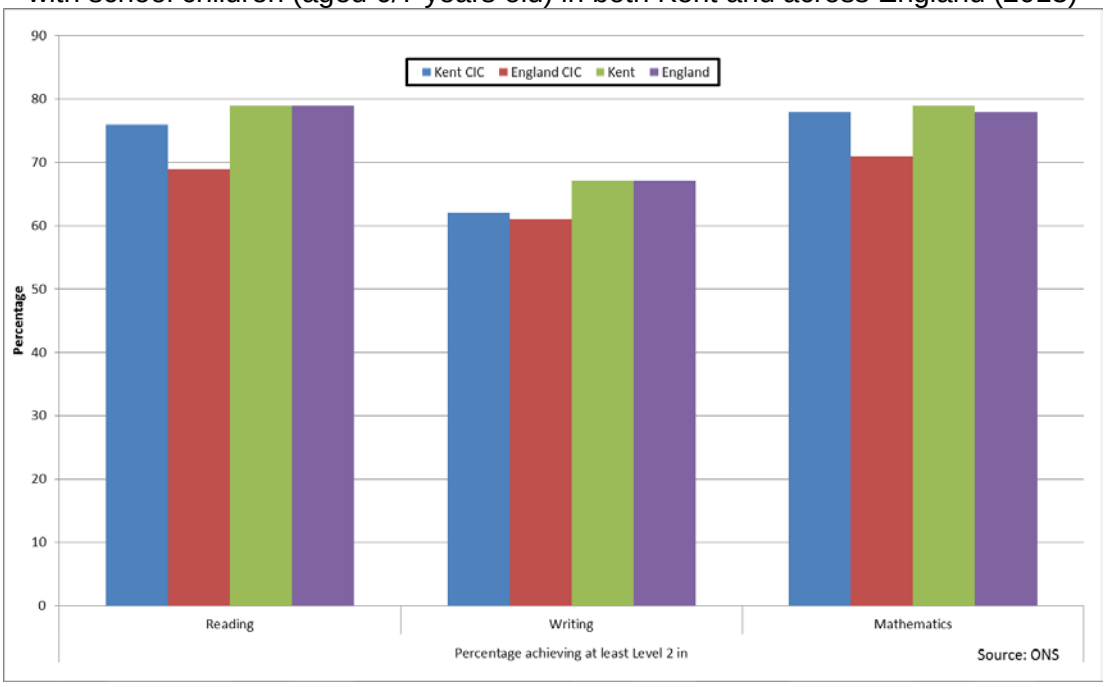
Source: ONS

Years 2009 to 2013 represent academic years 2008/09 to 2012/13 The denominator is children who have been looked after continuously for at least 12 months

Educational achievement

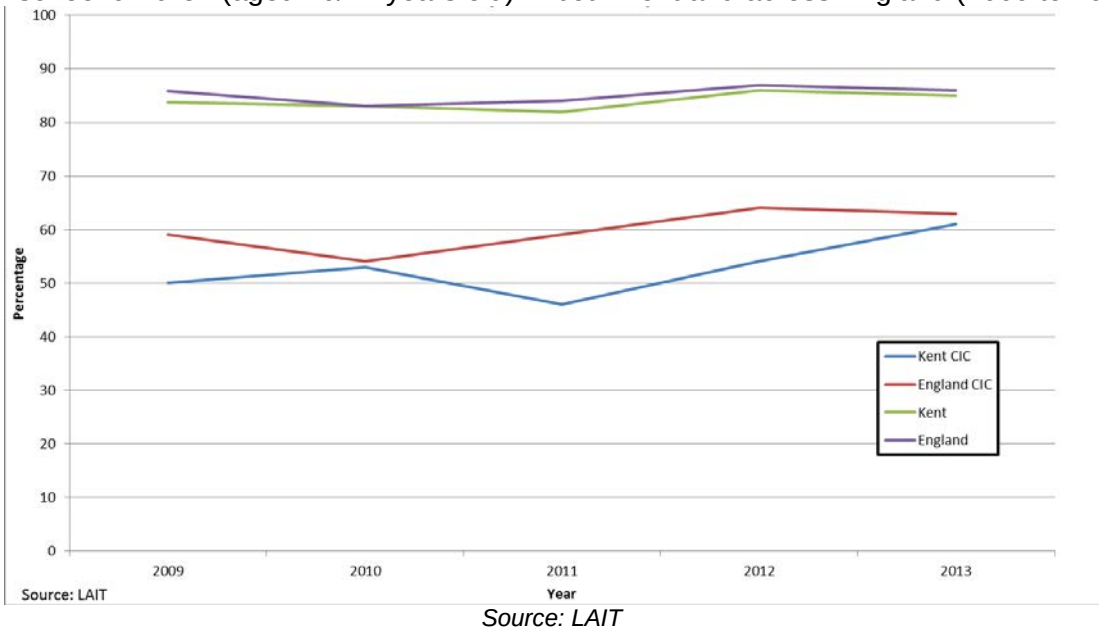
45 Kent children in care were eligible for key stage 1 assessments (2013). The lowest percentage of level 2 achievements was for writing (62%), while the percentage of children achieving level two in reading and mathematics was similar. The achievement of Kent children in care is higher than across England, but below that of children not in care, both in Kent and in England (Graph 20).

Graph 15d Key stage 1 performance of children in care in comparison with school children (aged 6/7 years old) in both Kent and across England (2013)



Source: ONS

Graph 15e Key stage 2 performance in reading of children in care in comparison with school children (aged 10/11 years old) in both Kent and across England (2009 to 2013)



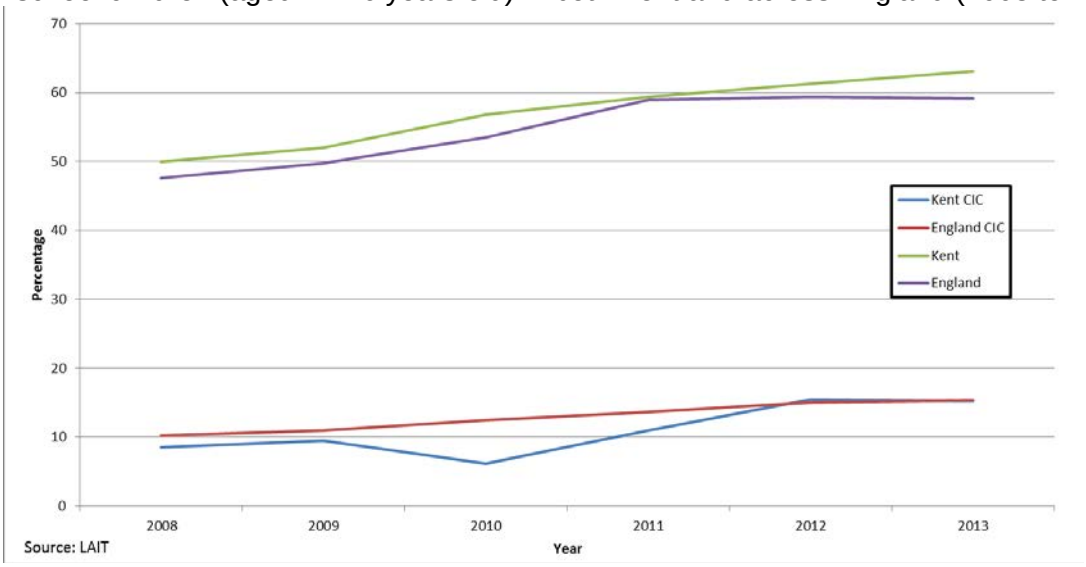
Source: LAIT

A lower percentage of Kent children in care achieved level 4 in reading or mathematics in key stage 2, than across England (2013). For reading, Kent children in care had a lower percentage of level 4 and above achievement than children in care across England over the past five years. The picture is less clear for mathematics (Graph 15 and see appendix graph 72).

The percentage of children in care achieving five or more GCSEs at grades A* to C has increased in both Kent and England. A significantly lower percentage of children in care in both Kent and England achieve five or more GCSEs at grades A* to C (including English and mathematics) compared to both Kent and England general school population (Graph 15f and see appendix graph 73).

Overall, there are differences in attainment between Kent children in care and the Kent general school children population at all levels of education.

Graph 15f Key stage 4 performance (5+ GCSEs A* to C, including English and mathematics) of children in care in comparison with school children (aged 14-16 years old) in both Kent and across England (2008 to 2013)



Source: LAIT

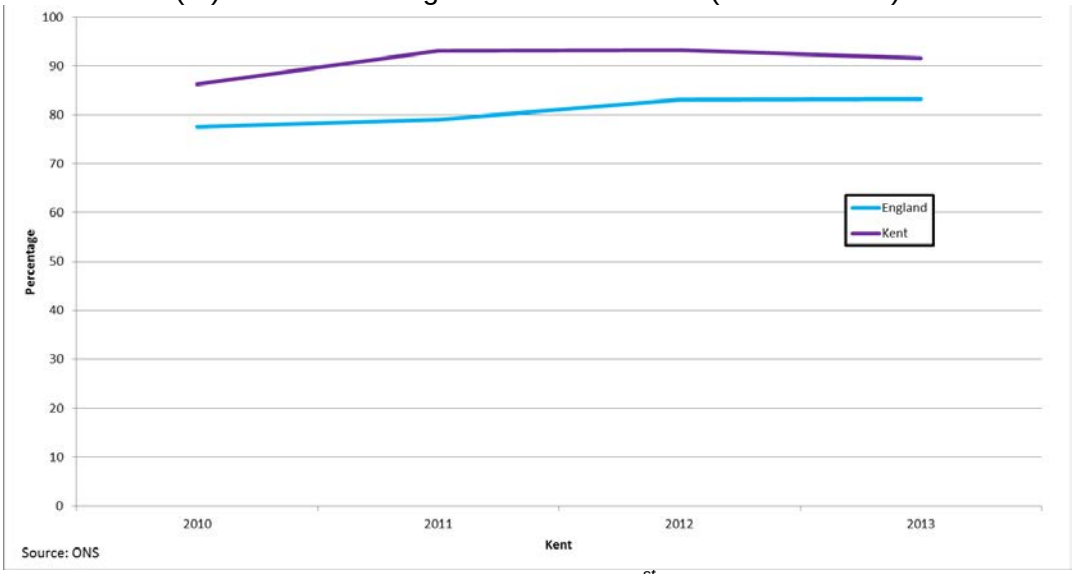
Although Thanet has the highest number of children in care who were classified as **Not in education, employment or training (NEETs)** (July 2014) (see appendix graph 74), Maidstone has the highest percentage of children in care classified as NEETs (16 out of 53 children in care) (see appendix graph 75).

SECTION 2. HEALTH

2.1 Statutory health reporting

The percentage of Kent children in care with up to date **immunisations** has been consistently higher than the percentage of children in care across England (Graph 16).

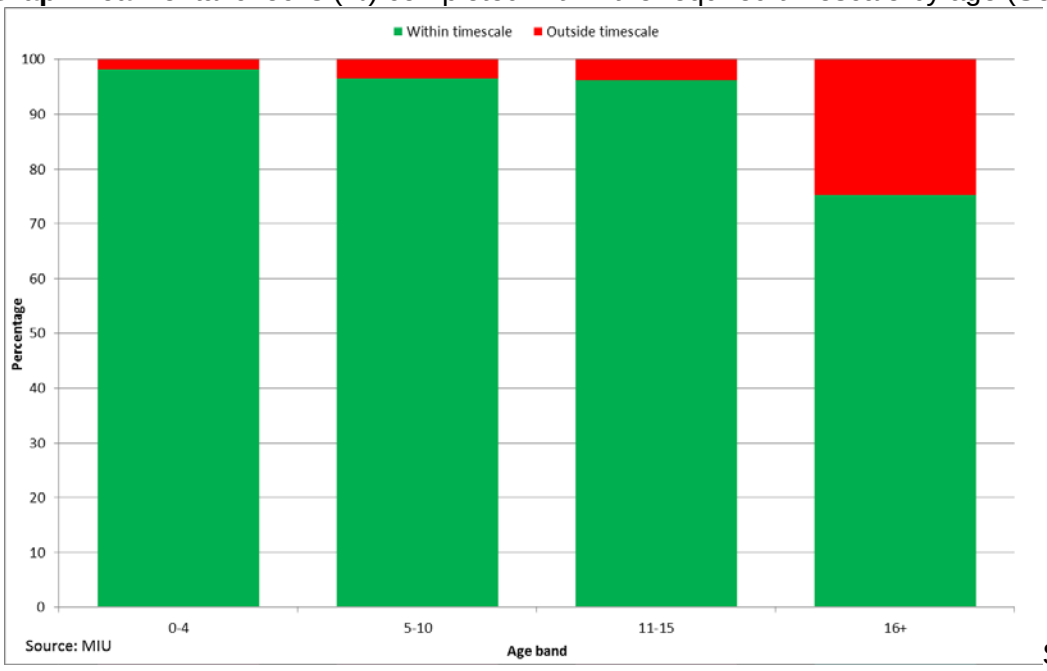
Graph 16 Up to date immunisations (%) of Kent and England children in care (2010 to 2013)



Source: ONS (data as of March 31st of each year)

Dental checks are better completed within the required timescale among children in the younger age groups. Across all ages, 92% of dental checks were completed within the required timescales (Graph 16a).

Graph 16a Dental checks (%) completed within the required timescale by age (Sept 2013)

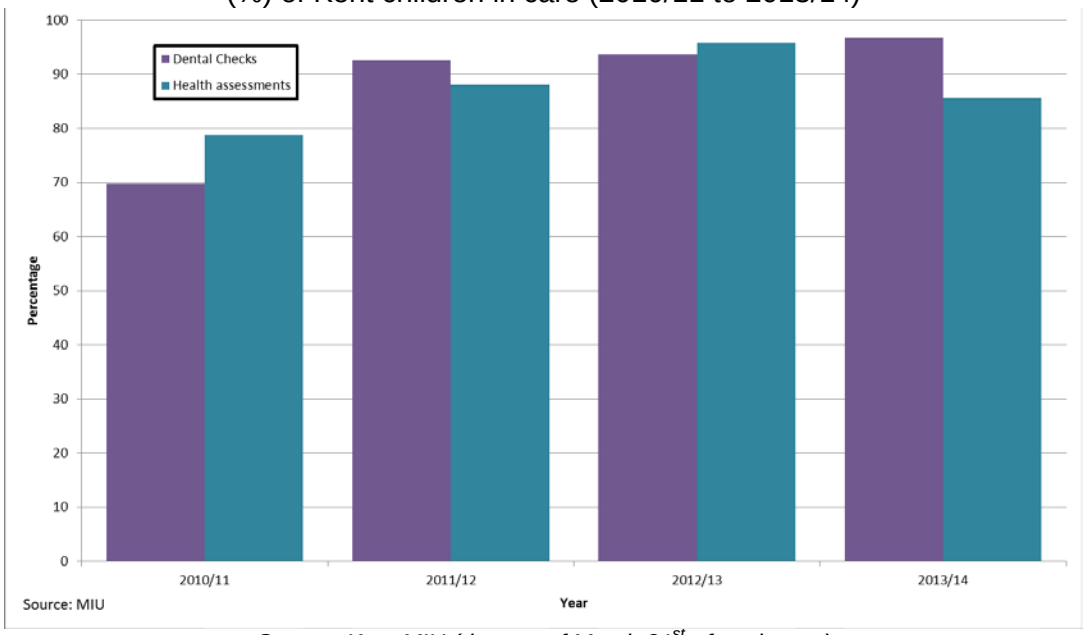


Source:

Source: Kent MIU

The percentage of **dental checks** completed within the required timescale has increased over the past four years, whilst the percentage of **health assessments** increased between 2010/11 and 2012/13 and decreased in 2013/14 (Graph 16b).

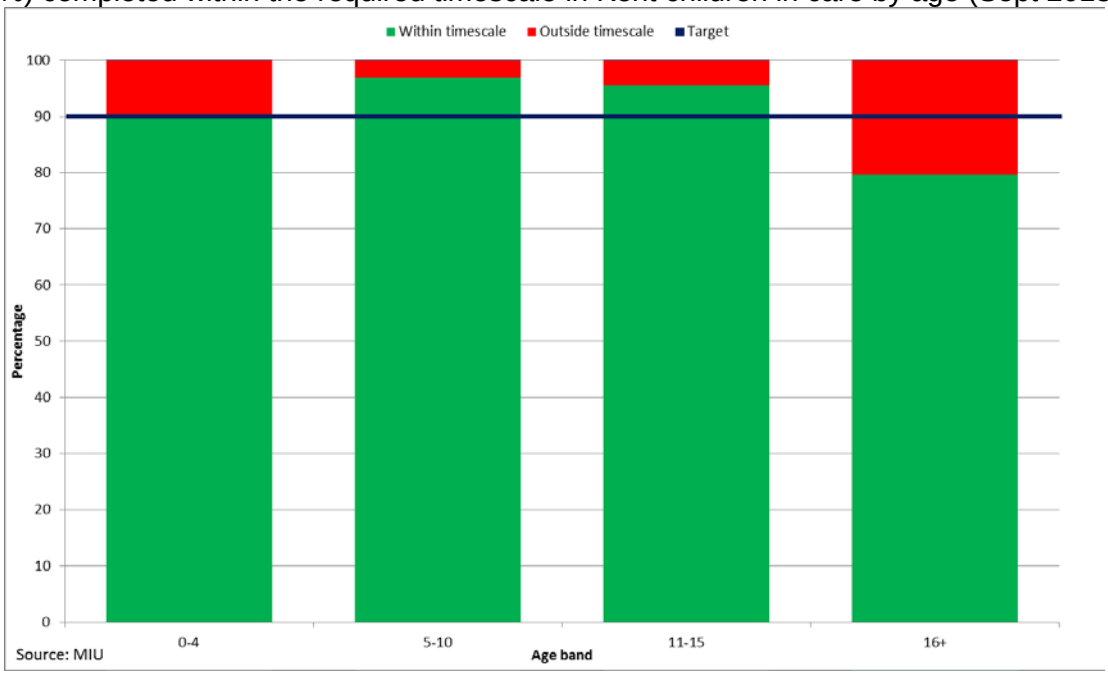
Graph 16b Health assessments and dental checks (%) of Kent children in care (2010/11 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

Kent children in care aged 5 to 10 years old had the highest percentage of **health assessments** completed within the required timescale (97%), whilst children in care aged 16+ years old had the lowest percentage completed (80%). Across all ages, 91% of health assessments were completed within the required timescale (Graph 16c).

Graph 16c Health assessments (%) completed within the required timescale in Kent children in care by age (Sept 2013)



Source: Kent MIU

It is important to note that the performance on health assessments, dental checks and up to date immunisation status is not routinely reported about children in care placed outside their local authority. Furthermore, with regard to children who did not have their checks within the statutorily required timescales, there is no reporting whether they had their checks with some delay (i.e. more than four weeks) or at all.

2.2 Strengths and difficulties questionnaire (SDQ)

All children in care aged between 4 and 16 years old should have a strengths and difficulties questionnaire (SDQ) completed by their main carer as part of their health assessment. The social worker completes the questionnaire for the young people aged below 17 years old, who live independently. The questionnaire asks the carer to judge how well various statements describe the child/young person living with them. If the SDQ score is assessed as being of concern, the school teacher and social worker are also requested to complete an SDQ questionnaire.

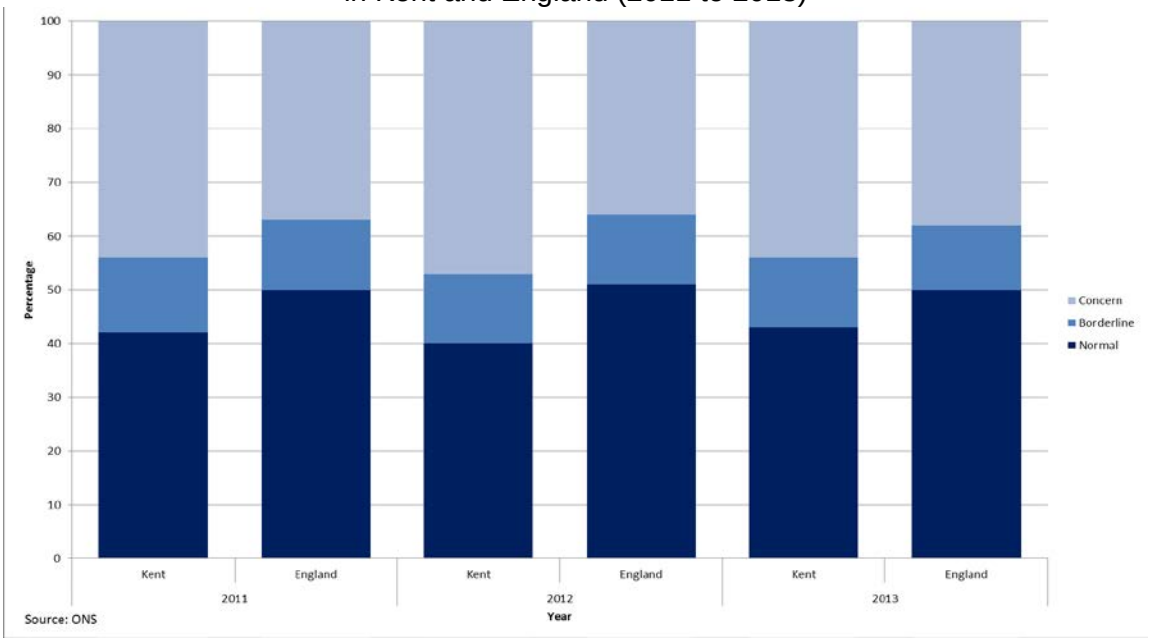
Table: Average score for children looked after at 31 March for whom a Strengths and Difficulties Questionnaire (SDQ) was completed

	Kent			**Stat Neighbour**			**England**		
	2011-12	**2012-13**	**2013-14**	**2011-12**	**2012-13**	**2013-14**	**2011-12**	**2012-13**	**2013-14**
Total number of eligible children	790	830	925	395	406	413	32,980	33,880	34,770
Number of eligible children with an SDQ score	555	490	700	230	235	214	23,470	24,100	23,650
Percentage of eligible children for whom an SDQ score was submitted	70.0	59.0	76.0	58.4	56.4	56.8	71.0	71.0	68.0
Average score per child	16.0	15.4	14.6	14.4	14.4	14.3	13.9	14.0	13.9
Percentage of eligible children with an SDQ score considered:									
* A higher score on the SDQ indicates more emotional difficulties. A score of 0-13 is considered normal, a score of 14-16 is considered borderline cause for concern and a score of 17 and over is a cause for concern.									
Normal	40.0	43.0	47.0	48.2	47.9	49.3	51.0	50.0	50.0
Borderline	13.0	13.0	12.0	12.4	12.9	12.2	13.0	12.0	13.0
Concern	47.0	45.0	41.0	40.1	40.0	38.3	36.0	38.0	37.0
Source: DfE Outcomes for children looked after									

A score below 13 is normal, 14-16 is border line and above 17 is cause of concern.

There are higher numbers in the concern band in comparison to statistical neighbours and the England average. The average SDQ score for eligible Kent children in care is higher than that in England (Graph 16e).

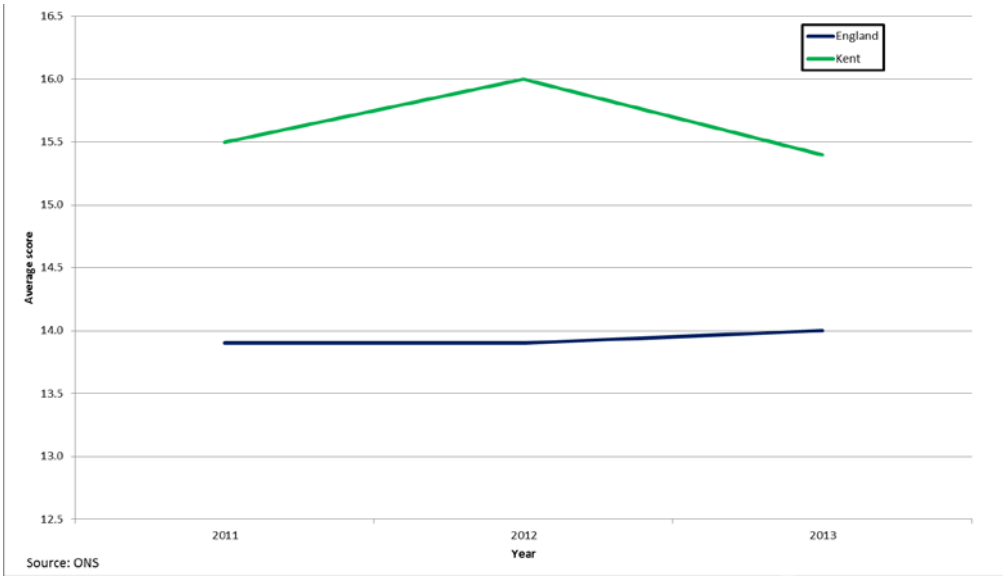
Graph 16d Children in care (%) by SDQ score banding in Kent and England (2011 to 2013)



Source: ONS

Graph 16e SDQ average scores for Kent and England children in care (2011 to 2013)

The denominator is children who have been looked after continuously for at least 12 months

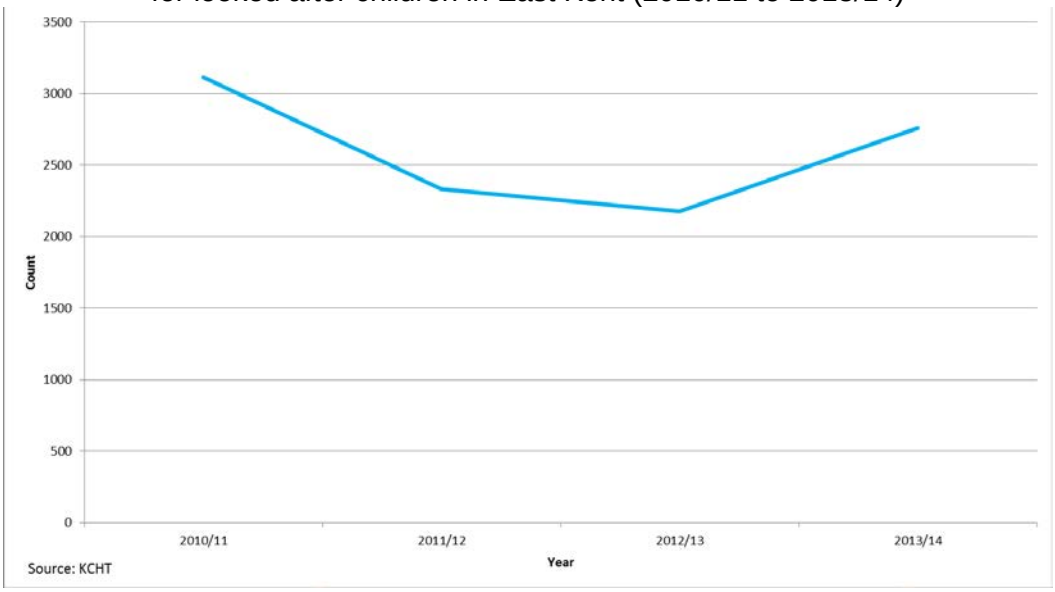


Source: ONS

2.3 Health assessments

Activity data on review health assessments of children in care is only available electronically for East Kent (not available for review health assessments in West Kent and initial health assessments across Kent). The total nursing for looked after children activity in East Kent has started to increase in 2013/14 after a decrease (2011/12 and 2012/13) (Graph 16f). There is no obvious explanation for this decrease, as the number of children in care has increased during the same period. Only 16 children in care had a health assessment at home in East Kent (2010/11 to 2013/14). There is considerable monthly variation in the activity levels with no obvious month on month pattern discernible. In 2013/14, the activity increased in relative terms more sharply compared to the actual number of children in care seen (see appendix graph 79).

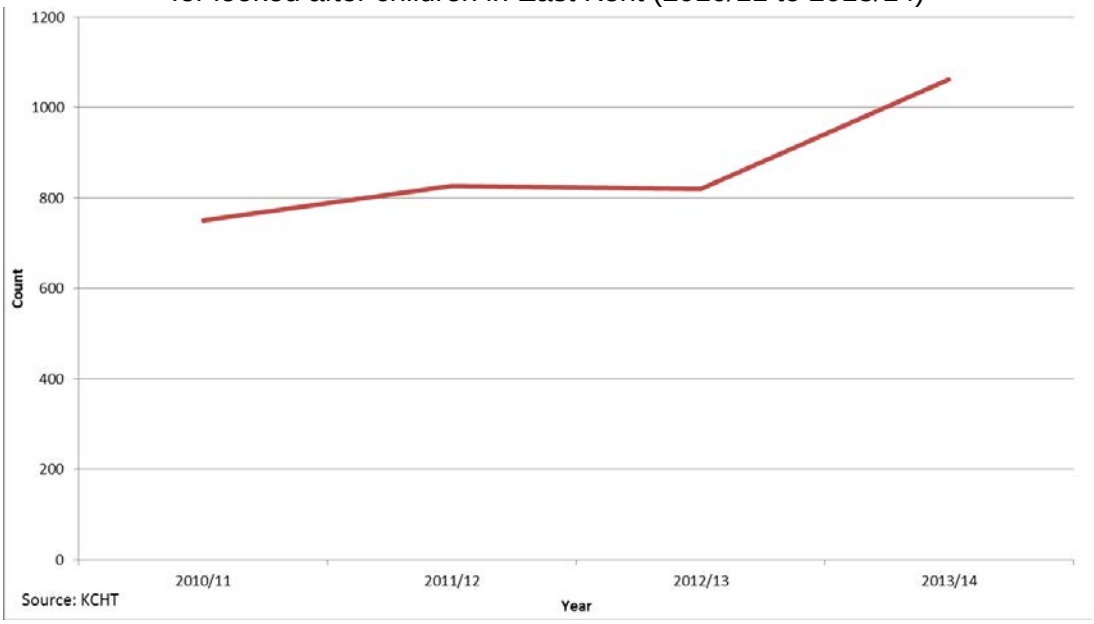
Graph 16f Number of activity episodes of nursing staff
for looked after children in East Kent (2010/11 to 2013/14)



Source: Kent Community Health Trust (KCHT)

On the other hand, the number of review health assessments performed by nursing staff for looked after children in East Kent has increased by 42% during the same period (from 750 in 2010/11 to 1062 in 2013/14) (Graph 16g). There is a similar considerable monthly variation in the number of review health assessments performed (see appendix graph 80). The number of health assessment administration sessions decreased substantially in the years 2011/12 and 2012/13 and has increased sharply in 2013/14 (see appendix graph 81). The percentage of DNAs for review health assessments has improved in the last year (see appendix graph 82).

Graph 16g Number of review health assessments by nurses for looked after children in East Kent (2010/11 to 2013/14)

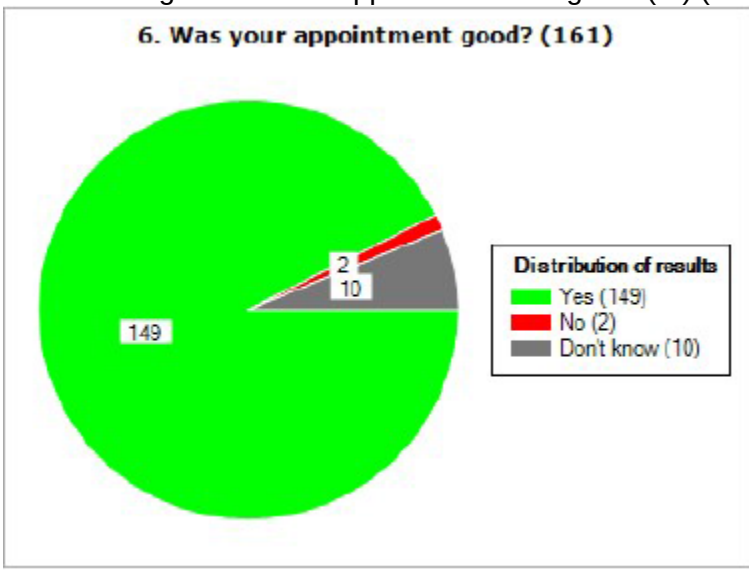


Source: Kent Community Health Trust (KCHT)

2.4 Patient satisfaction with review health assessments

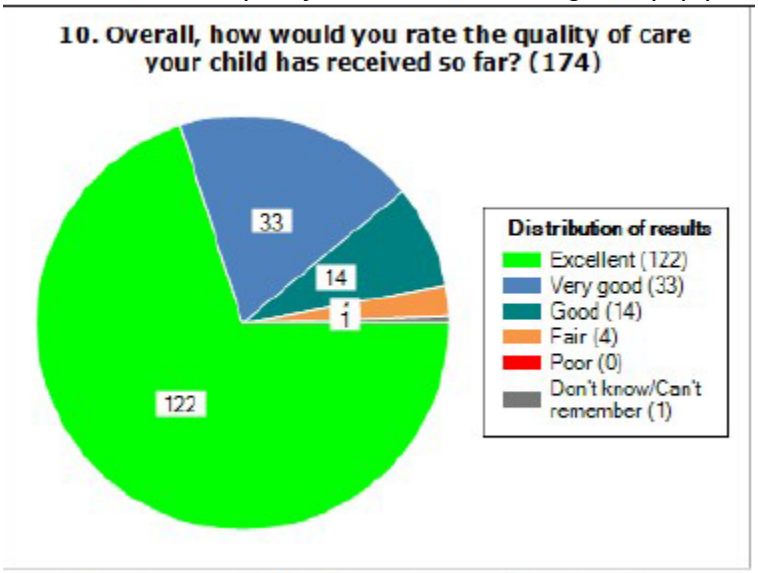
KCHT patient satisfaction surveys show high patient satisfaction rates. The great majority thought that the 'appointment was good' (93%) and 'would be happy to come to an appointment like this again' (83%) (Graph 16h and see appendix graph 83). Similarly the great majority 'liked the place where they were seen' (90%) (see appendix graph 84), thought that 'the time of the appointment was good' (84%) (see appendix graph 85) and that was 'easy to get to the place where the appointment was held' (95%) (see appendix graph 86). Overall, they rated the 'quality of care as at least good' (97%) (Graph 16i) and they were 'likely to recommend this service to friends and family if they needed similar care or treatment' (87%) (graph 34). Good included ratings of good, very good or excellent

Graph 16h Children in care who had a health assessment by a KCHT nurse for looked after children and thought that their 'appointment was good' (%) (2013/14)



Source: KCHT N=161

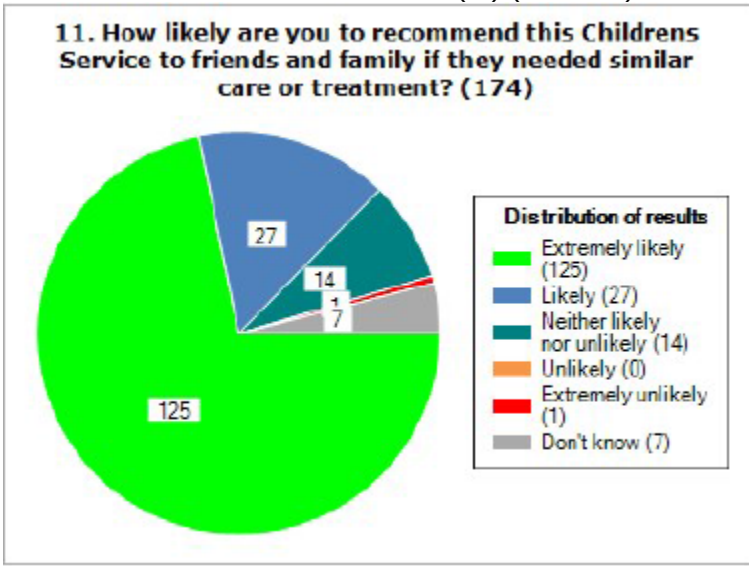
Graph 16i Children in care who had a health assessment by a KCHT nurse for looked after children and rated the 'quality of care as at least good' (%) (2013/14)



Source: KCHT N=174

KCHT nursing team do not record the number of looked after children and the number of carers who are offered the opportunity to complete the patient satisfaction survey.

Graph 16j Children in care who had a health assessment by a KCHT nurse for looked after children and were 'likely to recommend this service to friends and family if they needed similar care or treatment' (%) (2013/14)



Source: KCHT N=174

2.5 Audit of review health assessments

KCHT audited (2012) the quality of the review health assessments of children in care performed by KCHT nursing team for looked after children. The audit demonstrated that there was a high compliance rate in discussing all the elements of the health assessment across all ages, especially in the 11-18 year olds. This may be attributed to the use of the BAAF form which is formulated in such a way as to reduce the chance of a health element being missed. The audit also established that 100% of the health issues identified in the review health assessments were reflected in the subsequent health action pan.

The audit identified that on a number of cases, there was no obvious record of consent, copies of past health assessment records were not always available and that there was a lack of completeness of part A of the BAAF form; all of which could potentially have an impact on the quality of the health assessment. As a result of the audit an action plan was developed. A follow up audit was completed in May 2014.

2.6 Health Assessments in West Kent

The Care Quality Commission (CQC) undertook a review of services for children looked after In the West Kent area of, Swale, Dartford, Gravesham & Swanley Clinical Commissioning Groups (CCGs) in April 2014.

Initial health assessments (IHA) undertaken in West Kent were commended for being innovative and providing social care with an understanding of 'generic future risk'. However, there were a number of recommendations made about the need for improvements in a range of areas. The inspectors noted that the Children in Care nursing team was extremely stretched. All the recommendations made by the CQC are being addressed through a full action plan agreed with the CQC.

2.7 Child and Adolescent Mental Health Services (CAMHS)

The CAMH service for Kent children in care has been delivered by Sussex Partnership NHS Foundation Trust since September 2012. New criteria and pathways have been agreed and the waiting times are reported to have been reduced. There is an additional CAMHS service for Kent children in care to ensure these children who often have high needs for CAMH services get the services they need on a timely basis.

The CAMH service reported that 485 referrals of children in care had been received (Apr 14 to Mar 15).

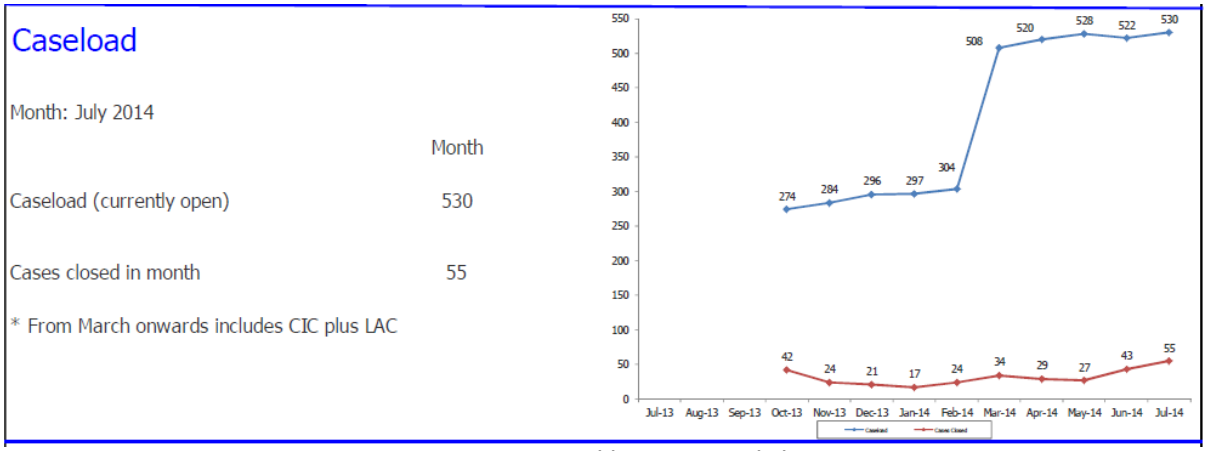
Table Number of referrals of Kent children in care to the CAMHS for looked after children (Sussex Partnership NHS Foundation Trust) by age and gender (Apr 2014 to Mar 2015)

Age (years)	Number of referrals (%)
0-3	5 (1)
4-10	145 (29.9)
11-15	214 (44.1)
16-18	120 (24.7)
18+	1 (0.2)
Gender	
Male	258 (53.2)
Female	227 (46.8)
Not recorded	15 (8)

The most common emotional/mental health issues managed by the service:

- Attachment disorders
- Trauma from early childhood
- Self harm
- Depression
- Separation anxiety
- Post traumatic stress disorder
- Drug and alcohol misuse
- Placement breakdown
- School absconding

Graph 17 Number of cases (Kent children in care) managed by Sussex Partnership NHS Foundation Trust mental health services by month (Oct 2013 to July 2014)



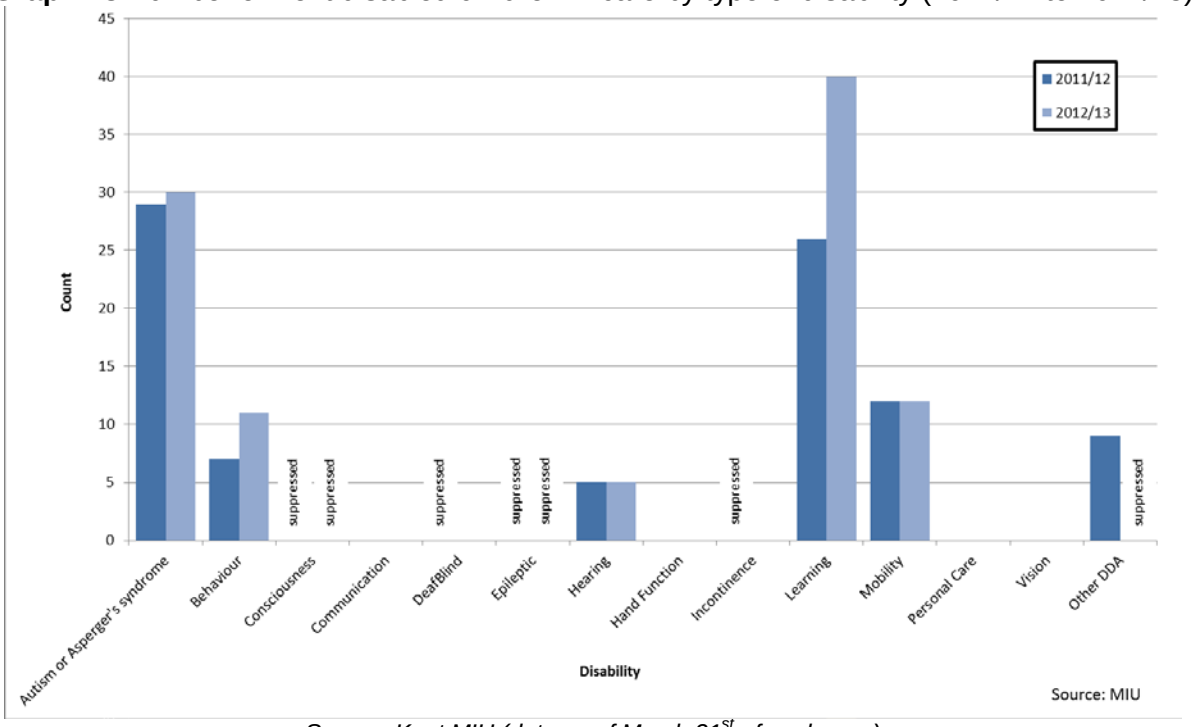
Source: Sussex Partnership NHS Foundation Trust

2.8 Drug and alcohol

Most of the children in care starting specialist treatment for substance misuse were male and aged 16 years old (see appendix graphs 90 and 91). 80% of children in care starting such treatment were from East Kent (see appendix graph 92). The number of children in care seen by KCA early intervention services is highest in Canterbury (67) and Swale (61) (see appendix graph 93).

2.9 Disability

Graph 18 Number of Kent disabled children in care by type of disability (2011/12 to 2012/13)



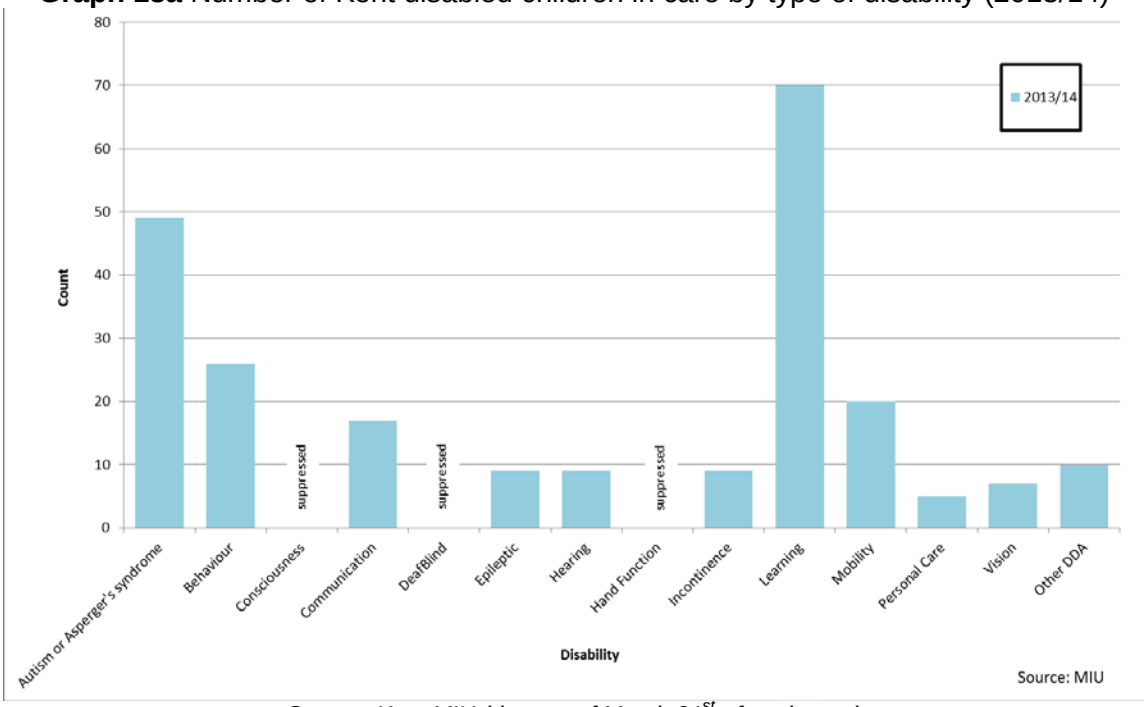
Source: Kent MIU (data as of March 31st of each year)

Disability data are not provided for 2009/10 and 2010/11 as there are reporting differences. From 2013/14, more than one type of disability per child can be recorded; a change from previous years where only the primary type of disability was recorded.

There was an increase in the number of Kent children in care with a disability (from 92 in 2011/12 to 141 in 2013/14). The increase was particularly observed in the behaviour and learning disabilities categories (Graph 18a). In 2013/14, 70 Kent children in care had a learning disability (Graph 18b).

There are 141 children in care with a disability record (March 2014). 43% (61 children) had a legal status of being accommodated under Section 20 of the Children's Act. 18% (25 children) were placed outside Kent.

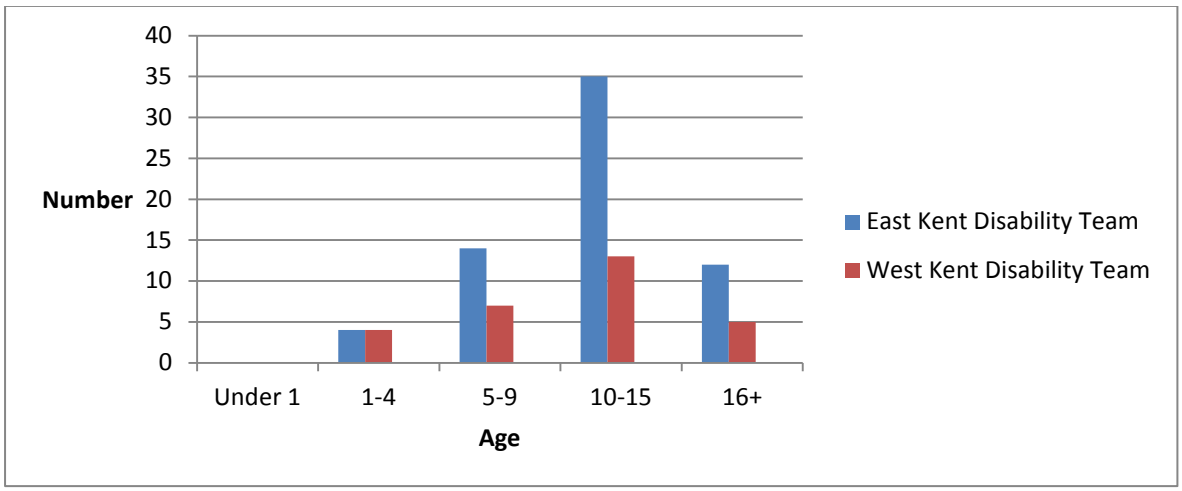
Graph 18a Number of Kent disabled children in care by type of disability (2013/14)



Source: Kent MIU (data as of March 31st of each year)

Kent has a total of 94 children in care with disabilities (February 2015), of these 65 are supported by the East Kent disabilities teams and the remaining 29 by the West Kent team

Graph 18b. Children in care with disabilities (by age and team)



The predominant disabilities in Kent's children in care are Autistic Spectrum Conditions and behaviour and learning issues. Children over the age of 10 are particularly represented in these needs (see graph 9) and are some of our most difficult children to place.

SECTION 3: THE FINDINGS

Findings, including themes/concerns from the interviews

First some recent changes

Since October and the first draft of this health needs assessment there have been a number of changes in the way that Kent County Council organises its services for children in care. In particular services for care leavers have been integrated and become part of the area Children in Care teams across Kent. This is designed to ensure delivery of the Government Strategy for Care Leavers to ensure they get the same support most children would get from their own parents. It also means there are fewer changes of social worker for children in care.

Early Help Services have also been transformed, integrating several services to deliver more integrated and focussed services designed to reduce the need for children to come into care.

Summary of main findings

- Limited availability of local data about the health needs of looked after children.
- Upward trend of the number of looked after children.
- Need to review the capacity and quality of the health assessment system.
- The average SDQ score for eligible Kent children in care is significantly higher than the England one.
- Significant differences in attainment between Kent children in care and the Kent general school children population at all levels of education.

Demography

- There has been a 25% increase in the number of Kent children in care in the last five years. The number of looked after children across England has increased by 12% (2008/09 to 2012/13).
- Thanet has the highest number of children in care. Overall, east and south Kent districts have more looked after children than the rest of the county. Children from these districts are more likely to be placed within the district of their home address.
- Most children in care are in the age group 12-18 years old. A decrease in the age group 0-4 years old has been observed in 2013-14.
- Children from non-white British background are over-represented amongst looked after children.
- Most looked after children are placed with foster parents; however the number of foster care placements has not increased in line with the increase in the number of looked after children. Relatively few children are placed in residential care.
- Across England, 59% of looked after children were placed under a care order (either interim or full) (42% in Kent).There has been a notable increase of special guardianships and adoptions in the last five years.

Education

- Kent children in care have a higher rate of fixed school exclusions compared to the general school child population of Kent. The number of fixed school exclusions has fallen rapidly in Thanet in the last five years. Swale has relatively high numbers of fixed school exclusions and SEN statements amongst their looked after children.

- The percentage of Kent children in care that had a SEN statement is approximately 10 times higher than the percentage of children who had a SEN statement amongst the general school children population for both Kent and England.
- There has been a marked decrease in school absences amongst children in care both in Kent and across England
- Overall, there are significant differences in attainment between Kent children in care and the Kent general school children population at all levels of education.
- 73% of children now aged 19 years old who were looked after when aged 16 years old are deemed to be living in suitable accommodation.
- 8.8% of children in care aged over 10 years old were subject to a conviction, final warning or reprimand in Kent.

Health

- Kent has a higher percentage of children in care who have up to date immunisations and dental checks than England; however the percentage of children in care with their annual health assessments completed is lower than England.
- The majority of Kent children in care have scored in the concern band (>16) of the strengths and difficulties questionnaire. The average SDQ score for eligible Kent children in care is higher than the England one.
- The number of review health assessments performed by nursing staff for looked after children in east Kent has increased by 42%. The number of health assessment administration sessions decreased substantially in the years 2011/12 and 2012/13 and has increased sharply in 2013/14.
- Audit of the review health assessment of children in care demonstrated a high compliance rate in discussing all the elements of the health assessment across all ages. The audit also established that 100% of the health issues identified were reflected in the health action plan. The audit identified that on a number of cases, there was no obvious record of consent, copies of past health assessment records were not always available and that there was a lack of completeness of part A of the BAAF form; all of which could potentially have an impact on the quality of the health assessment.
- 90% of referrals to CAMHS were initiated by social workers. The average waiting time is 5 weeks. 173 (65%) of appointments attended are face to face.
- There was an increase in the number of Kent children in care with a disability.

Other

- The number of UASCs becoming looked after peaked in 2009/10 and since then decreased by almost a third. More than half of UASCs come from only two nationalities (Afghanis and Eritreans).
- The number of OLA children in care placed in Kent has decreased by 16% (from 1421 in 2009/10 to 1200 in 2013/14). The decrease in number of OLAs has been observed for most placing OLAs with the exception of Greenwich, Medway, Hammersmith and Fulham and Southwark. Thanet and Swale have the highest number of children in care from other local authorities placed within them. The majority of children in care placed in Kent by other local authorities (OLAs) come from London.
- The number of Medway children in care placed in Kent increased by more than 50% (from 77 in 2009/10 to 120 in 2012/13). A considerable number of Medway children in care have been in care for a number of years before being placed in Kent.

Summary of interesting findings from interviews and focus groups

Care for looked after children

- There is a spike of new entrants into care at the age of 16 or 17 years old that is relatively costly to look after and they may have worse outcomes.
- Following the 'Southwark judgment', social services have to become responsible and find accommodation for the children who leave their homes and declare themselves 'homeless', in some cases until the age of 25 years old.
- Strengths of Kent LAC arrangements are the development of:
    - the Virtual School Kent team. Although it is a statutory requirement for every local authority to have a nominated Virtual School head, some local authorities are doing very little in this area
    - a dedicated CAMH team for LAC. As a result, health professionals have the opportunity to become more specialists in addressing the needs of LAC.

CAMHS – mental health

- KCC commissions a general CAMH service for all Kent children and a dedicated service for LAC. The service is not yet fully staffed.
- UASCs have difficulty accessing CAMH service for LAC. The waiting times can be long.
- Some UASC staff has mental health training, but they do not have the structures and protocols.

Care leavers

- Important issues are: the transition to adult services e.g. age of transition for young peple under CAMHS and variability across Kent of access to adult social services; the Liberi pathway plans are not in their current format a useful working document for young peple; insufficient accommodation for 18-21 year olds as there has been a reduction of social housing and increasingly private landlords avoid tenants on housing benefits and care leavers do not have guarantors.
- There is an increasing number of young people under the 16+ service with mental health issues; primarily conduct disorders. Care leavers are often also over represented amongst young people in custody.

Disability

- Important issues are: the need for more CAMHS provision for disabled children; more reources to support families to avoid their disabled children entering into care; to develop more residential care capacity within Kent, so could potentially repatriate Kent disabled looked after children that are placed outside Kent.

Employment

- Employment opportunities for looked after children; it is difficult for looked after children to find employment.

Health assessments

- The uptake of health assessments by 16+ children in care is around 75%. Catch 22 has tried to increase uptake by organising health days, offering vouchers with some limited success. Young people do not like the health assessments as they perceive them as 'stigmatising' and they cannot see the benefit 'as they are not ill' and their non looked after peers do not have to attend. It may be useful for LAC nurses to pilot the use of consultations by telephone or Skype. It is important that they are timed to avoid a child missing school. It is unlikely that a health assessment will identify new problems that the case workers will not be already aware of.

- We need to think innovatively on how to engage with this age group, make the service more accessible and flexible e.g. a 16+ LAC who had an initial and a couple of review health assessments may not need a face to face one, or may need one every two years, or just send information leaflets, or be contacted by phone call or complete a postal questionnaire. One size may not fit all.
- For health assessments, we report whether completed within statutory time limits, but not any health outcomes (e.g. drinking, smoking) and any follow up to establish whether any change took place. There is no way to know whether we make any difference. The impression is that we do not make the difference that we could.
- There is evidence that health assessments make a difference; however if they are performed in isolation, the benefits are significantly reduced. If they are completed as part of a continuous engagement (e.g. health histories for care leavers, training and support to other health professionals and foster parents) with the children and their carers, they can be very effective. It is important that health action plans are followed up and ensuring that are implemented. The KCHT LAC nursing team is not currently involved in much of this work other than health assessments, as they do not have the capacity.

Nurses for looked after children

- It would be useful to model the required capacity to deliver health care to looked after children (initial and review health assessments).
- In east Kent, health assessments mostly take place in local health clinics, where in west Kent, there are a greater number of health assessments that take place as part of home visits. A possible explanation is that the west Kent is more rural than the east and LAC are geographically more widely dispersed. Home visits for health assessments are justified only in exceptional circumstances, as they are much more labour intensive.
- The main provider of universal health care for LAC is their GP and their school nurse. Communication with school nurses can be improved and to be made aware of the LAC (especially those placed from OLAs) that attend schools in their patch.
- Nurses often do not know if the child has seen other health professionals, as they are not routinely copied in the correspondence between health professionals.
- The number of looked after children has increased and as a result the number of health assessments has increased; consequently they have limited time resource to support LAC for other issues (that are not statutorily required). The LAC nurses have recently started doing health assessments for under 5s, for children with complex needs and for children that are placed for adoption. These changes were primarily in response to lack of capacity of community paediatricians (in east Kent) and although some were supposed to be temporary measures, they have now become permanent arrangements. These issues are currently being addressed. They feel that they are not adequately trained and experienced for these assessments (especially for the review adoption medicals).

Health care

- We should address the need to develop effective consent pathways for the situations where LAC required invasive interventions (e.g. insertion of grommets). It was also important that LAC, when they had to change placements while they are on the waiting list for specialist treatment, do not go to the bottom of the waiting list if they had to be transferred between health providers.

Health information

- Catch 22 used to record (as part of their contract reporting) referrals to CAMHs, for sexual health advice, pregnancies (this has stopped, once the collaboration with the teenage pregnancy coordinator ceased).

- We do not have a good understanding of the health needs of LAC and as a result may not be commissioning appropriate services (e.g. speech and language problems, dealing with substance misuse during pregnancy). As a result, it is difficult to make the case to commissioners about the health care needs of LAC. On the other hand, we have no reason to believe that the health care needs of Kent LAC are different from those of the rest of country. Similarly, it is not possible to describe the areas of Kent where the children with specific health needs are located.
- It is important that local health services collect their own data about the health needs of looked after children (e.g. KCHT recording health needs and outcomes electronically), so we are able to provide commissioners good information to inform future commissioning decisions. At present most LAC health records that are electronically recorded are not retrievable as they are saved as free text documents.
- A health database for LAC in Medway is operational and provides a wealth of information about LAC health needs.

OLAs looked after children placed in Kent

- OLAs looked after children are usually older children (rarely under 5s) who are placed in Kent because there is increased local foster care capacity. Some of those placed in Kent are difficult to place in their originating localities. Financial considerations are also an important driver, but not the only one.
- The health assessments for OLAs looked after children are performed by one WTE nurse. This resource is insufficient to complete assessments for all OLAs LAC (approximately 1200); it is sufficient for about 300 health assessments per year. We do not have information about who covers the needs of the rest of the OLA children.
- For some OLA children in care, LAC nurses have limited information when they receive requests to perform their review health assessments.
- The reasons for the placement of OLAs LAC in Kent are that: London LAs do not have sufficient foster care places within their areas; some looked after children are moved to Kent for safety reasons (usually teenagers); Kent having spare capacity both in foster and residential care (e.g. Thanet) and financial reasons.
- Two years ago, an OLA LAC workshop was organised locally. One of the outcomes was the confirmation that placing local authorities were not aware of the issues around LAC placements in Thanet. It is important that prospective placing local authorities are informed about these issues as this potentially affects the wellbeing of LAC.
- The LAC nurses have the impression that OLA LACs have more complex health needs (especially mental health). The mental health support of OLAs LAC can be variable.

Placements

- Most Kent children in care that are placed outside the county are placed in Medway. The remaining are placed outside Kent because they are with family and friends or placements for adoption or in need of specialist provision that is not available in Kent.
- Kent has relatively few looked after children placed outside the county. A significant number of those children placed outside Kent have specific needs that cannot be provided locally.

Teenage pregnancy

- It is important to look in teenage fathers as well, not only teenage mothers. Another consideration is to avoid the babies of teenage mothers who are looked after entering care as well.
- Teenage pregnancy is an issue. On one hand, there is evidence that looked after children have a higher prevalence of teenage pregnancies, on the other hand looked after teenagers can be pressured in getting a long term contraceptive implant because of this.

Thanet

- There are more children in care from Thanet because of high deprivation and increased drug misuse; however many children from across Kent are also placed in Thanet. Kent County Council has tried to raise the issue of other local authorities looked after children being placed in Thanet, as it is a high risk area for looked after children.

UASCs

- UASCs have to some extent different health needs from the other LAC. One of the important issues is emotional and mental health needs and access to translation services. In the majority of cases, their physical health is good. Screening for infectious diseases such as blood-borne viruses and tuberculosis should be prioritised. This is not easy to manage during a routine health appointment and there are difficulties in obtaining consent as if treatment is required, this can be long and difficult.
- Local health services were not well equipped to deal with UASCs. The local contract with primary care team providing initial health assessments to UASCs is under review, as it is not as effective as it should be. As numbers of new UASCs have increased, the local primary care team does not have the capacity to see them in a timely manner.
- Many of the UASCs are resilient and resourceful, but equally some of them find it difficult to manage their new life situations. They have a health assessment at the time of entry into care. Their physical health needs are similar to other adolescents. They however sometimes cannot understand and describe well their emotional issues.
- UASC service had not had many children with hepatitis B or C. However, they are not routinely tested or vaccinated, despite most of them coming from high risk countries for hepatitis B & C.
- All participants at the Care Leavers focus group thought that health assessments were ‘too long’, age inappropriate and on occasions lacking tact. It was suggested that a LAC nurse should contact the social worker in advance of the health assessment that could lead to a better understanding of the child. They should be flexible to better tailor their assessment to the needs of the individual child. It was also suggested that health professionals should have specific training as to how to talk to young people. Looked after children should be asked if they had any concerns of their own.
- One respondent noted that she did not want ‘things to go down on her medical record’. She was worried about health professionals sharing information.

SECTION 4: RECOMMENDATIONS

Children's Social Care

- Involve looked after children as much as feasible in decisions about their own care
- Improve the Pathway Plans for care leavers
- Improve the emotional and mental health support for children in care, particularly care leavers
- Develop a service to support proactively the health and wellbeing of care leavers
- Review the need for mental health training of care leaver service staff
- Develop links with private care providers in Kent to looked after children

Health organisations

- Organise systematic screening for infectious diseases (e.g. tuberculosis and blood-borne viruses)
- Implement the guidance for the vaccination of children with unknown immunisation status and organise vaccinations as appropriate (consider using accelerated Hepatitis B vaccination schedule)

Shared improvements to Information Systems and shared developments

- Improve coding of the Children in Care nursing team activity (update codes and develop coding guidance)
- Model capacity of looked after children team to deliver health assessments (initial and review) and benchmark against other local authorities (e.g. Medway)
- Improve health assessment uptake among 16+ LAC and UASCs (e.g. avoid appointments during school time, accessible locations, review need for face to face appointments, frequency and duration, consider using phone and questionnaires, organise health days, offer vouchers as incentives). There is also a need to Improve follow up of health action plans (developed as part of a health assessment)
- Develop a more proactive involvement of Children in Care health team to support the health needs of children under their care (e.g. health histories for care leavers, support other professionals involved with Children in Care, follow up of A&E attendances and hospital discharges, improve follow up of health action plans)
- Develop better communication (information gathering) with social workers and carers in preparation for a health assessment
- Develop confidentiality policy about health assessments (be explicit with Children in Care about what and with whom will be shared)
- Develop consent pathways for Children in Care
- Ensure that Children in Care are not disadvantaged when they have to move placements while on health care waiting lists
- Prioritise Children in Care in local action plans being developed as part of the implementation of the Kent teenage pregnancy strategy
- Investigate the underlying reasons of high SDQs amongst Kent children in care

- Ensure that CAHMS deliver what they are contracted to do around Children in Care needs
- Improve the collection of information on mental health outcomes and collect information about CAMHS for disabled looked after children
- Improve data about the health needs of children in care (including USAC and OLA). This should include ADHD, self-harm, Speech and language difficulties, bedwetting, Smoking, drug misuse, alcohol, sexual health, obesity, physical activity, A&E attendances, injuries, hospital admissions, GP registration and Teenage pregnancy. Data linkage (i.e. social care and health data) also needs to be developed.

Appendix: Detailed findings from interviews

What about the care for looked after children?

- Until a looked after child reaches her/his 16th birthday they may be with Kent In-House foster parents, with IFA foster parents, or in a Residential Care setting. After their 16th birthday, 'supported lodgings' becomes an option that is a 'lighter version' of foster care. After the age of 18 years old, foster care is not available anymore; however foster carers can become 'supported lodgings'. Alternatively, care leavers can access the housing benefit system and rent private accommodation.

- A concern is the spike of new entrants into care at the age of 16 or 17 years old who are relatively costly to look after and may have worse outcomes. We may not be doing enough for them. Many of these young people live at home, perhaps neglected or already known to Children's Social Care services. They and their families are not resilient enough to cope, and as a result they end up in care. A similar situation arises with some disabled young people when they become too challenging to care for during adolescence.

- Situations arises when an under 18 year old has left home and declares him/herself homeless. Following 'the Southwark judgment' (a legal challenge by a young person to Southwark Local Authority), any Local Authority has to assess them, and find them accommodation if this is seen to be necessary. In some cases this will mean supporting a young person until the age of 25 years old and is potentially a significant strain on local authority resources.

- Mark Kerr (University of Kent) is currently working with KCC to develop a social impact bond. The government provides funding to pilot a new model for multi-disciplinary assessments for children and young people in care. The project is in the second phase of funding.

- The existing strengths of arrangements for Kent children in care are:

    - The development of the Virtual School Kent team. Although it is a statutory requirement for every local authority to have a nominated Virtual School head, some local authorities are doing very little in this area, but in Kent this team is having a massive impact.

    - A dedicated CAMHS team for children in care. As a result, the treatment thresholds are lower for children in care who have high prevalence of mental health problems. Health professionals have the opportunity to become more specialists in addressing the needs of looked after children.

What about children who need mental health services?

- Overall the CAMHS service for looked after children was felt to be a good service. CAMHS for Children in Care is mainly a support service for foster parents and to a lesser degree offers direct work with looked after children. There may currently be insufficient capacity in the service. The service does not have access to a child psychiatrist.

- An important issue is the long term impact of poor attachment of young people who have suffered from inconsistent parenting (e.g. parents with mental health issues) throughout their childhood. By the time they enter care as teenagers, they are likely to have

difficulties with school, and be using alcohol and illicit substances. Some foster carers find it difficult to deal with these children.

- Staff recruitment is a big issue for both social care and mental health services, especially in West Kent, as local professionals often prefer to work in London or neighbouring counties. CAMHS currently sees around 500-550 children in care and their carers. Kent CAMHS is commissioned to provide care to 600 children in care and they usually offer 12 sessions per child. There is also another CAMHS service dedicated to disabled children but there is no recent data available about this service. There is no difference in treatment threshold criteria between the service for the general child population and the service for children in care.

- UASC children have difficulty accessing CAMHS. The waiting times can be long. Help from CAMHS is more forthcoming when there is an acute situation. The UASC service has a resource that supports UASC with emotional problems. There is need for more emotional support and guidance to UASC, to help them deal with their emotional traumas. Some SUASC staff have had mental health training, but they do not have the structures and protocols they need.

What about care leavers?

- Catch 22 is a voluntary organisation that has delivered services for care leavers in Kent (Kent 16+ service) for over 15 years, but from 1st October 2014 the operational responsibility has moved in house with Kent County Council. Care leavers are now supported in their transition from the care system to adulthood and independent living, including accessing suitable and secure accommodation by area team social workers and personal advisers. The transfer of operational responsibility back to Kent County Council has already reduced the disruption to looked after children caused at the age of 16 years old by a change of worker.

- Important issues are the transition to adult services. For example age of transition for young people under CAMHS and the variability across Kent of access to Adult Social Care services.

- The Liberi (Children's Social Care Child Record System) pathway plans are not in their current format a useful working document for young people.

- There is insufficient accommodation for 18-21 year olds as there has been a reduction of social housing and increasingly private landlords avoid tenants on housing benefits and care leavers do not have guarantors.

- Kent 16+ operates a supported lodging scheme for young people (16-25 years old), whereby they live within a family-type environment paying rent and being supported to acquire the living skills (such as budgeting, cooking, cleaning) and emotional resilience necessary to enable them to live independently. The carers (who are private providers) within this scheme are approved and receive comprehensive training and on-going support and supervision from the dedicated supported accommodation Catch 22 officers. The care leavers are given a living allowance that covers the cost of food, clothing, and utilities. Catch 22 pays for the accommodation and support costs. Once the young people turn 18 years old, they claim housing benefits that covers the rent; the support costs continue to be met by Catch 22.

- In recent years, there has been an increase of children aged 16 and 17 years old that enter care following the 'Southwark judgment'. Some young people enter the care

system not so much because they need a replacement family, but for independence. Most of these late entries (16 and 17 year olds) live in supported accommodation, as there is a limited number of foster carers who would accept children of this age.

- There is an increasing number of young people under the 16+ service with mental health issues; primarily conduct disorders. Care leavers are often also over represented amongst young people in custody.

What about children with a disability?

- It is sometimes difficult to find foster carers for disabled children. As a result, it is more likely for a disabled child in care to be placed in a residential home and on occasions because of their specialist needs to be placed outside Kent.

- When a disabled child in care is placed in a residential home, costs may be shared between health, education and social services. Children who are severely disabled (e.g. children with severe autism) are at a higher risk of becoming looked after in adolescence as a voluntary arrangement (where the responsibility remains with parents).

- Consequently, the age profile of disabled looked after children, is older. East Kent has a higher number of disabled children as a whole than west Kent and in particular higher number of disabled looked after children. This is partly explained by the higher deprivation in East Kent and West Kent has historically had better provision for disabled children (supporting disabled children to stay with their families).

- Health assessments are usually performed by the lead health professional that provides health care to the disabled child. Kent disability team is responsible only for Kent disabled children in care. There is a learning disability CAMHS service supporting disabled children and their families.

- The disability team provides support to approximately 1300 disabled children (of those 100 are looked after). The service has strict entry criteria. Important issues are: the need for more CAMHS provision for disabled children; more resources to support families to avoid their disabled children entering into care; to develop more residential care capacity within Kent, so could potentially repatriate Kent disabled looked after children that are placed outside Kent.

What about Education and Virtual School Kent?

- Kent has a multi-agency team for looked after children (Virtual School Kent). It comprises of a head teacher with his team and a social care team. It employs fostering liaison, education, family liaison, support officers (who work alongside looked after children) and the LAC nursing team and LAC health coordinators are co-located with VSK. VSK is responsible for Kent children in care.

What about health assessments?

- The uptake of health assessments by 16+ users is around 75%. We have tried to increase uptake by organising health days, offering vouchers with some limited success. Young people do not like health assessments as they perceive them as ‘stigmatising’ and they cannot see the benefit ‘as they are not ill’ and their non-looked after peers do not have to attend. They are more likely to comply if they have been in care long term. It

may be useful for LAC nurses to pilot the use of consultations by telephone or Skype. It is important that they are timed to avoid a child missing school. It is unlikely that a health assessment will identify new problems that the case workers will not be already aware of.

- Over 16s LAC have worse attendance record of their health assessments. We need to think innovatively on how to engage with this age group, avoid arranging the appointments during school hours and make them more accessible and flexible e.g. a 16+ LAC who had an initial and a couple of review health assessments may not need a face to face one, or may need one every two years, or just send information leaflets, or be contacted by phone call, or complete a postal questionnaire. One size may not fit all.

- The performance on timely completion of health assessments is in the low 90's; it is particularly low for over 16 year olds. This is an issue around the country. Half of those over 16 years old who have not had a health assessment have refused to have one. There is on-going work needed to improve health assessment uptake by making it more flexible, consulting with young people on their preferences. There is a need to better understand the health needs of looked after children (e.g. ADHD, autism), because if these are not identified it can cause challenges to their carers and teachers.

- For health assessments, we report whether they were completed within statutory time limits, but do not report any health outcomes (e.g. drinking, smoking) and any follow up to establish whether any change took place. There is no way to know whether we make any difference. The impression is that we do not make the difference that we could.

- However, there is evidence that health assessments make a difference, but if they are performed in isolation, the benefits are significantly reduced. If they are completed as part of a continuous engagement with the children and their carers, they can be very effective. It is important that health action plans are followed up and implemented.

What about Nursing capacity for children in care?

- It would be useful to model the required capacity to deliver health care to looked after children (initial and review health assessments). This has been already done in Medway; i.e. the LAC team employed 5 WTE nursing staff for 400 LAC children and 390 OLAs placed in Medway.

- Health care to looked after children entails more than the timely completion of the statutory health assessment (e.g. health histories for care leavers, training and support to other health professionals and foster parents). The KCHT LAC nursing team is not currently involved in much of this work other than health assessments, as they do not have the capacity. Although the local team has not provided the information to demonstrate this, it is likely that there is a need for more staff.

- Possible reasons for LAC nursing work increasing are:

    - short term transfer of responsibility for review assessments of children placed for adoption from community paediatricians to LAC nurses
    - In the past, social workers were not submitting timely requests for all the looked after children but this has changed in more recent years.
    - In East Kent, health assessments mostly take place in local health clinics, whereas in West Kent, there are a greater number of health assessments that take place as part of home visits. It is unclear whether this reflects unequal distribution of nursing resources. A possible explanation is that West Kent is more rural than the east and

LAC are geographically more widely dispersed. Home visits for health assessments are justified only in exceptional circumstances e.g. for disabled LAC, foster parents having other disabled children, or concerns about how the child functions at home. They are much more labour intensive as it takes as much time for a LAC nurse to complete three reviews in clinic as one during a home visit. If a higher DNA rate of health assessments is an issue, then social workers should be involved to encourage attendance.

- LAC nurses look after both children in care placed by KCC and from other local authorities. They do not provide services to care leavers. The LAC nurses are commissioned by CSU on behalf of all Kent CCGs and are employed by KCHT. They are physically co-located and closely collaborate with the VSK team.

- Review health assessments usually last between 30-60 minutes. For most review health assessments, nurses require extra time to prepare and follow up actions arising from the assessment (these are recorded as health assessments administration sessions as 1-2 per health assessment). LAC nurses do not routinely attend multi-agency plan meetings or LAC reviews. They do not immunise looked after children.

- LAC nurses do not receive information systematically about the private providers in Kent. They have developed good working relationships with one private provider.

- The main provider of universal health care for LAC is their GP and their school nurse. Communication with school nurses can be improved and to be made aware of the LAC (especially those placed from OLAs) that attend schools in their patch. Issues may also arise from the fact that many residential homes with educational facilities are private and are not routinely supported by school nurses (have open access to the school nursing service).

- Lack of coordination between services has sometimes been an important issue. This is often apparent during the health assessment. Nurses often do not know if the child has seen other health professionals, e.g. paediatricians, as they are not routinely copied in the correspondence between health professionals. This has been compounded from the fact that they are not co-located anymore with community paediatricians.

- The number of looked after children has increased and as a result the number of health assessments has increased; consequently nurses have limited time to support LAC for other issues (that are not statutorily required) such as puberty and sexual health advice. They have recently started doing health assessments for under 5s, for children with complex needs and for children that are placed for adoption. These changes were primarily in response to lack of capacity of community paediatricians (in east Kent) and although some were supposed to be temporary measures, they have now become permanent arrangements. These issues are currently being addressed. They feel that they are not adequately trained and experienced for these assessments (especially for the review adoption medicals).

- In west Kent, the designated doctors for looked after children are employed by KCHT and in east Kent by East Kent Hospital University NHS Trust. They are specialist community paediatricians. KCHT has just appointed a nurse consultant for looked after children who will be undertaking initial health assessments. The nurses for looked after children complete the review health assessments up to the age of 18 years old. All requests for health assessments are submitted by the social workers to the LAC coordinator. All health assessments include a health action plan.

- The designated nurse for looked after children for Kent and Medway works for the 8 clinical commissioning groups across the county providing expert strategic leadership and direction for looked after children. Kent CCGs have to provide services to meet the statutory health requirements for Kent looked after children, irrespective of where they are placed.

- It is important that health assessments are performed by experienced specialist doctors and nurses that have better understanding of the health needs of LAC. The health assessments completed by GPs are not of sufficient quality mainly due to lack of training or understanding.

- It is preferable that the same doctor should assess all siblings who are looked after; however this is not always feasible due to appointment availability.

What about Health care in general?

- It is important that services where looked after children are referred to are flexible and have sufficient capacity.

- There is a high number of looked after children that fall within the autistic spectrum; however diagnosis is not easy, as it is important to differentiate between autism and attachment issues. Many of the looked after children have also learning difficulties or balance/coordination difficulties. Access to SLT services and drug and alcohol services is limited.

- Other issues that needed to be addressed were the development of effective consent pathways for the situations where LAC required invasive interventions (e.g. insertion of grommets). It was also important that LAC, when they had to change placements while they are on the waiting list for specialist treatment, do not go to the bottom of the waiting list if they had to be transferred between health providers.

What about health information?

- Catch 22 used to record (as part of their contract reporting) referrals to CAMHS for sexual health advice and pregnancies (this has stopped, once the collaboration with the teenage pregnancy coordinator ceased).

- We do not always have a good understanding of the health needs of LAC and as a result may not be commissioning appropriate services (e.g. speech and language problems, dealing with substance misuse during pregnancy). More information was needed about the prevalence of speech and language problems and access to SLT services amongst LAC (agreed it is a problem across England).

- Overall, we do not have good information on the health of either Kent or OLAs looked after children placed in Kent (e.g. need for SLT therapy). As a result, it is difficult to make the case to commissioners about the health care needs of LAC. On the other hand, we have no reason to believe that the health care needs of Kent LAC are different from those of the rest of country. Similarly, it is not possible to describe the areas of Kent where the children with specific health needs are located.

- It is important that local health services collect their own data about the health needs of looked after children (e.g. KCHT recording health needs and outcomes electronically), so we are able to provide commissioners good information to inform future commissioning decisions. KCHT has some electronic records and has plans to develop this further.

However, at present most LAC health records that are electronically recorded are not retrievable as they are saved as free text documents.

- Getting data from any source across the local health economy is difficult. SystemOne records immunisations and other child health related information. It is unlikely that we can request information specific for looked after children.

- A health database for LAC in Medway is operational and provides a wealth of information about LAC health needs.

- The Liberi information system has recently been introduced in Kent as an electronic system to record the care of looked after children. It is not currently being used at its full potential to capture health care and health status information, including the use of the NHS number. These are the following areas:
    - parental risk factors
    - health conditions
    - other significant health events
    - substance misuse
    - medication
    - development
    - disability

- At the initiation of this health needs assessment, it was expected that it would be possible to link social and health care data to better understand the health needs of looked after children. This has not materialised to date, but it is expected that will be feasible in the near future. This initiative will provide a valuable source of information about the health service utilisation and health care needs of these children.

- No information is routinely available on the initial health assessments across Kent that are performed by community paediatricians and the review health assessments performed by KCHT LAC nurses in West Kent.

- The only information available was on the review health assessments performed by KCHT LAC nurses in East Kent. This information was of uncertain quality.

- KCC is currently developing plans for a school health survey across all Kent schools. As part of this survey, it is being considered whether children completing the survey should be asked whether they are looked after. If this question is incorporated in the survey, this would allow an analysis of the questionnaires by looked after status.

What about Other LAs looked after children placed in Kent?

- In principle, the placing authority is required to inform KCC when a child is placed in Kent. LAC nurses support KCC MIU team to keep the register updated. MIU team also writes to all local authorities every three months asking for information about children being placed in Kent. The response rate is variable. Overall, the information collected (from originating LA, school nurses, A&E staff and LAC nurses) captures better (however not complete) the time that children are placed in Kent, but less satisfactorily the time that they leave Kent. This issue used to be more pronounced some years ago, but now it has improved.

- OLAs looked after children have similar health issues to the Kent children in care. They are usually older children (rarely under 5s) who are placed in Kent because there is increased local foster care capacity. Some of those placed in Kent are difficult to place in

their originating localities. Financial considerations are also an important driver, but not the only one.

- Other LAs make requests to KCHT LAC nurses to perform review health assessments for their looked after children placed in Kent. The nurses will perform the assessment depending if the requesting LA is willing to pay for the assessment (nationally agreed tariff £262 per assessment. There is no charge for LAC placed in Kent prior to 1st April 2007) and if there is available capacity (that varies significantly throughout the year). Capacity depends upon the number of requests received from other local authorities at any one time that KCHT has no control over. Requests are often received late and it is therefore impossible to satisfy the statutory time frames.

- On receipt of a request to complete a review health assessment from another local authority, the earliest appointment date available is offered. The LA can accept or make alternative arrangements such as arranging for the child's GP to complete the health assessment or KCHT may offer arranging for a clinical room in Kent for the OLA LAC nurse to visit and complete the health assessment. The nurses try to accommodate as best as they can the needs of requesting local authorities. Although they are only commissioned to complete health assessments, they try when there is a need and it is feasible to provide additional support to the children (e.g. by sign posting to other services available).

- The health assessments for OLAs looked after children are performed by one WTE nurse (as an extra income generating service for KCHT). This resource is however insufficient to complete assessments for all OLAs LAC (approximately 1200); it is sufficient for about 300 health assessments per year. We do not have information about who covers the needs of the rest of the OLA children. KCHT nurses are aware that some local authorities send their own LAC Nurse to Kent to complete the review health assessments. For some OLA children in care, LAC nurses have limited information when they receive requests to perform their review health assessments.

- The reasons for the placement of OLAs LAC in Kent are that:

  1. London LAs do not have sufficient foster care places within their areas;
  2. Some looked after children are moved to Kent for safety reasons (usually teenagers);
  3. Kent having spare capacity both in foster and residential care (e.g. Thanet) and
  4. Financial reasons.

  It is also an indirect consequence of the decision taken by KCC to increase the number of Kent children in care being placed as close to home as possible, resulting in the number of Kent children in care being placed in Thanet to being reduced.

- Two years ago, an OLA LAC workshop was organised locally. One of the outcomes was the confirmation that placing local authorities were not aware of the issues around LAC placements in Thanet. It is important that prospective placing local authorities are informed about these issues as this potentially affects the wellbeing of LAC.

- The LAC nurses have the impression that OLA LACs have more complex health needs (especially mental health). The mental health support of OLAs LAC can be variable.

What about the placements of Kent children in care?

- Most Kent children in care that are placed outside the county are placed in foster care in Medway. The remaining are placed outside Kent because they are with family and friends or placements for adoption or in need of specialist provision that is not available in Kent.

- Kent has relatively few looked after children placed outside the county. A significant number of those children placed outside Kent have specific needs that cannot be provided locally.

- Being placed away from home (this is nationally reported as more than 20 miles away from home address), on one hand can be due to the child having special needs that can only be met by being placed further afield, but on the other hand can have a significant impact on the child's health and emotional wellbeing.

- The number of children in foster care is far higher than those in residential care in Kent. The proportion of children in residential care is fairly small, mostly boys. This is overall a beneficial development.

What about sexual exploitation?

- Catch 22 also records young people going missing as there are growing concerns about sexual exploitation and drug misuse. The child sexual exploitation (CSE) tool kit is completed when sexual exploitation is believed to be an issue.

What about teenage pregnancy?

- It was thought that there was a relatively small, but significant number of teenage pregnancies amongst Catch 22 service users.

- Being a looked after child is a well-recognised risk factor for teenage pregnancies, however it may be difficult to find information about teenage pregnancies amongst looked after children.

- Catch 22 provides reports. It is not an issue amongst UASCs as they are predominantly male. A report was also produced last year in response to an Ofsted request. It is important to look at teenage fathers as well, not only teenage mothers. Another consideration is to avoid the babies of teenage mothers who are looked after entering care as well.

- Teenage pregnancy is an issue. On the one hand, there is evidence that looked after children have a higher prevalence of teenage pregnancies, on the other hand, looked after teenagers can be pressured in getting a long term contraceptive implant because of this.

- The Kent teenage pregnancy has just been developed. Looked after children are one of the high risk groups for teenage pregnancies. They should be prioritised as part of the implementation of the strategy

What about 'the Thanet factor'?

- There are more children in care from Thanet because of high deprivation and increased drug misuse; however many children from across Kent are also placed in Thanet. Kent

County Council has tried to raise the issue of other local authorities looked after children being placed in Thanet, as it is a high risk area for looked after children.

What about UASCs ?

- UASCs arrive unaccompanied through local ports (mostly Dover) and immediately enter care. Service staff firstly assesses their age and their needs. Age is an important factor in decisions about the provision of care. The age assessment is not easy and is primarily based on the history, not medical tests. For some young people, it is concluded that they are not children. The ones that are deemed to be children are looked after until the age of 21 years old, unless they are in education when they are looked after until the age of 25 years old. Some are repatriated because they are not successful in their asylum applications or more rarely choose to go back home voluntarily. UASCs are placed evenly across Kent.

- UASCs are mostly males 13 years old and older. They appear to have less physical disability problems, although there were some young people with hearing problems that caused difficulties with translation. Some UASCs find difficult to understand their own language or are more illiterate than is originally thought. Some do not even know the name of their country of origin. There are also issues with cultural diversity.

- UASCs have to some extent different health needs from the other LAC. It is important to assess the additional support they need and make the necessary commissioning arrangements. One of the important issues is emotional and mental health needs and access to translation services. In the majority of cases, their physical health is good. Screening for infectious diseases such as blood-borne viruses and tuberculosis should be prioritised. This is not easy to manage during a routine health appointment and there are difficulties in obtaining consent, because if treatment is required, this can be long and difficult.

- This is also complicated by the fact that UASCs move out from Millbank (assessment centgre) within a few (6-8) weeks of arrival that makes follow up and referral arrangements more difficult. During their stay in Millbank, they normally have their initial health assessments, tests and immunisations. R felt that local health services were not well equipped to deal with UASCs. The local contract with primary care team providing initial health assessments to UASCs is under review, as it is not as effective as it should be. As numbers of new UASCs have increased, the local primary care team does not have the capacity to see them in a timely manner.

- Kent is the second local authority in the country (after Croydon) in the number of UASCs received. Most UASCs are boys over 13 years old. At present, there is a high number of Eritreans. Other nationalities well represented are Afghanis, Moroccans, Albanians and Syrians. There are very few UASCs with disabilities. When they arrive, they make a claim about their age and subsequently they are assessed to determine their age by having conversations, observation and assessing their development stage (e.g. emotional development, cognition). This is an important assessment as there are significant benefits for the individuals concerned in the support they receive if they are deemed to be children (under 18 years old). The assessment usually lasts 6-8 weeks while being accommodated in Millbank. If the UASC is under 16 years old, he/she is placed in foster care (currently about 50-60 children). If they are over 16 years old, they are placed mostly in community accommodation, living on their own.

- UASC service had a handful of children whose behaviour was below their biological age and who had difficulties to settle and cope emotionally. The UASC service also looks

after care leavers (18+) until they are 21 years old (or 25 years old if they are in education). Care leavers are provided with accommodation and pay their rent (if they are not receiving housing benefits). They can also claim benefits while in education. Even at a later stage, UASC service continues to have a duty of care, and they may come back for advice or assistance. They very occasionally receive UASCs placed from other LAs and in a few cases their UASCs are placed outside Kent.

- When UASCs become 18 years old and if they had failed their asylum application, the UASC service completes a human rights assessment in order to make a decision whether they can return to their home country or continue being in care; however they do not deport children. UASC service tries to avoid having to make such decisions at times of crisis.

- There are concerns about the physical and emotional health of UASCs; the impact of migration on their wellbeing during their formative years, and how well they manage without any parental or family support. In many cases, the UASC service is all they have; therefore it is important to support them to avoid escalation of mental health problems. The way they become looked after children is different from the majority of LAC. It is like becoming 'orphans'. Many of the UASCs are resilient and resourceful, but equally some of them find difficult to manage their new life situations. They have a health assessment at the time of entry into care. Their physical health needs are similar to other adolescents. They however sometimes cannot understand and describe well their emotional issues.

- There are young people who are more pre-disposed/susceptible to mental illness compared to others. It is difficult to know how best to address the emotional and mental health needs of these children. Sometimes we are good in describing the problems, but less effective in finding the right people and right resources to address them.

- UASC service had not had many children with hepatitis B or C. However, they are not routinely tested or vaccinated, despite most of them coming from high risk countries for hepatitis B & C.

- Kent has the highest number of UASC care leavers studying in universities and doing well. School attendance is patchy. Many of UASCs become despondent if they do not learn English quickly enough. Some try but give up eventually.

- UASC team has 16 social workers and 30 support workers. Interpretation service is a major consideration and expense. They are currently using interpreters for forty languages for interviews and important meetings. They work closely with the police, home office and education.

Appendix: Findings and themes from the focus groups

UASCs focus group

- One of the UASC had been in England for three years. He had a partner and a child and he was unemployed. He reported that he was registered with a GP, but rarely visited him. He did not think that he had a health assessment.

- Another UASC had been in England for 6 months. He was attending college, while living in private accommodation in another town (so travelling was an issue for him). He reported that he had weekly meetings with his social worker. He was registered with a GP, but he had not had a health assessment. He had some blood tests, but never received any results. He stayed in Millbank for 8 weeks.

- Overall, respondents would like more freedom, more financial support for personal spending and transport.

Care leavers focus group

Participants:

- 1st girl - 19 year old who has been in care for 10 years with the same foster family together with her brother. She now lives in supported accommodation and attends college and is looking for a job.
- 2nd girl – 18 year old who has been in care for three years living now with her mother. She attends college.
- 3rd girl – 20 year old who has been in care for three years. She now lives in supported accommodation.
- 4th girl – 18 year old who has been in care for a year. She now lives in supported accommodation
- Two Catch 22 16+ project workers

Health assessments (HA) - was it a good or bad experience?
1st had only two health assessments whilst in care for ten years. She thought that the assessment was too long (2.5 hours) and was asked age inappropriate questions and advice. Overall she thought that they were a 'waste of time', so as a result she did not attend anymore.
2nd had three health assessments while being looked after. She thought that they 'took too long' and were age inappropriate. She felt that the questions were not tactful e.g. weight issues, especially as the LAC professional was overweight.
3rd had one health assessment while in foster care, but none since. She felt that the style of questioning was inappropriate. She thought that half an hour should be enough.
4th did not have any health assessments. She heard negative comments from other children, so she did not attend.

Where would you go for advice/help?
All said would go to GP or sexual health clinics.

What did foster carers think about health assessments?
1st noted her foster carers agreed that health assessments were a 'waste of time'.
3rd responded that she was the first child fostered and her foster parents thought that there was a lack of understanding.

All girls thought that health assessments were 'too long', age inappropriate and on occasions lacking tact. It was suggested that a LAC nurse should contact the social worker in advance of the health assessment that could lead to a better understanding of the child and that they should be flexible to better tailor their assessment to the needs of the individual child. It was also suggested that health professionals should have specific training as to how to talk to young people. Looked after children should be asked if they had any concerns of their own. They all thought that looked after children should not be 'singled out' for health assessments, when those who are not looked after do not have to have health assessments.

One of the participants also responded that she did not want 'things to go down in her medical record'. She was worried about health professionals sharing information.

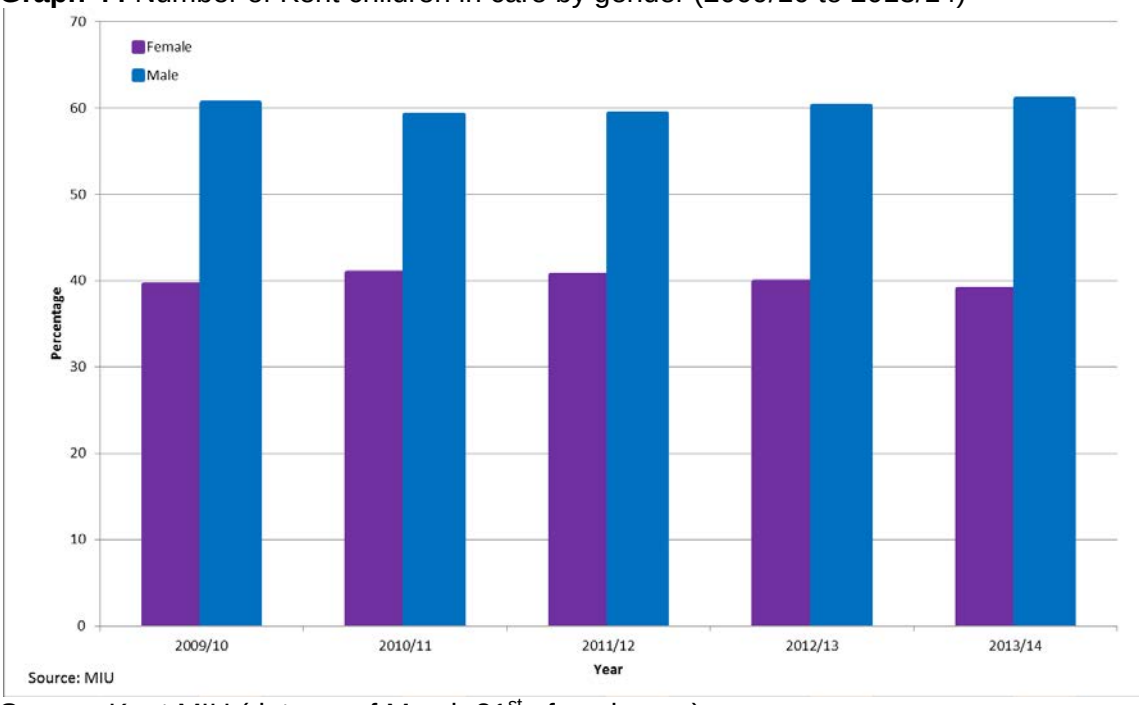
Have they had any contact with the CAMH service?
2nd attended once, but it was not a good experience.
3rd never heard of this service.
4th was invited, but did not attend.

How Catch 22 supports them?
Catch 22 support team organises events, talks, activities. A number of participants felt that social workers were not so good. Catch 22 support worker reported that less than 10% of children under their care engaged with this programme. There is apathy amongst their service users. Incentives have not been effective.

What would they wish to be different?
They all noted the need to improve continuity with social workers and that rules about CRB checks should be more flexible e.g. to be able to stay over in friends' homes.
1st did not wish to change anything as she had a good foster placement with her brother.
2nd felt that in her case decisions were not optimal and she would welcome an acceptance of this fact from her social workers.
3rd suggested that would be useful for health professionals to be more up to speed with the young person's history/background. She has voluntarily entered care and as a result her personal circumstances have improved immensely.
4th suggested that looked after children should be allowed to be more involved in decisions about their own care.

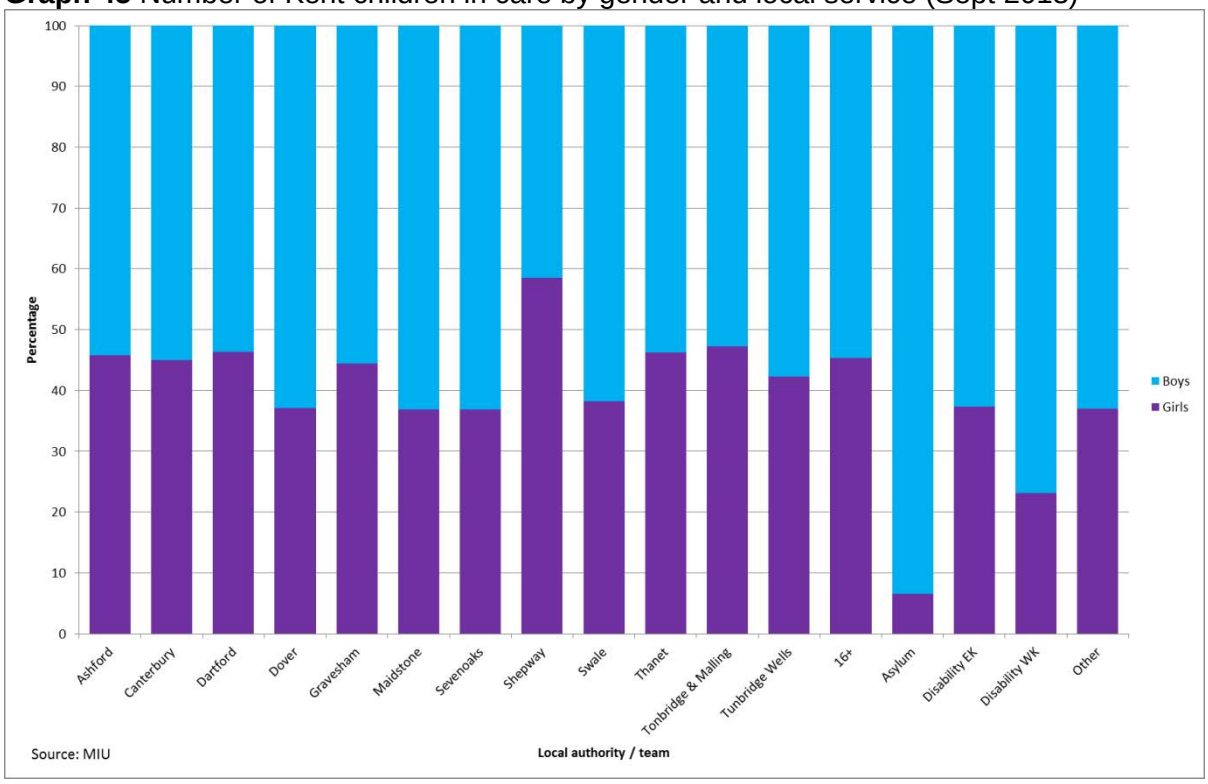
Appendix 1: Supplementary statistical information

Graph 44 Number of Kent children in care by gender (2009/10 to 2013/14)



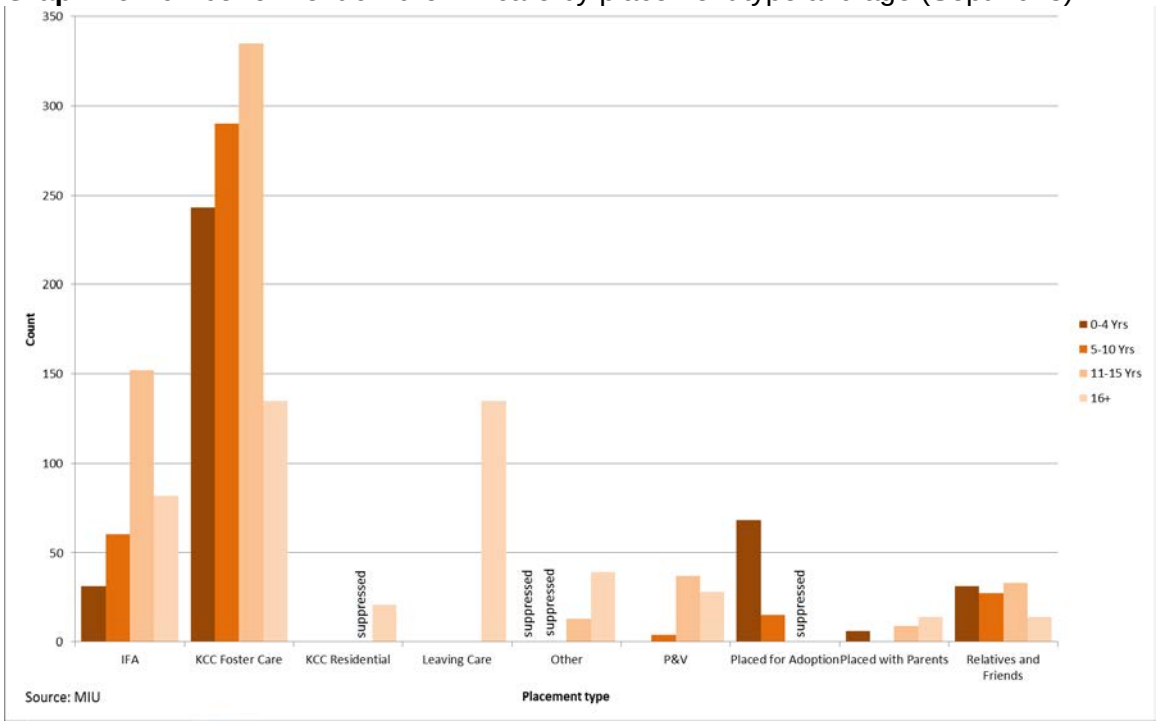
Source: Kent MIU (data as of March 31st of each year)

Graph 45 Number of Kent children in care by gender and local service (Sept 2013)



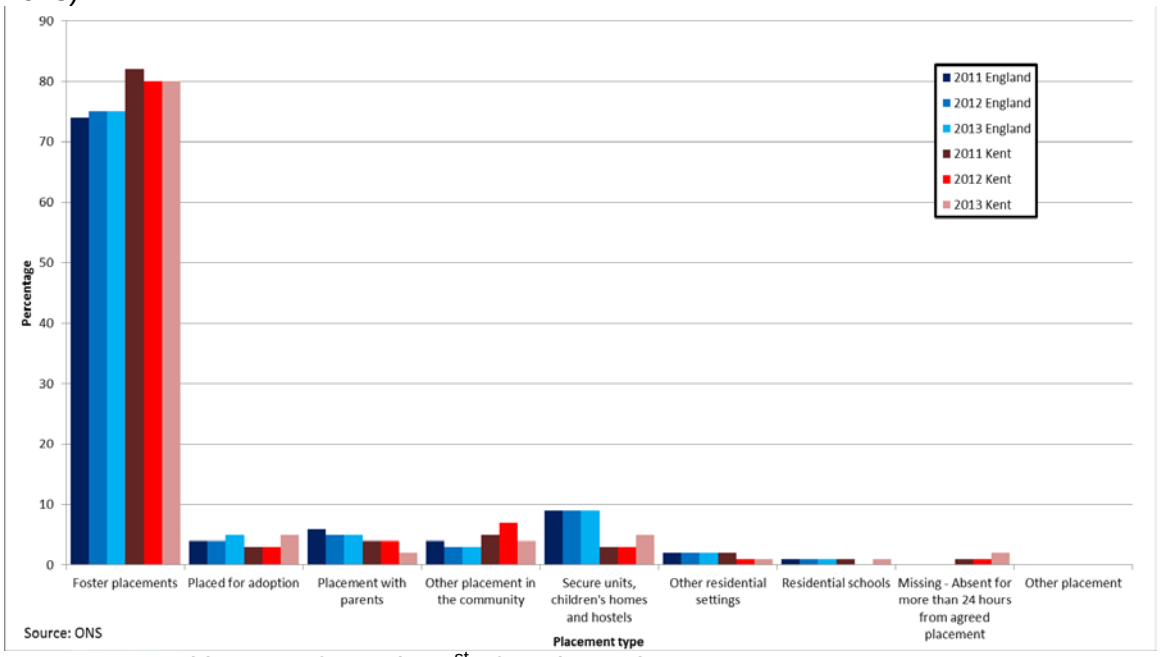
Source: Kent MIU

Graph 46 Number of Kent children in care by placement type and age (Sept 2013)



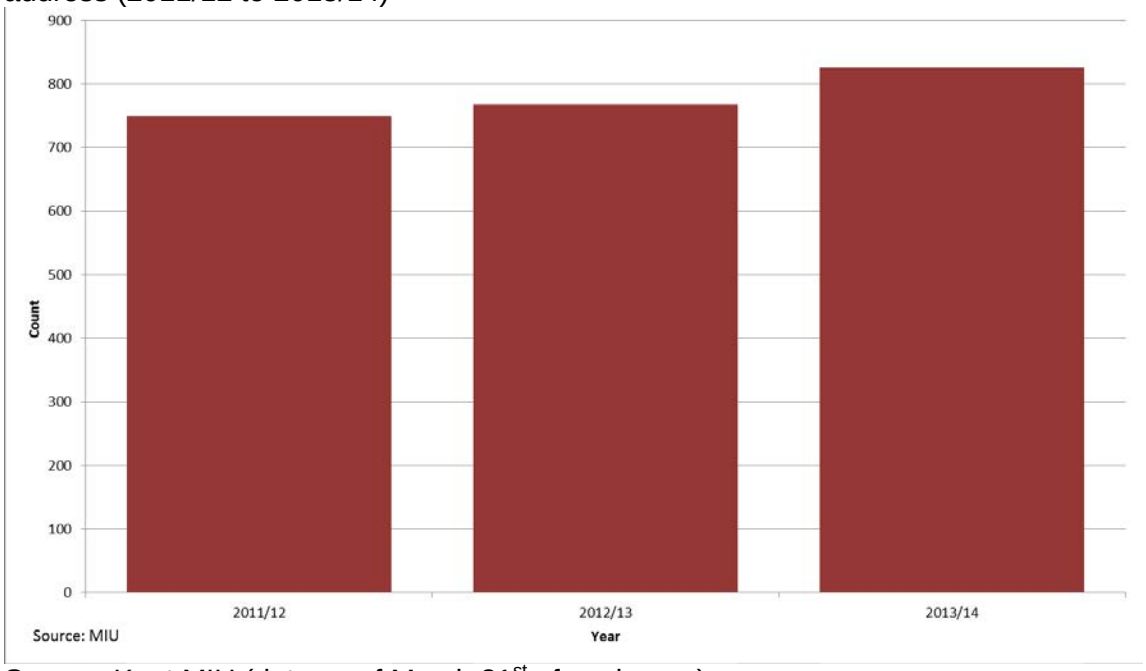
Source: Kent MIU
*IFA=independent foster agency; P&V=private and voluntary residential care
** Numbers <5 have been suppressed

Graph 47 Kent children in care (%) by placement type in comparison to England (2011 to 2013)



Source: ONS (data as of March 31st of each year)

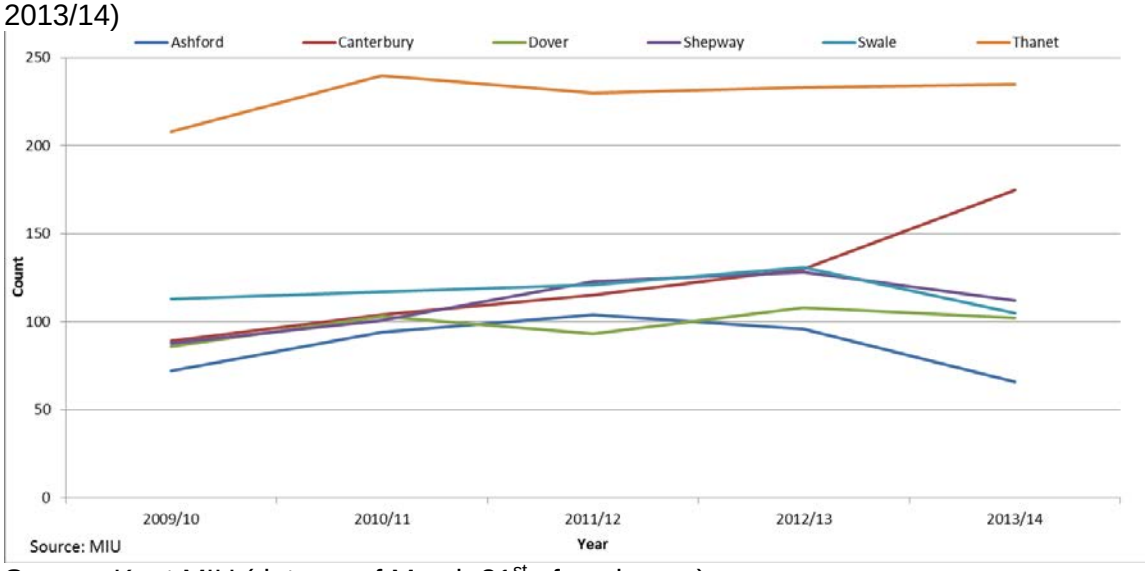
Graph 48 Number of Kent children in care placed in foster care within 10 miles of their home address (2011/12 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

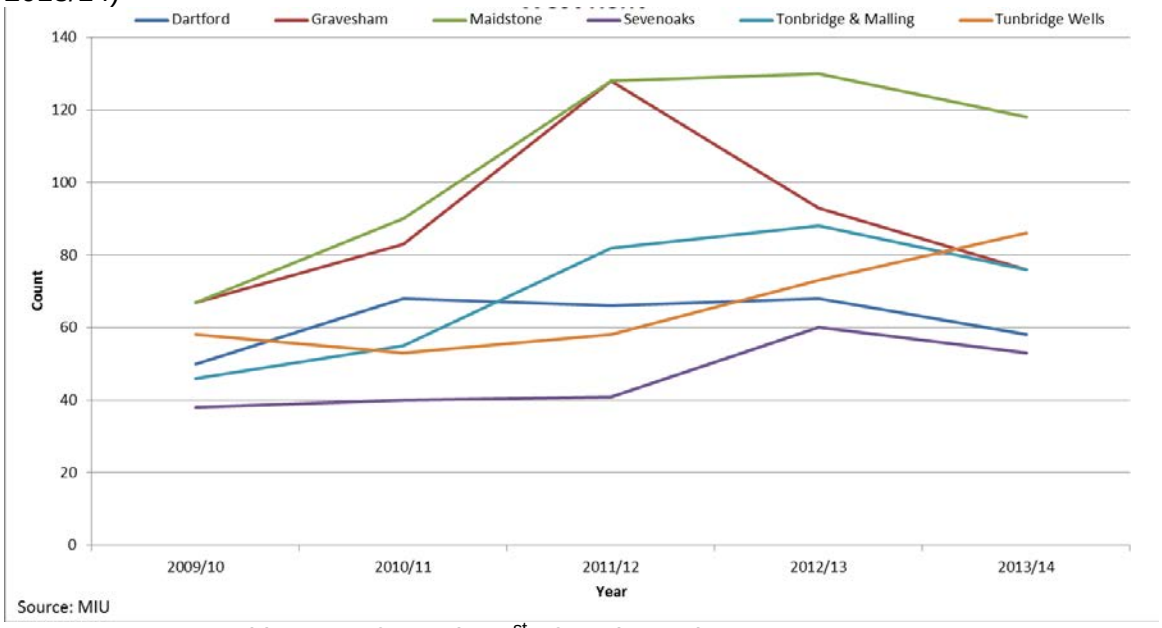
*This indicator was not recorded prior to 2011/12

Graph 49 Number of Kent children in care by district in East and South Kent (2009/10 to 2013/14)



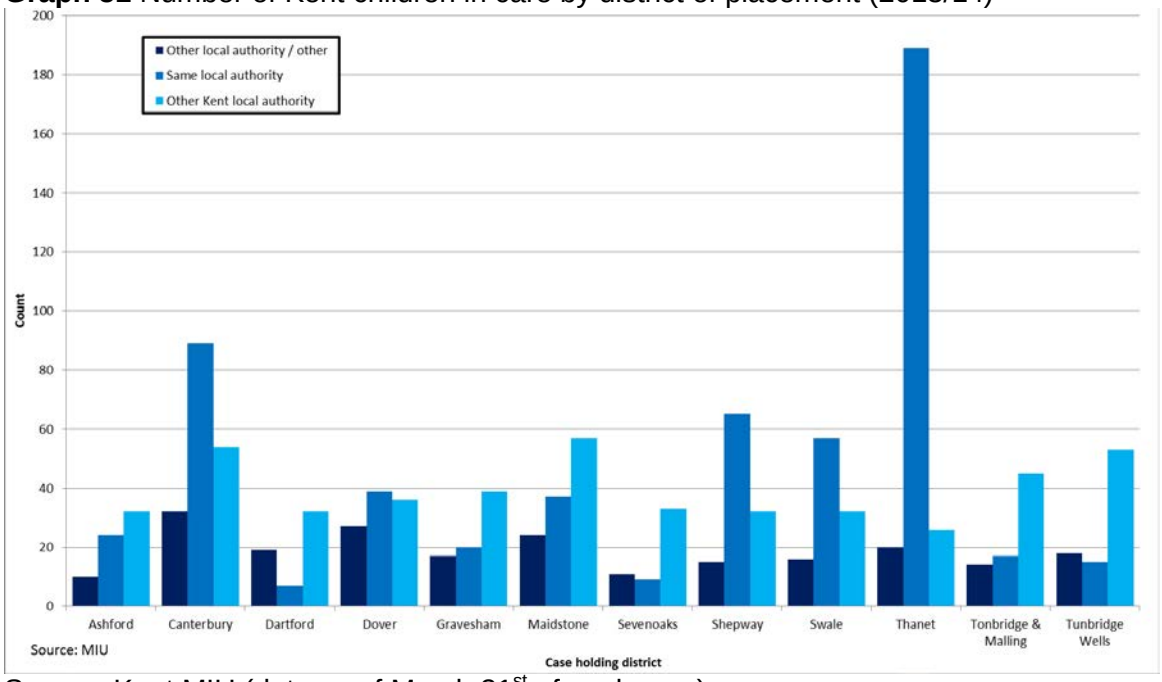
Source: Kent MIU (data as of March 31st of each year)

Graph 50 Number of Kent children in care by district in West and North Kent (2009/10 to 2013/14)



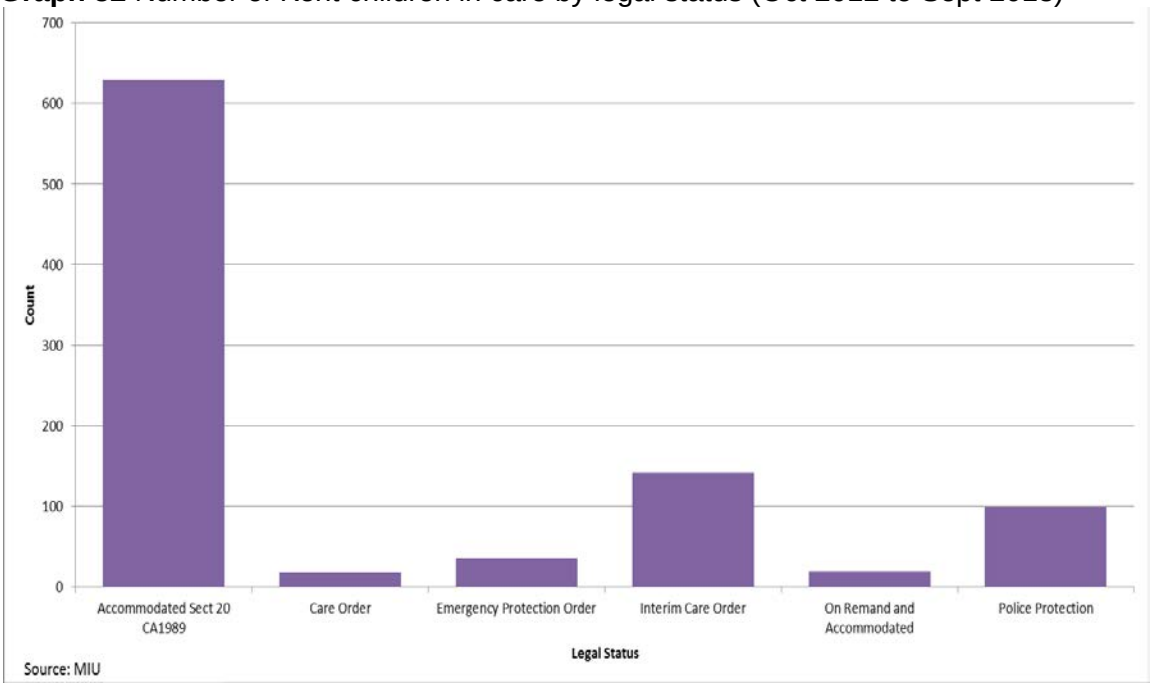
Source: Kent MIU (data as of March 31st of each year)

Graph 51 Number of Kent children in care by district of placement (2013/14)



Source: Kent MIU (data as of March 31st of each year)

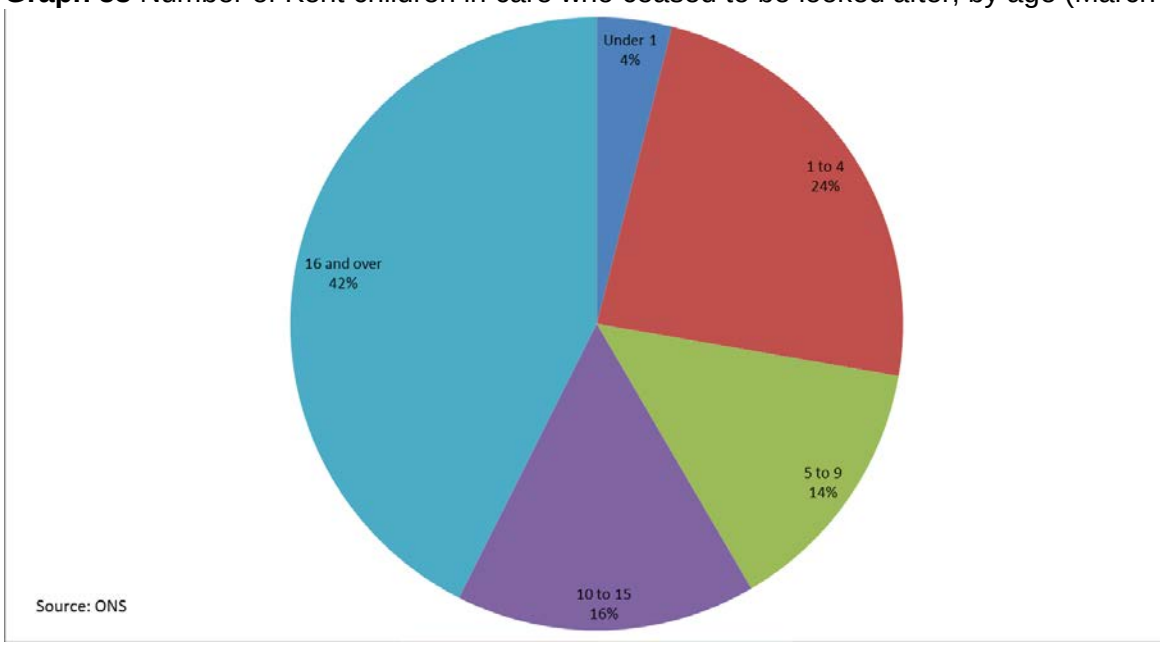
Graph 52 Number of Kent children in care by legal status (Oct 2012 to Sept 2013)*



Source: Kent MIU

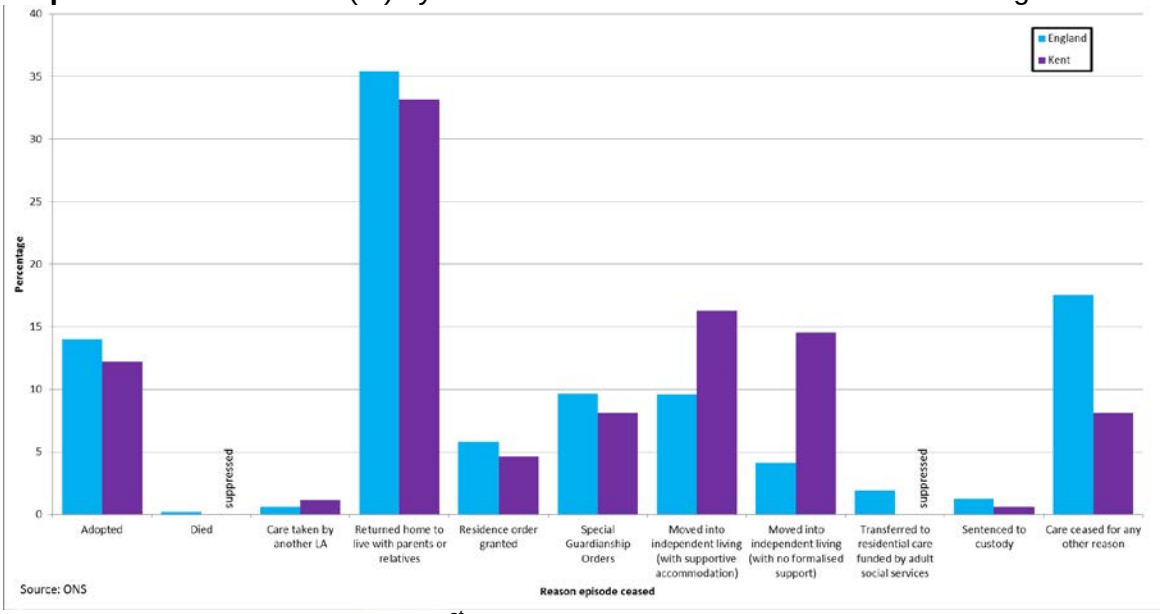
* Data reported up to Sept 2013 due to change in data collection system

Graph 53 Number of Kent children in care who ceased to be looked after, by age (March 13)



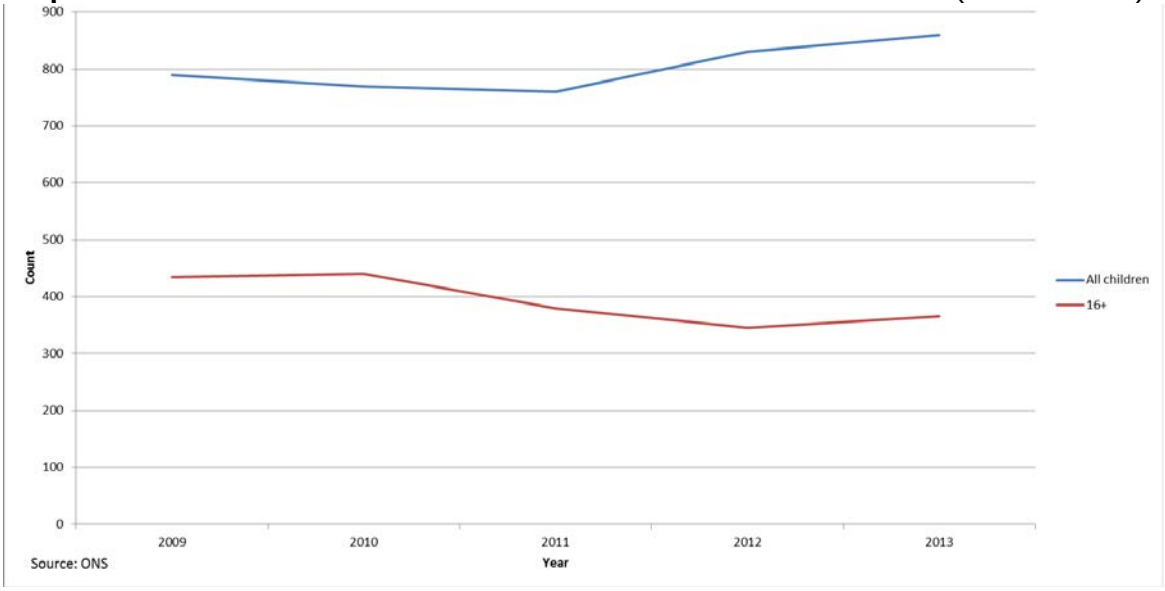
Source: ONS

Graph 54 Children in care (%) by reasons that ceased to be looked after during 2012/13



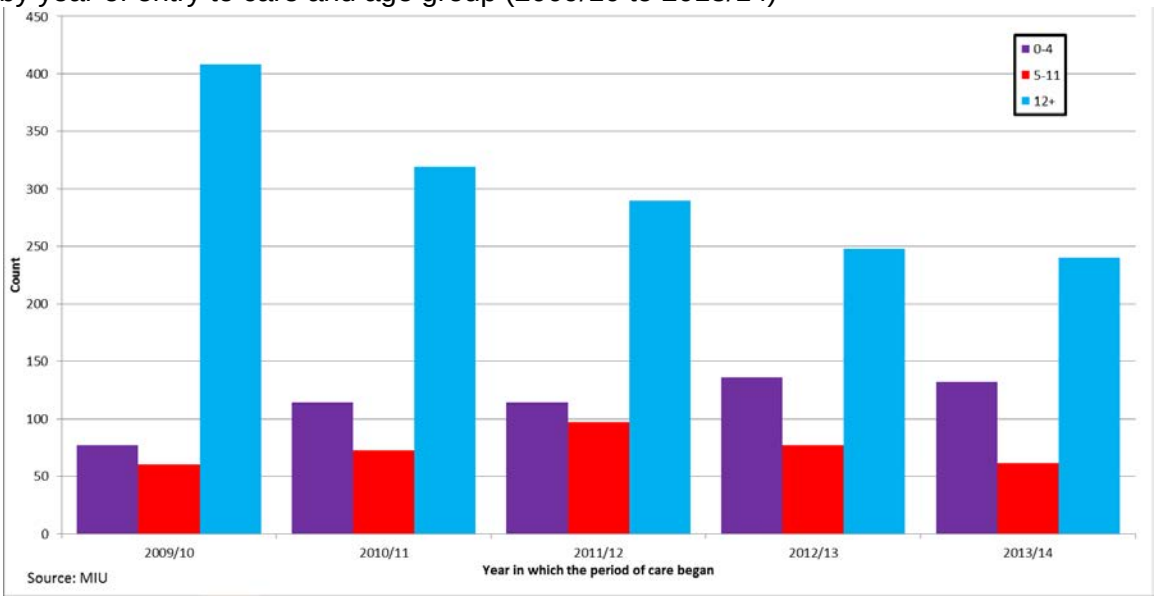
Source ONS: (data as of March 31st)
* Numbers <5 have been suppressed

Graph 55 Number of Kent children in care who ceased to be looked after (2009 to 2013)



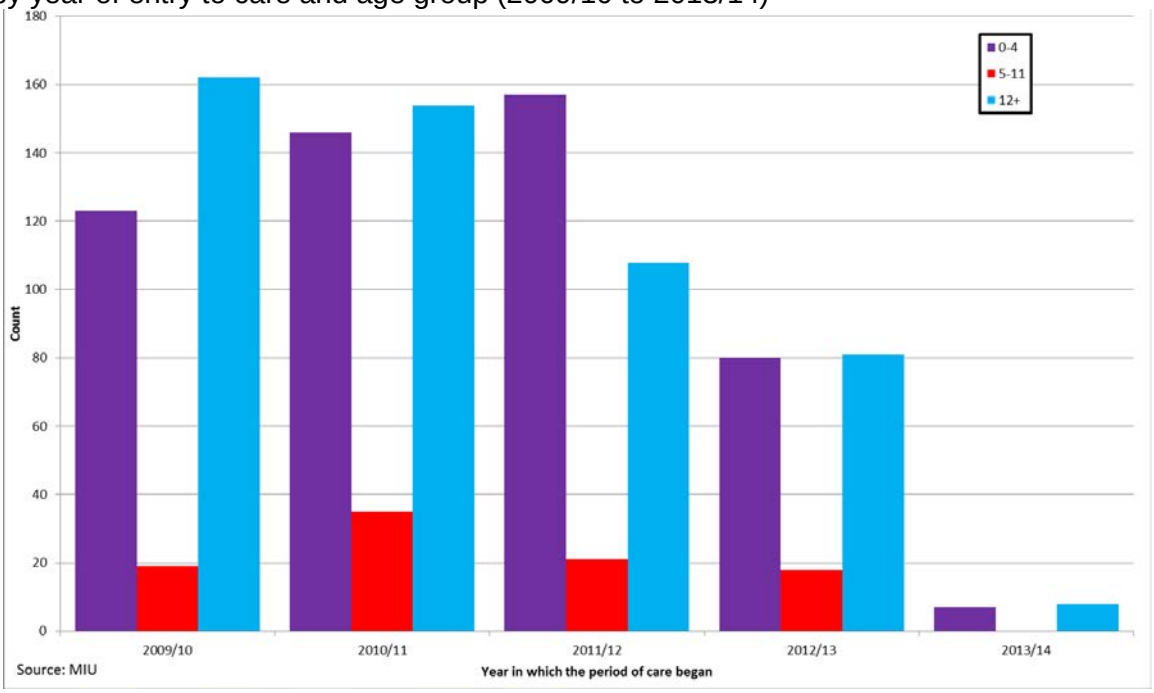
Source: ONS

Graph 56 Number of care episodes that lasted less than one year for Kent children in care, by year of entry to care and age group (2009/10 to 2013/14)



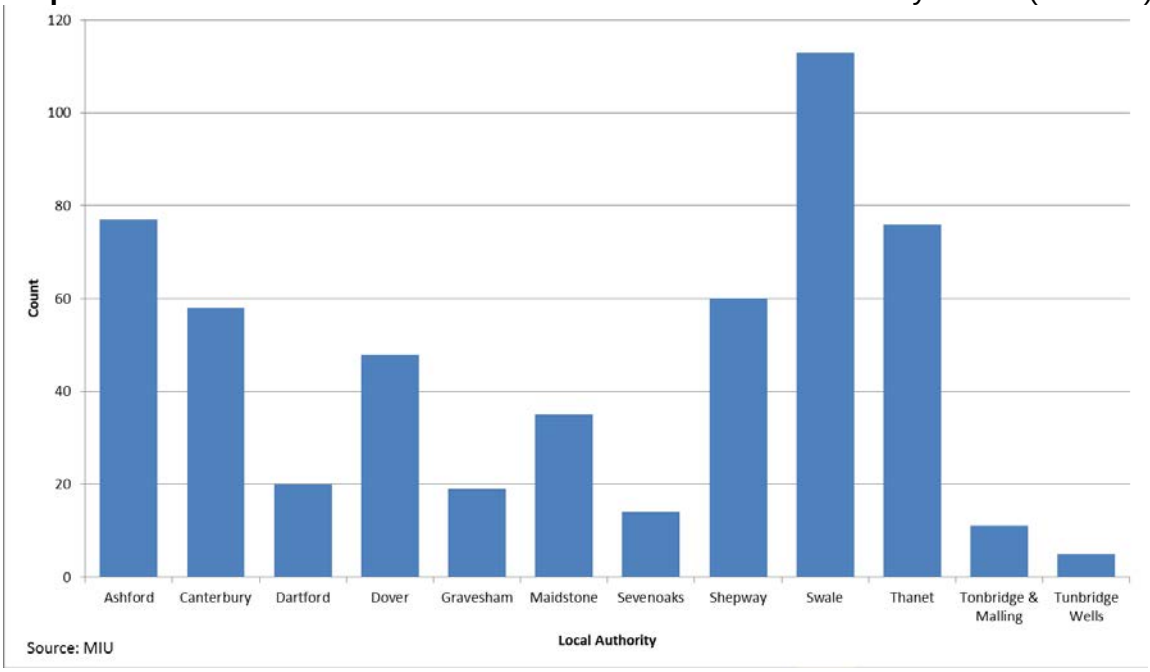
Source: Kent MIU

Graph 57 Number of care episodes that lasted more than one year for Kent children in care, by year of entry to care and age group (2009/10 to 2013/14)



Source: Kent MIU

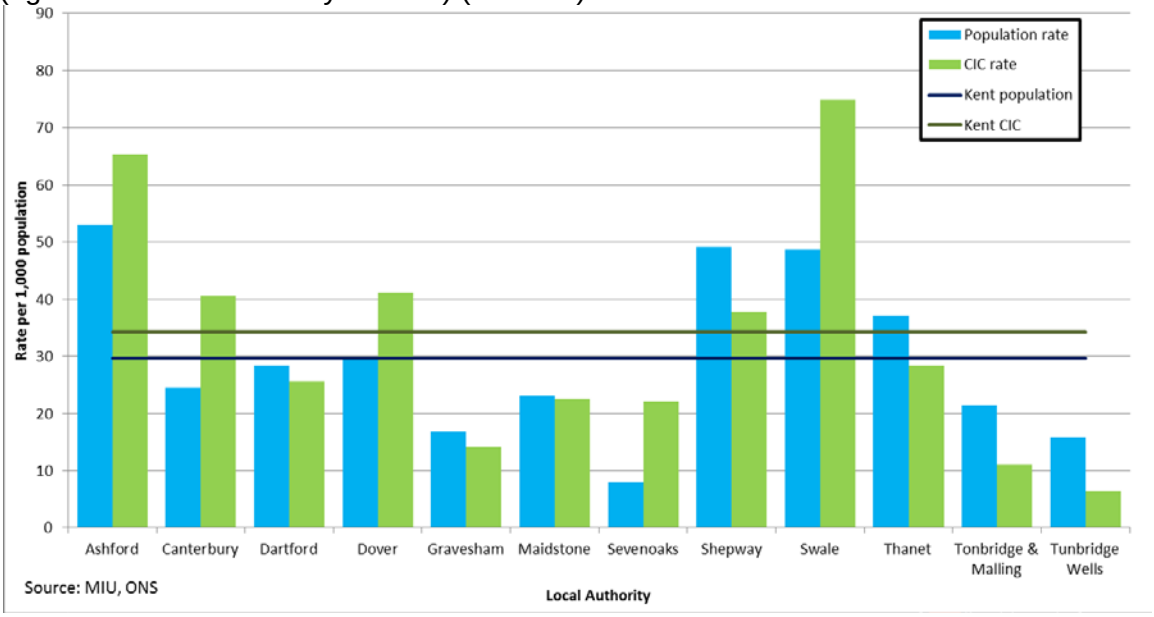
Graph 58 Number of fixed school exclusions of Kent children in care by district (2013/14)*



Source: Kent MIU

* A child can have more than one fixed exclusion per year

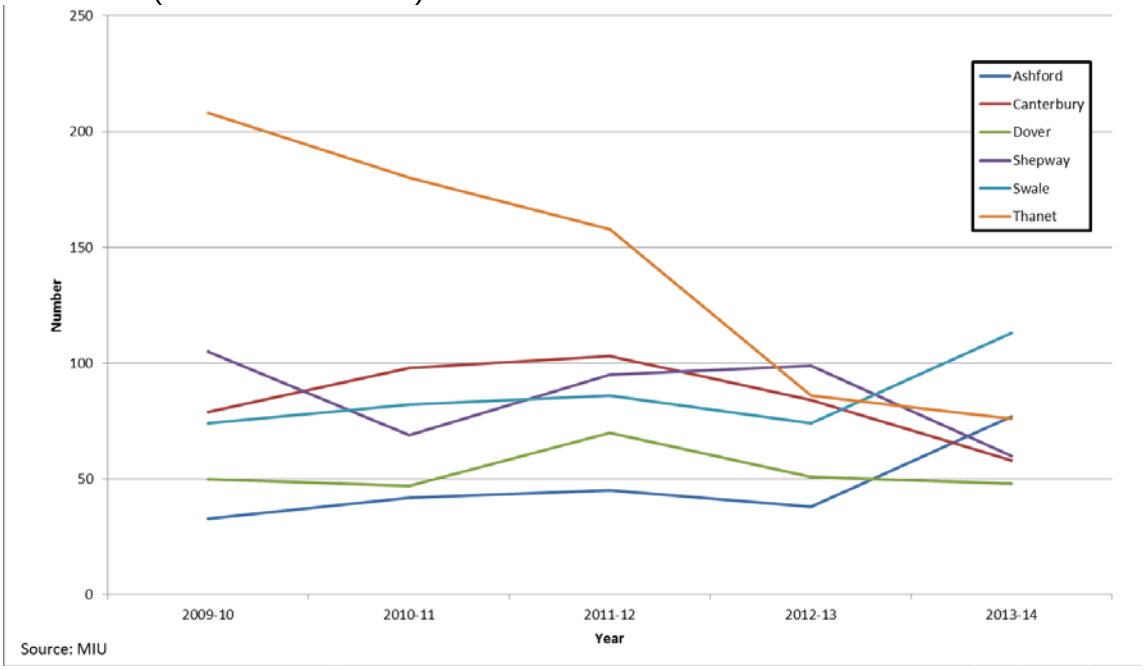
Graph 59 Rates of fixed school exclusions for Kent children in care and Kent school children (aged between 4 and 18 years old) (2013/14)



Source: Kent MIU and ONS (2012)

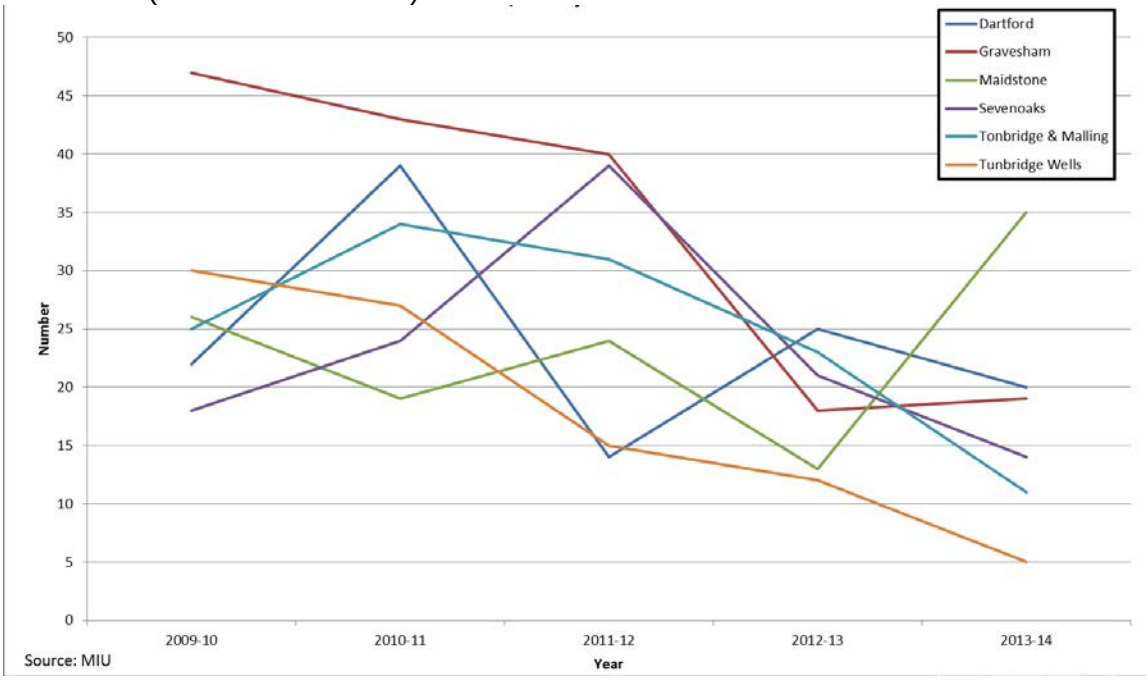
* Rates were calculated using 2012 ONS mid-year estimates for the general population (<18) and 2012/13 data for children in care

Graph 60 Number of fixed school exclusions of Kent children in care, by district in East and South Kent (2009/10 to 2013/14)



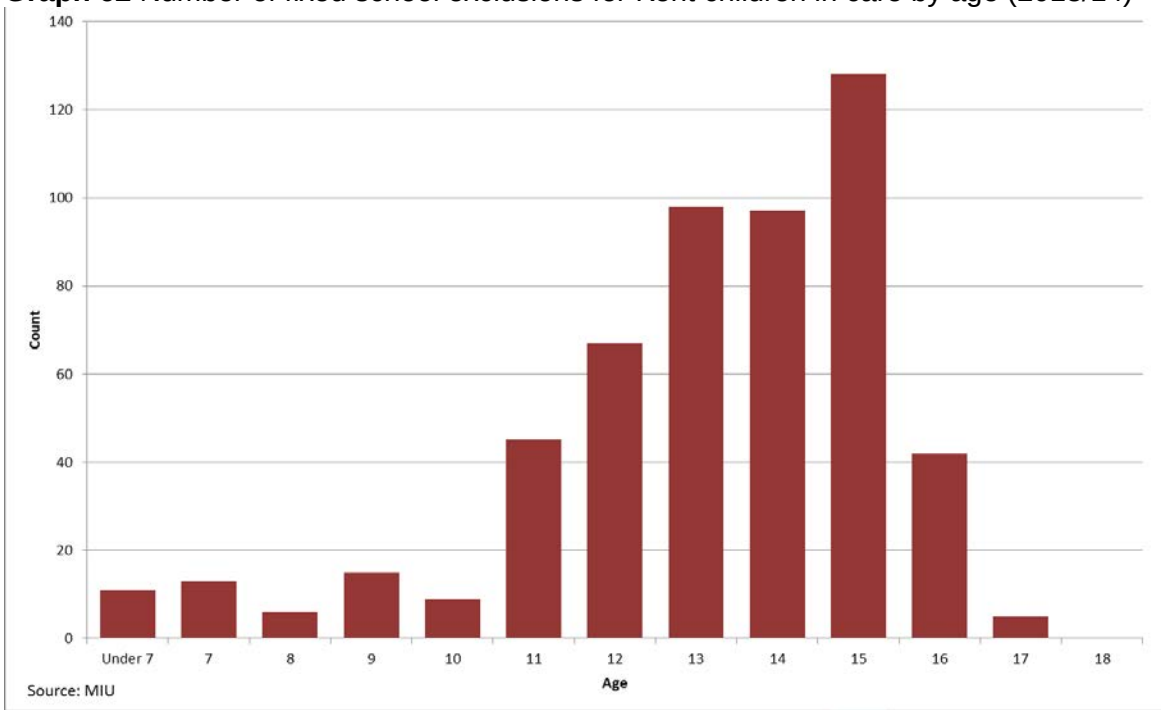
Source: Kent MIU

Graph 61 Number of fixed school exclusions of Kent children in care by district in West and North Kent (2009/10 to 2013/14)



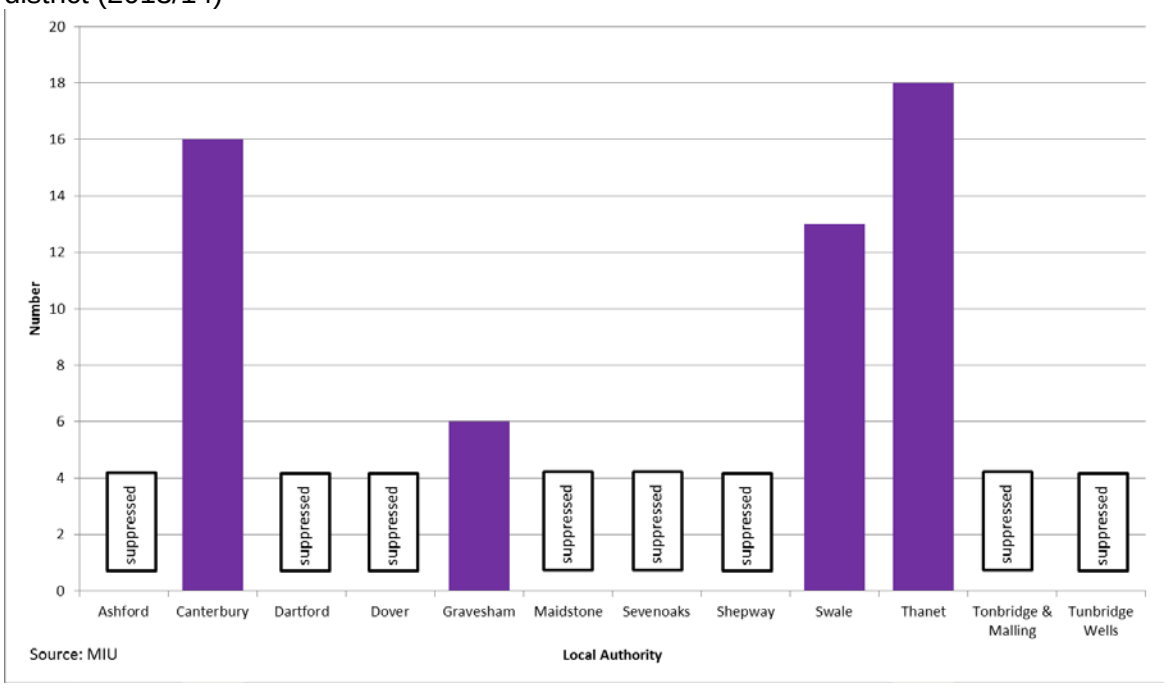
Source: Kent MIU

Graph 62 Number of fixed school exclusions for Kent children in care by age (2013/14)



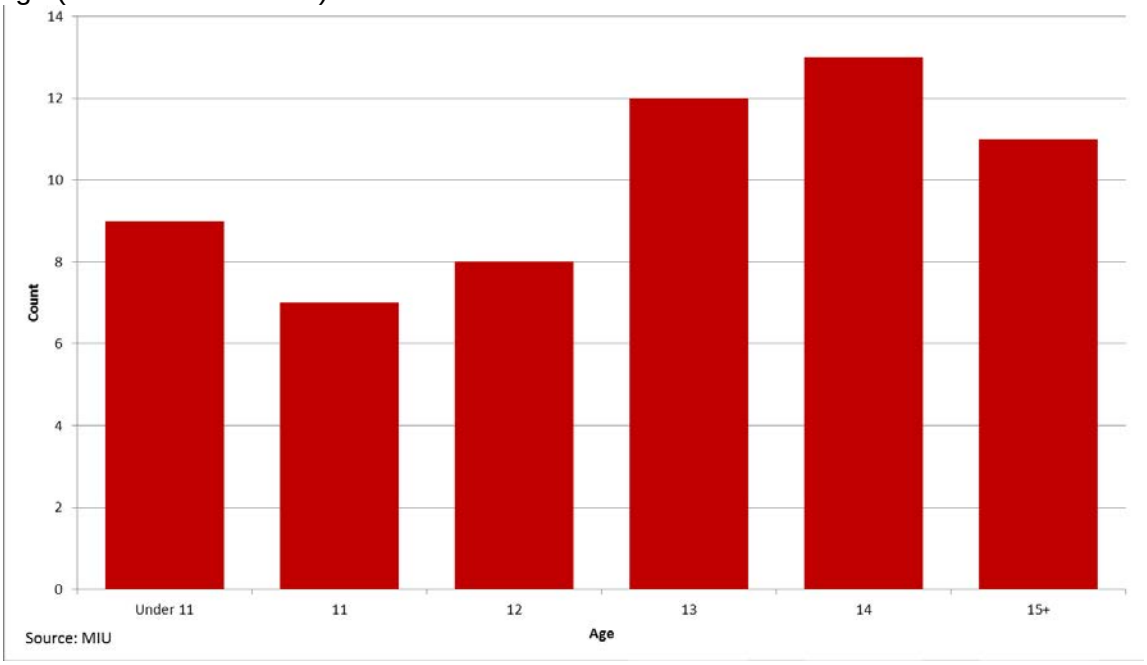
Source: Kent MIU

Graph 63 Cumulative number of permanent school exclusions of Kent children in care by district (2013/14)



Source: Kent MIU

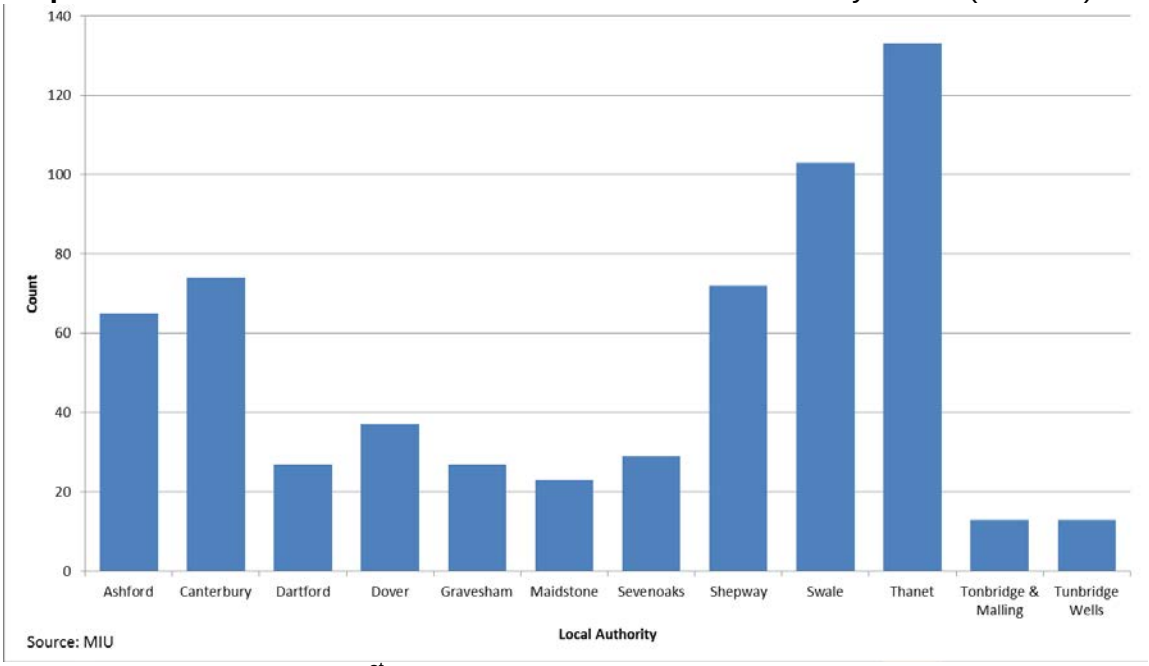
Graph 64 Cumulative number of permanent school exclusions in Kent children in care by age (2009/10 to 2013/14)



Source: Kent MIU

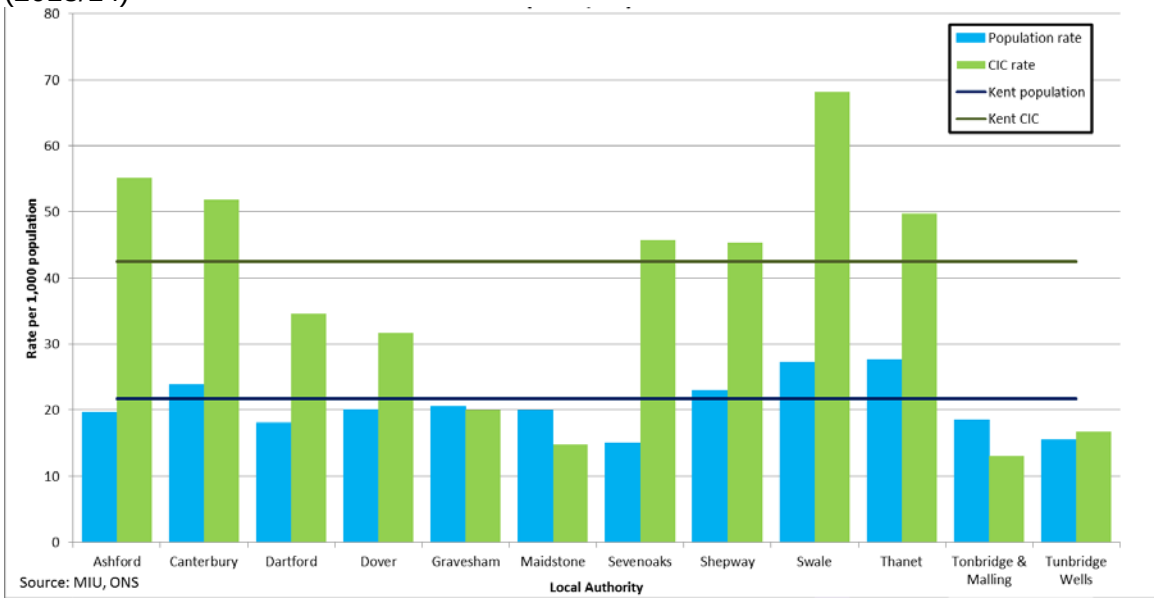
* Small number of permanent school exclusions was given to children aged <11 or >15, so these ages have been pooled

Graph 65 Number of Kent children in care with SEN statements by district (2013/14)



Source: Kent MIU (data as 1st January 2014)

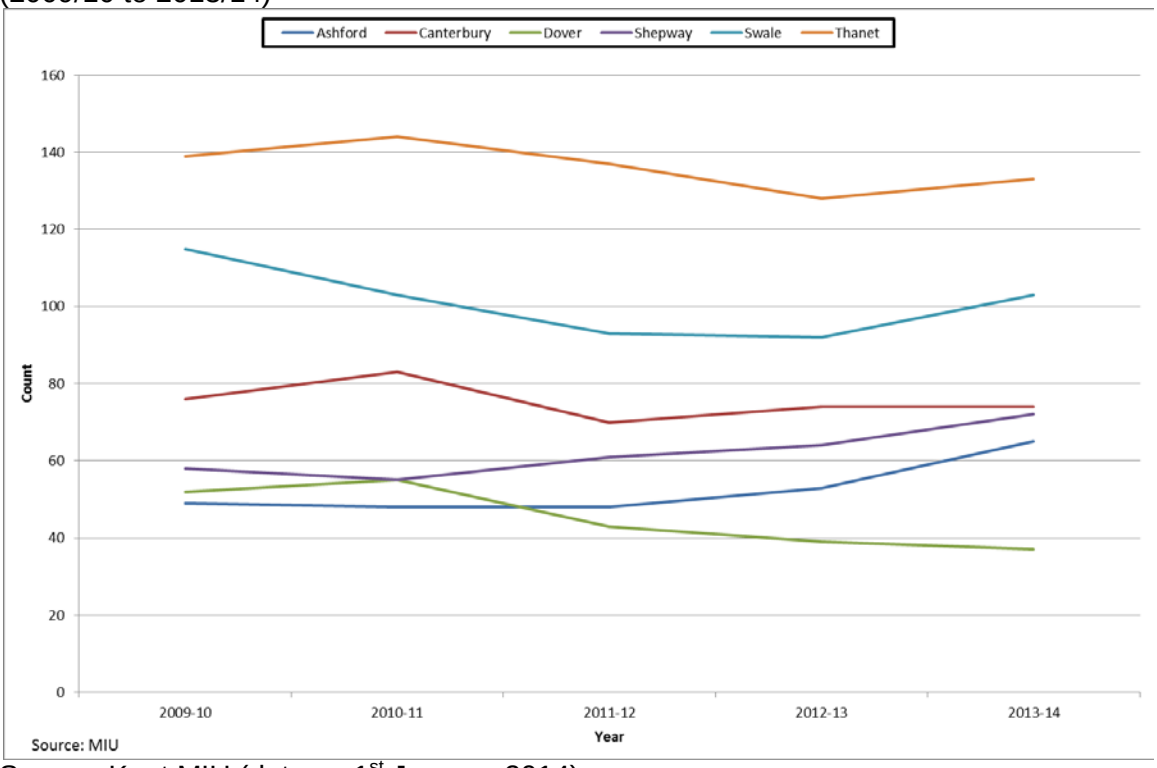
Graph 66 Rates of SEN statements for Kent children in care and Kent school children (2013/14)



Source: Kent MIU (January 2014) and ONS (2012)

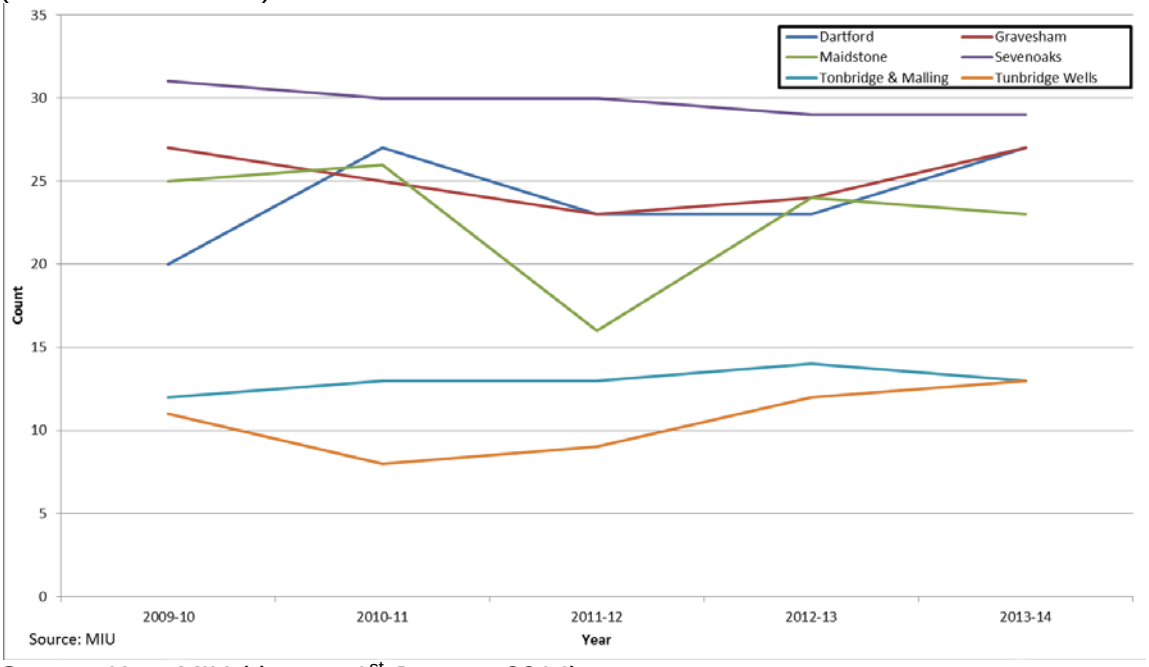
* Rates were calculated using 2012 ONS mid-year estimates for general population (<18 years old) and 2012/13 population data for children in care

Graph 67 Number of children in care with SEN statement in East and South Kent districts (2009/10 to 2013/14)



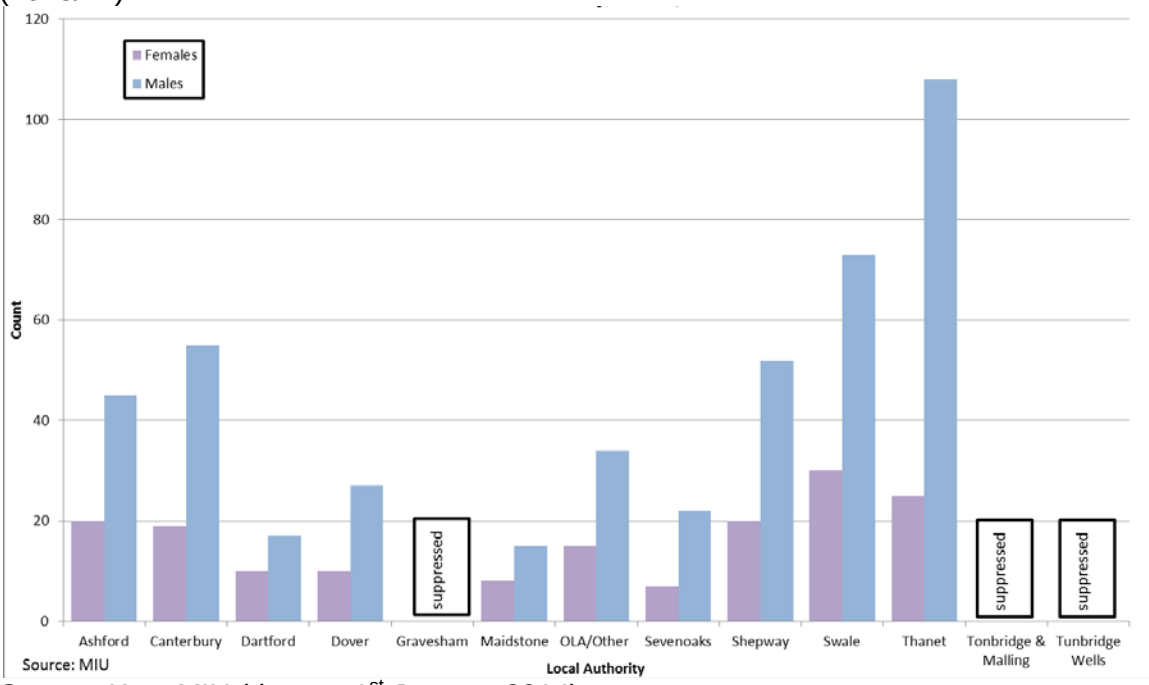
Source: Kent MIU (data as 1st January 2014)

Graph 68 Number of children in care with SEN statement in West and North Kent districts (2009/10 to 2013/14)



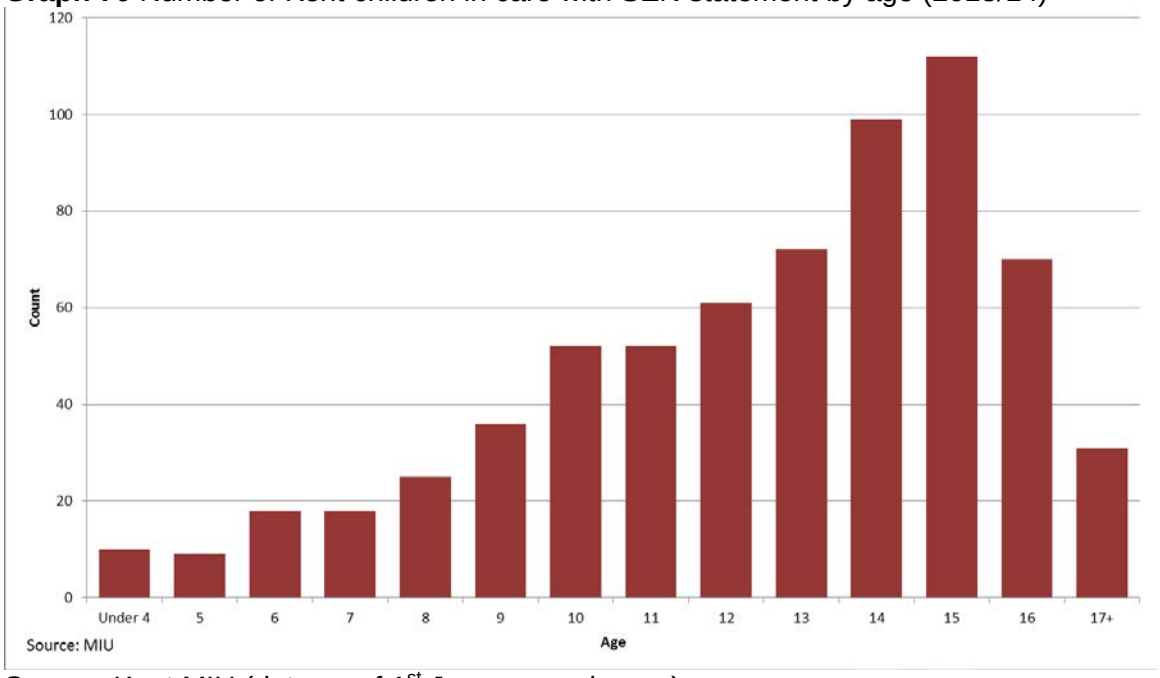
Source: Kent MIU (data as 1st January 2014)

Graph 69 Number of Kent children in care with SEN statements by gender and district (2013/14)



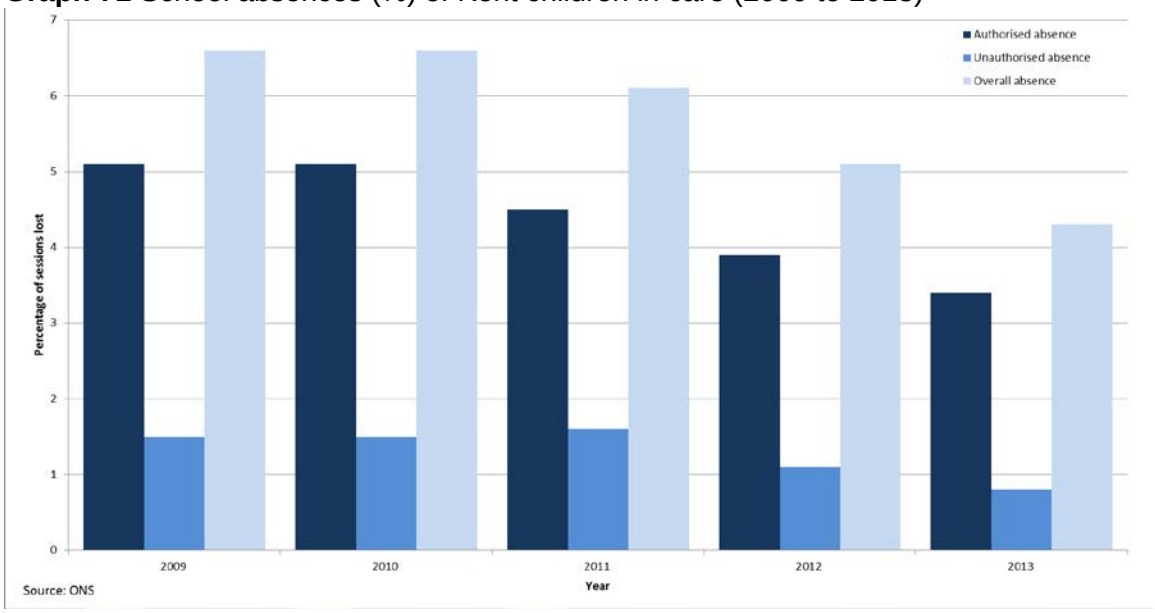
Source: Kent MIU (data as 1st January 2014)
* Numbers <5 have been suppressed

Graph 70 Number of Kent children in care with SEN statement by age (2013/14)



Source: Kent MIU (data as of 1st January each year)

Graph 71 School absences (%) of Kent children in care (2009 to 2013)

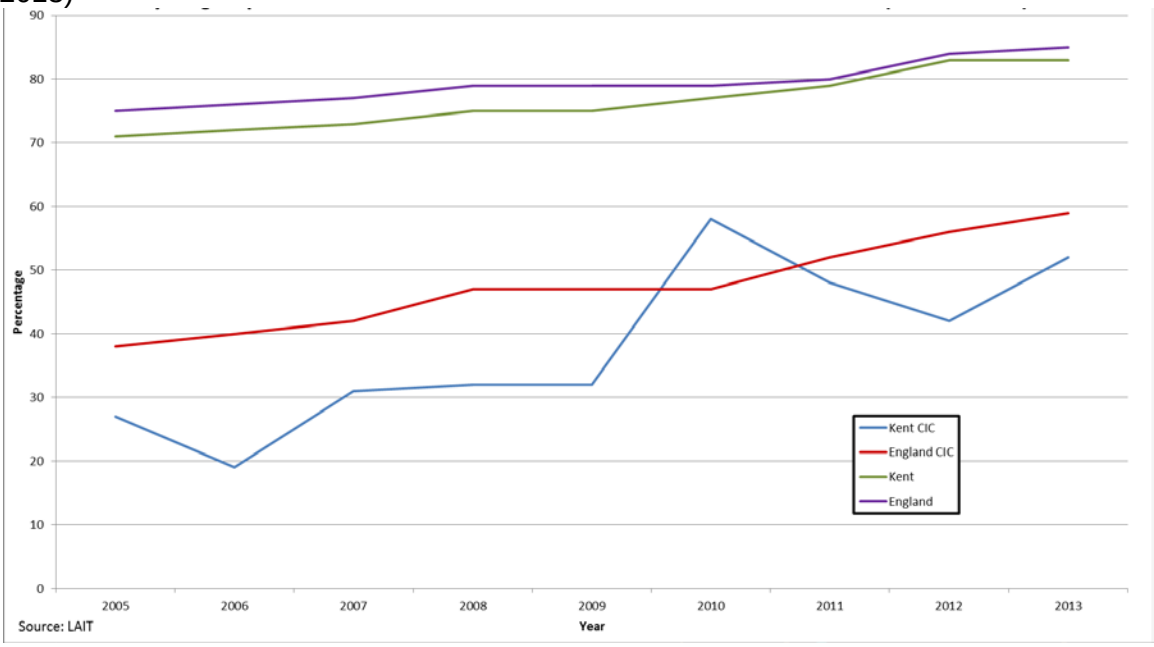


Source: ONS

* Years 2009 to 2013 represent academic years 2008/09 to 2012/13

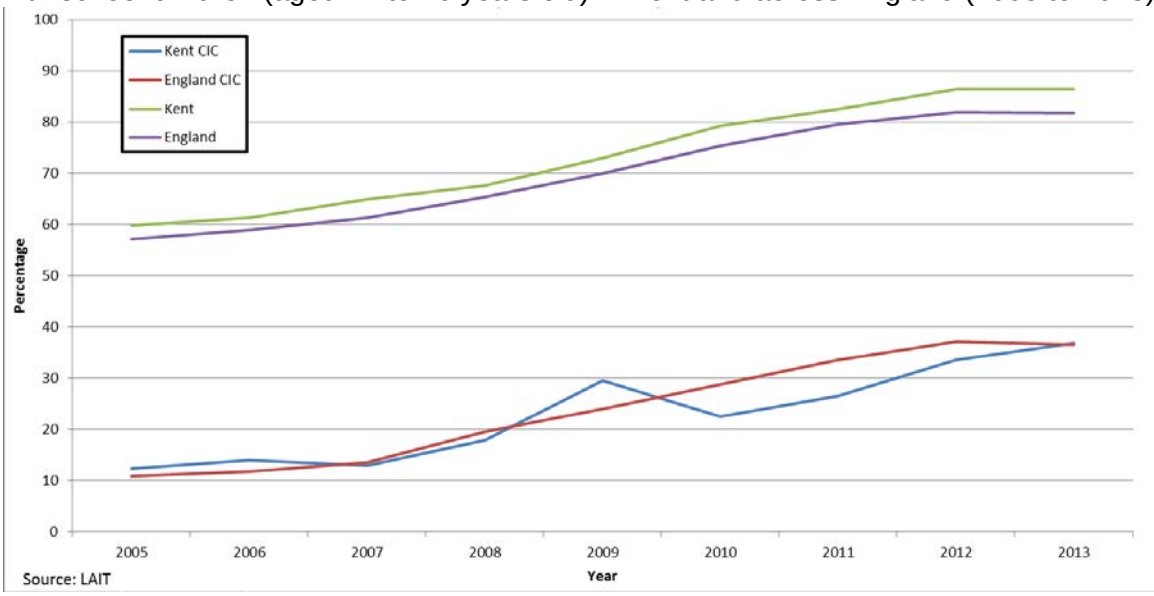
** The denominator is children who have been looked after continuously for at least 12 months

Graph 72 Key stage 2 performance in level four mathematics of children in care in comparison with school children (aged 10/11 years old) in Kent and across England (2005 to 2013)



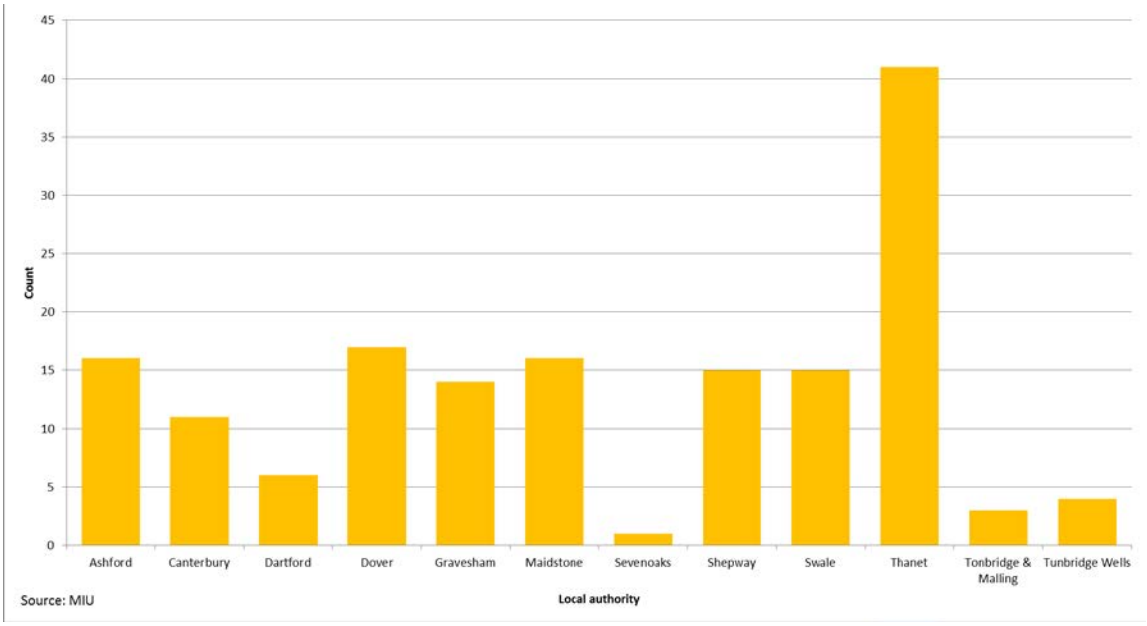
Source: LAIT

Graph 73 Key stage 4 performance (5+ GCSEs A* to C) of children in care in comparison with school children (aged 14 to 16 years old) in Kent and across England (2005 to 2013)



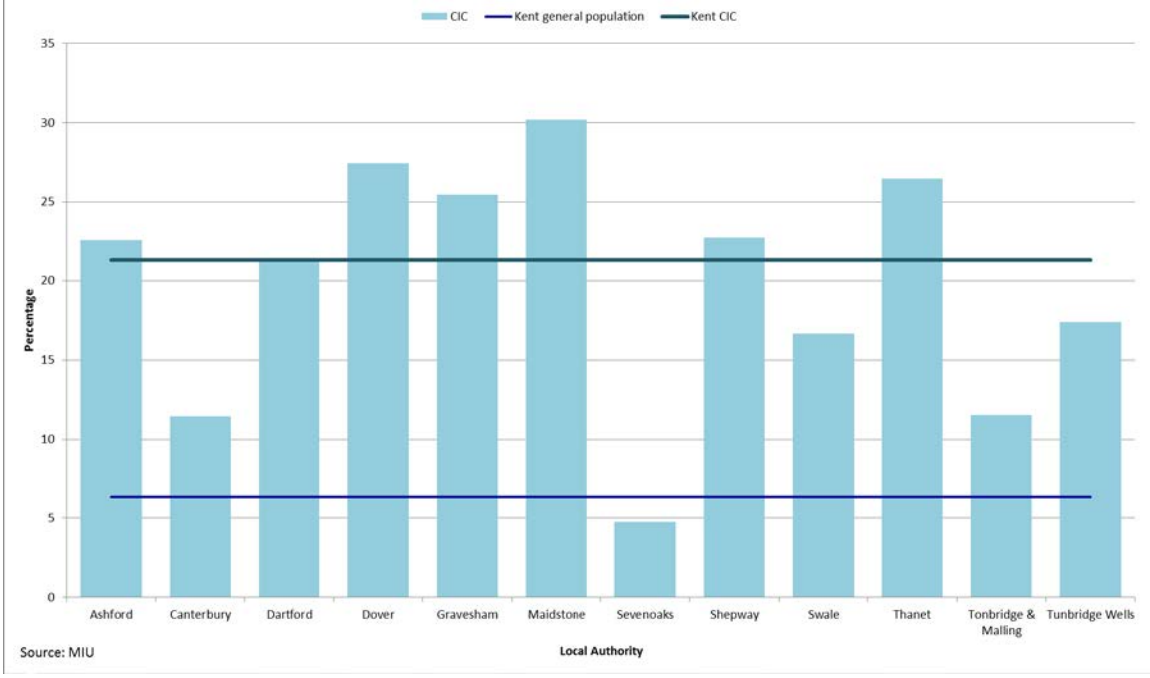
Source: LAIT

Graph 74 Number of Kent children in care (16-18 years old) not in education, employment or training (NEETs) by district (July 2014)



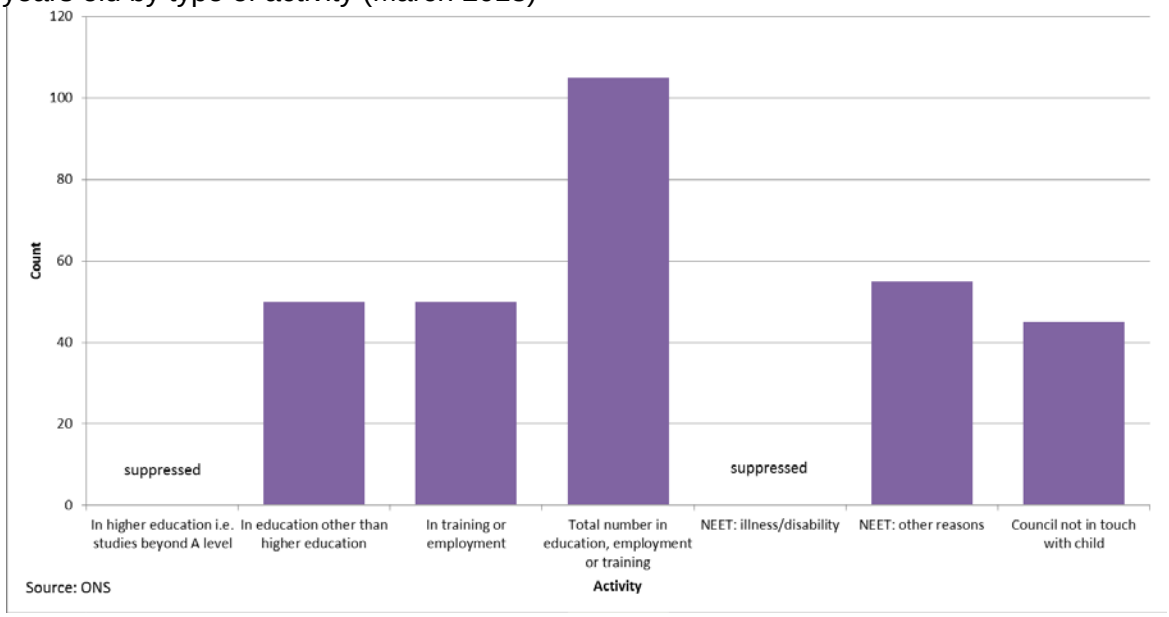
Source: Kent MIU

Graph 75 Kent children in care not in education, employment or training (NEETs) (%) by district (July 2014)



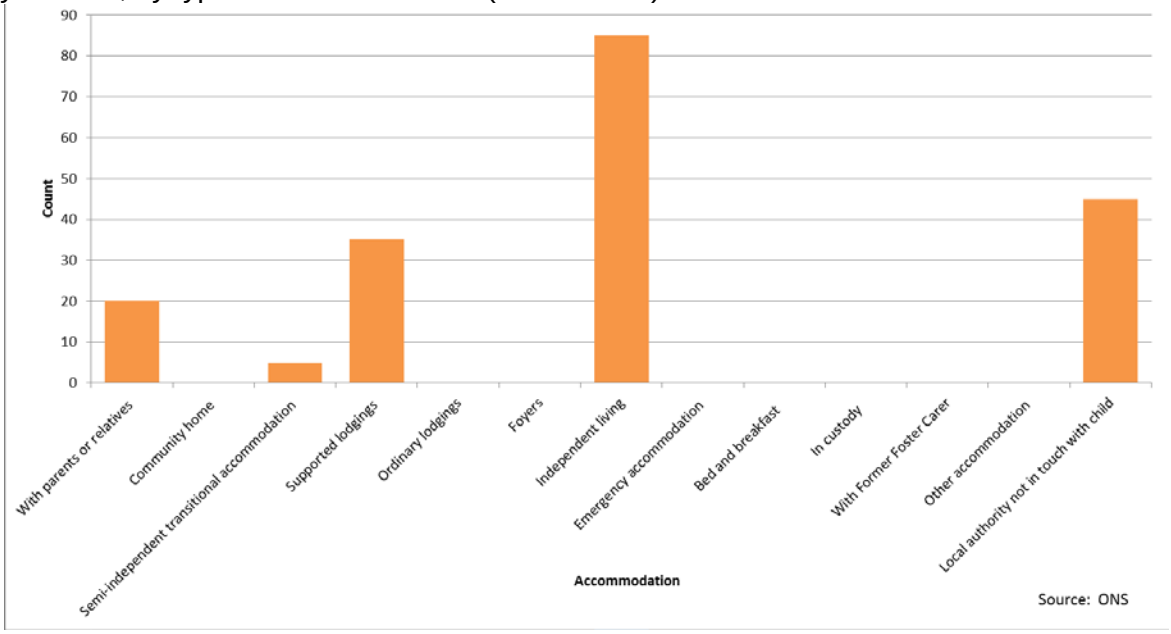
Source: Kent MIU

Graph 76 Number of Kent children aged 19 years old who were in care at the age of 16 years old by type of activity (March 2013)



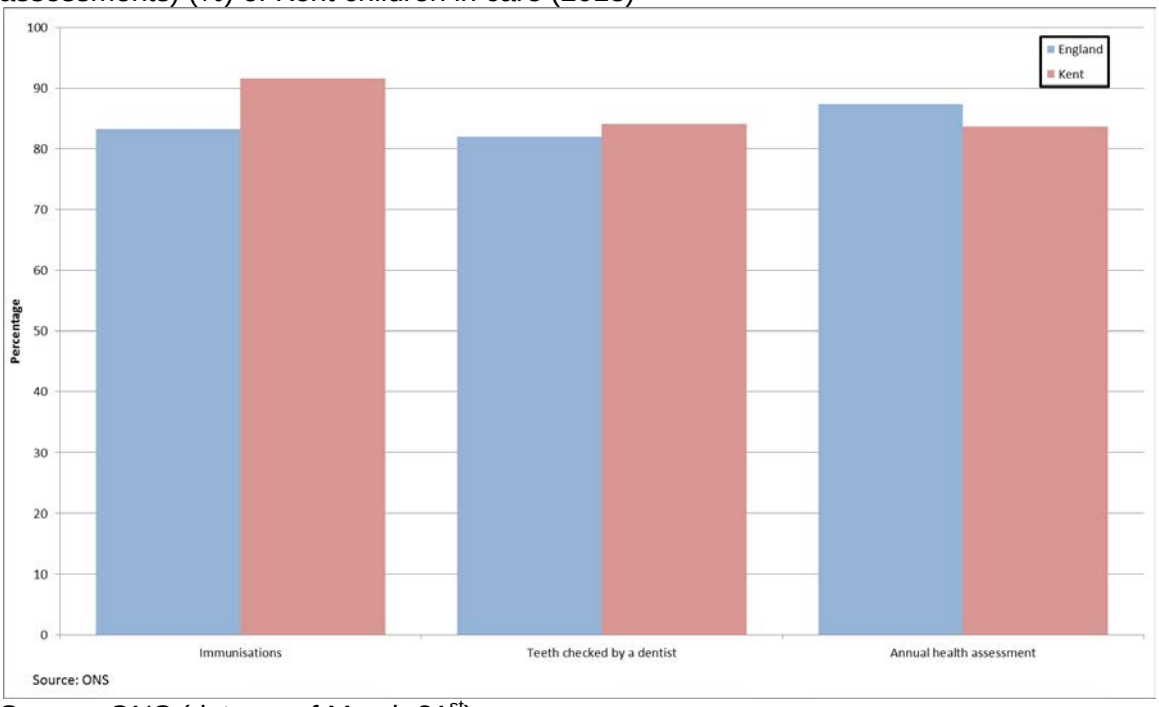
Source: ONS
* Numbers <5 have been suppressed

Graph 77 Number of Kent children aged 19 years old who were in care at the age of 16 years old, by type of accommodation (March 2013)



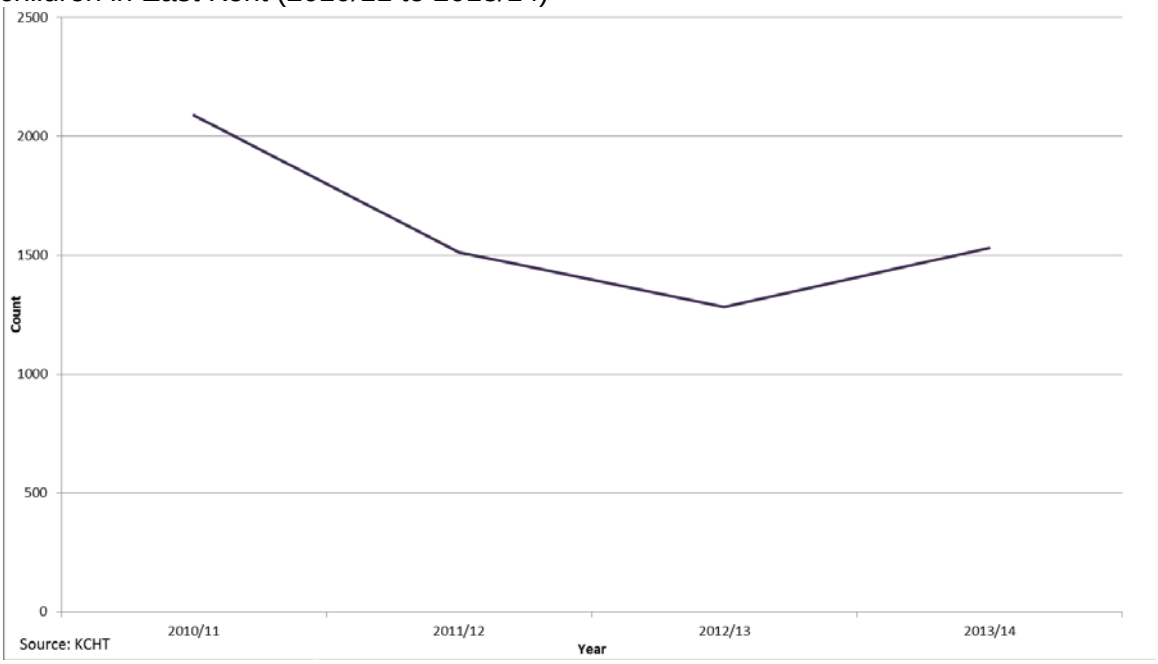
Source: ONS

Graph 78 Health care (up to date immunisations, dental checks, annual health assessments) (%) of Kent children in care (2013)



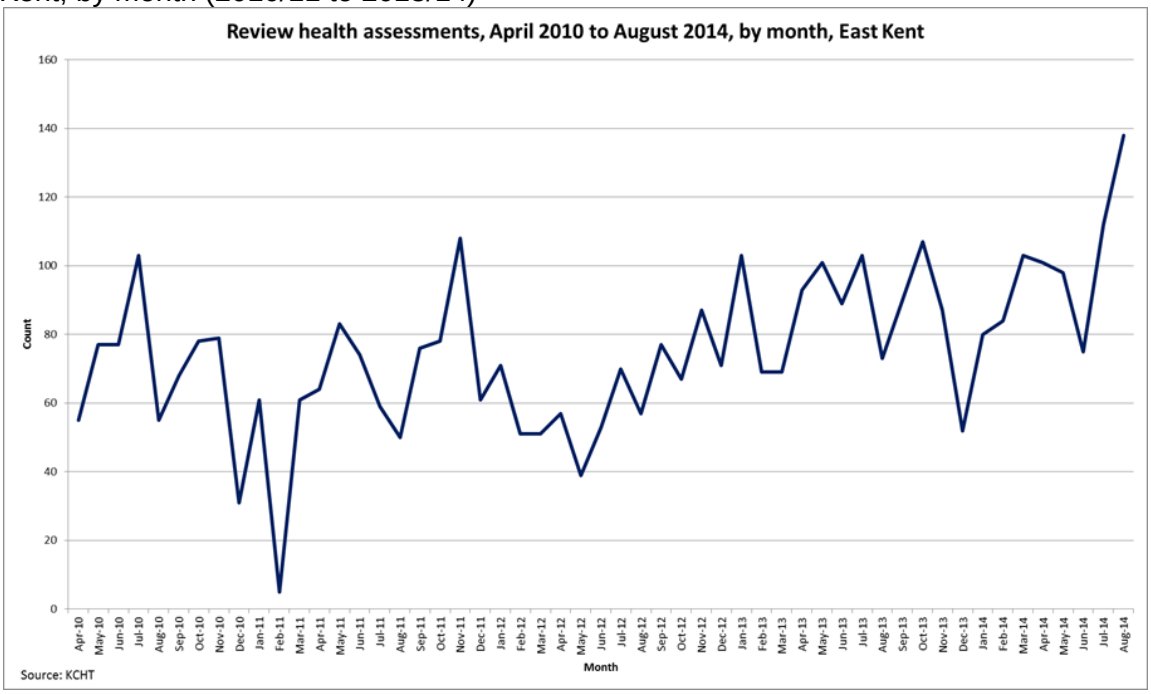
Source: ONS (data as of March 31st)
* HA = health assessment

Graph 79 Number of Kent children in care who received care from nurses for looked after children in East Kent (2010/11 to 2013/14)



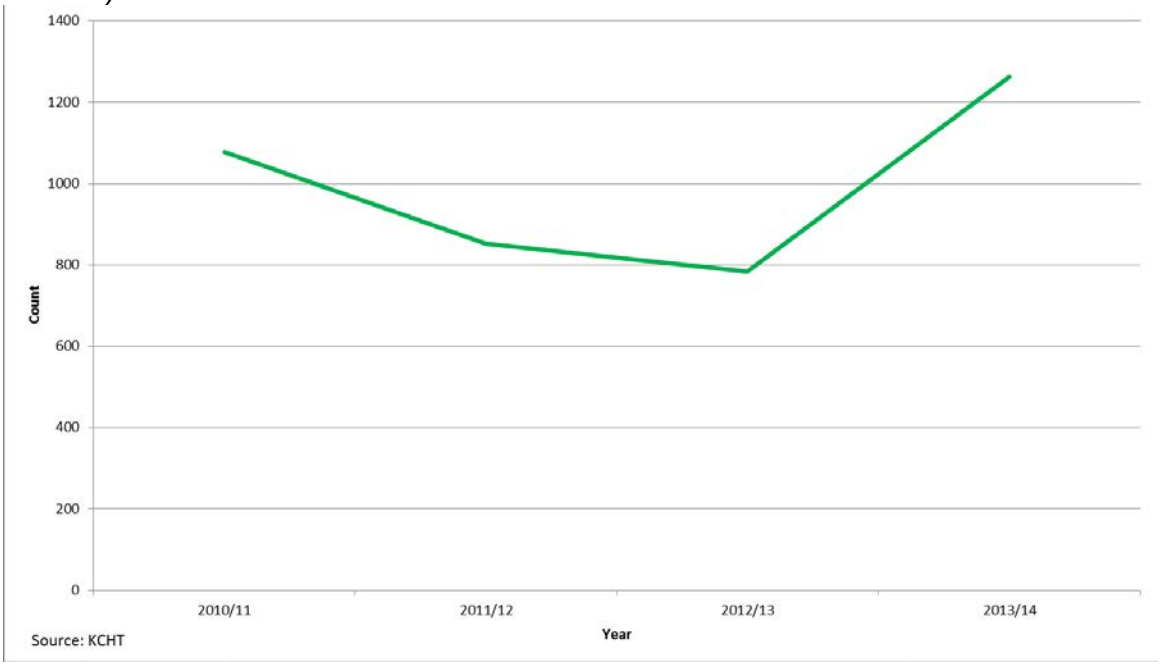
Source: KCHT

Graph 80 Number of review health assessments by nurses for looked after children in East Kent, by month (2010/11 to 2013/14)



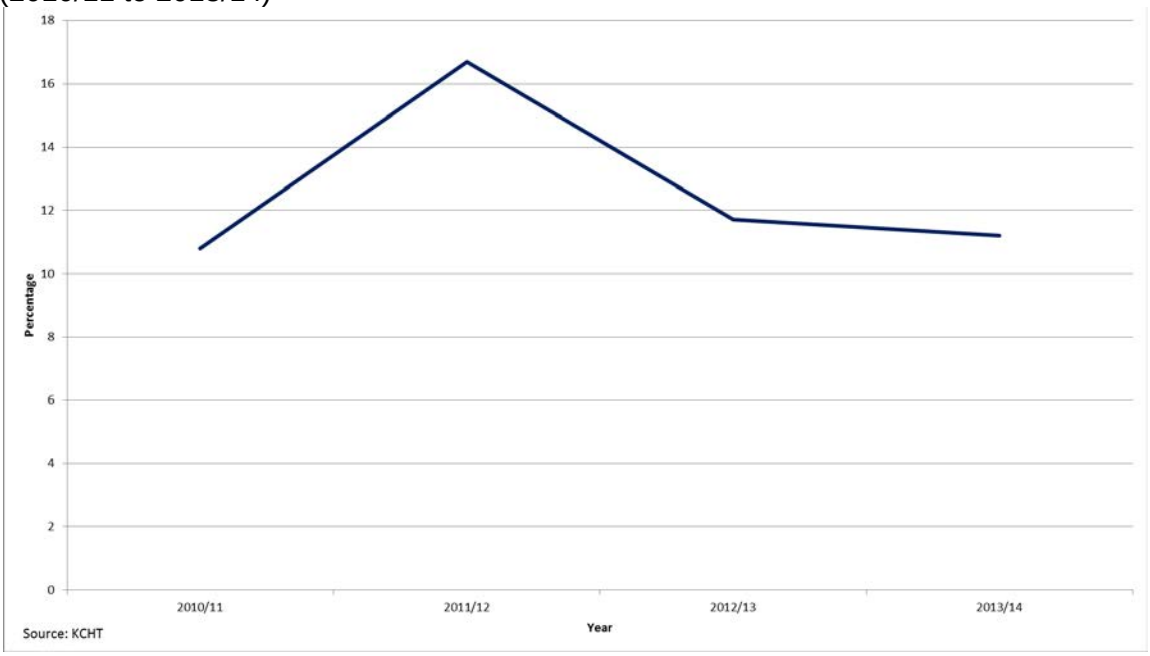
Source: KCHT

Graph 81 Number of health assessment administration sessions in East Kent (2010/11 to 2013/14)



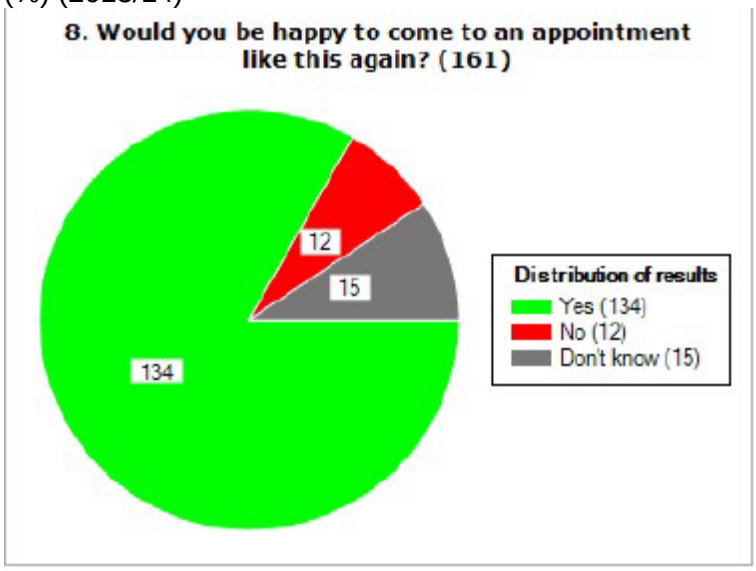
Source: KCHT

Graph 82 DNAs* (%) of review health assessments for children in care in East Kent (2010/11 to 2013/14)



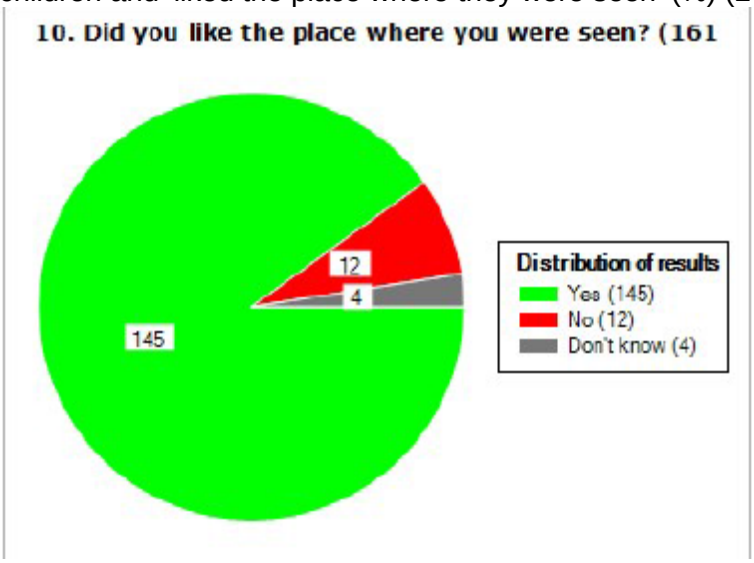
Source: KCHT
* DNAs= did not attend

Graph 83 Children in care who had a health assessment by a KCHT nurse for looked after children and thought that they 'would be happy to come to an appointment like this again' (%) (2013/14)



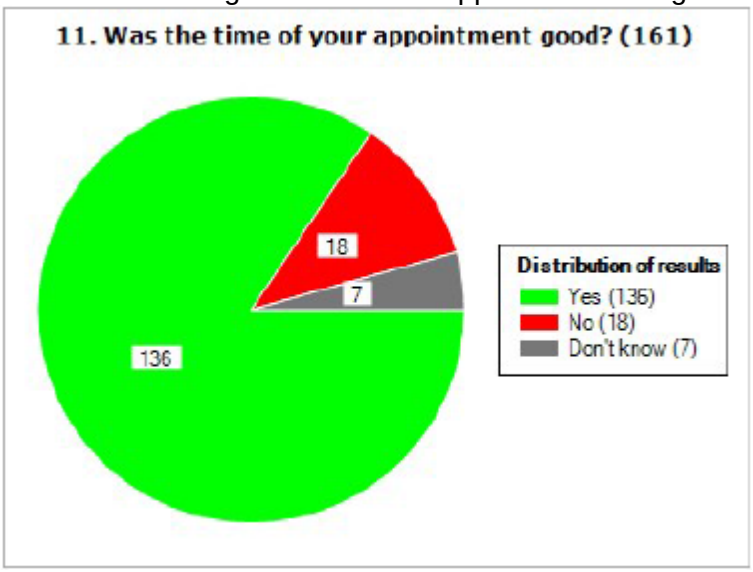
Source: KCHT N=161

Graph 84 Children in care who had a health assessment by a KCHT nurse for looked after children and 'liked the place where they were seen' (%) (2013/14)



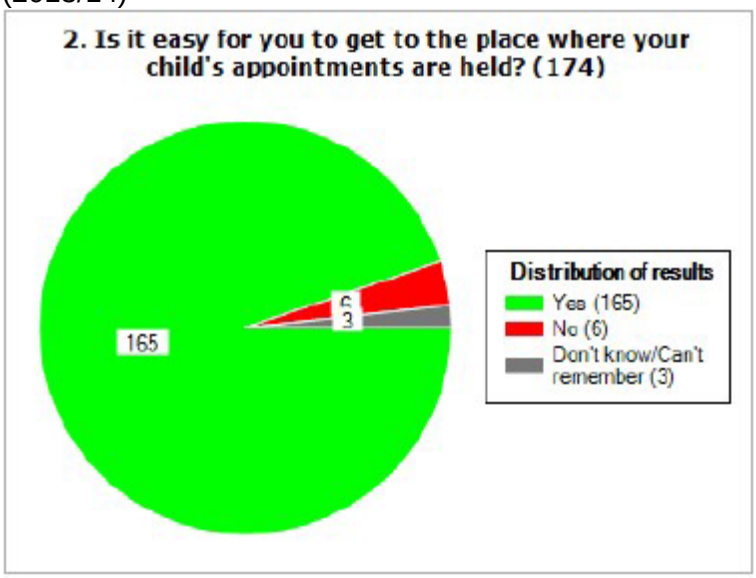
Source: KCHT N=161

Graph 85 Children in care who had a health assessment by a KCHT nurse for looked after children and thought 'time of their appointment was good' (%) (2013/14)



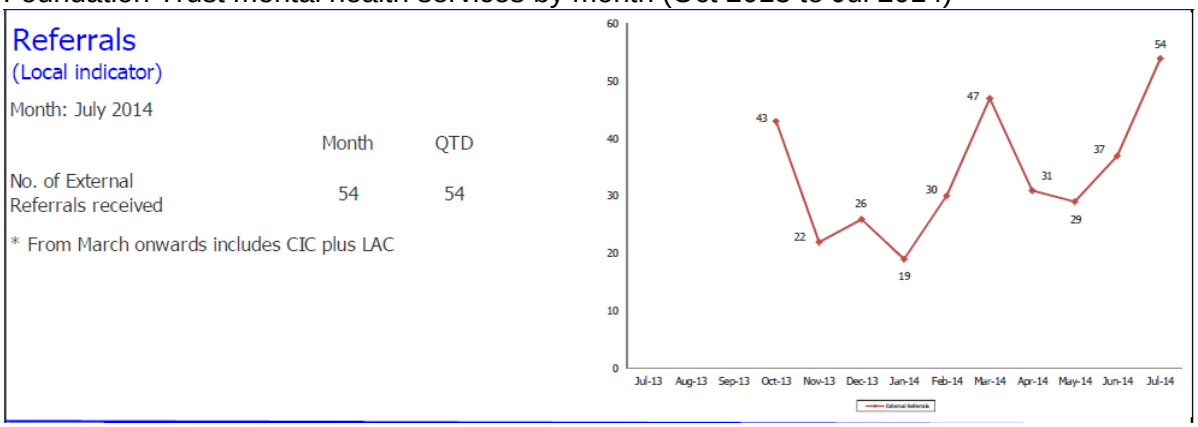
Source: KCHT N=161

Graph 86 Children in care who had a health assessment by a KCHT nurse for looked after children and thought that was 'easy to get to the place where the appointment was held' (%) (2013/14)



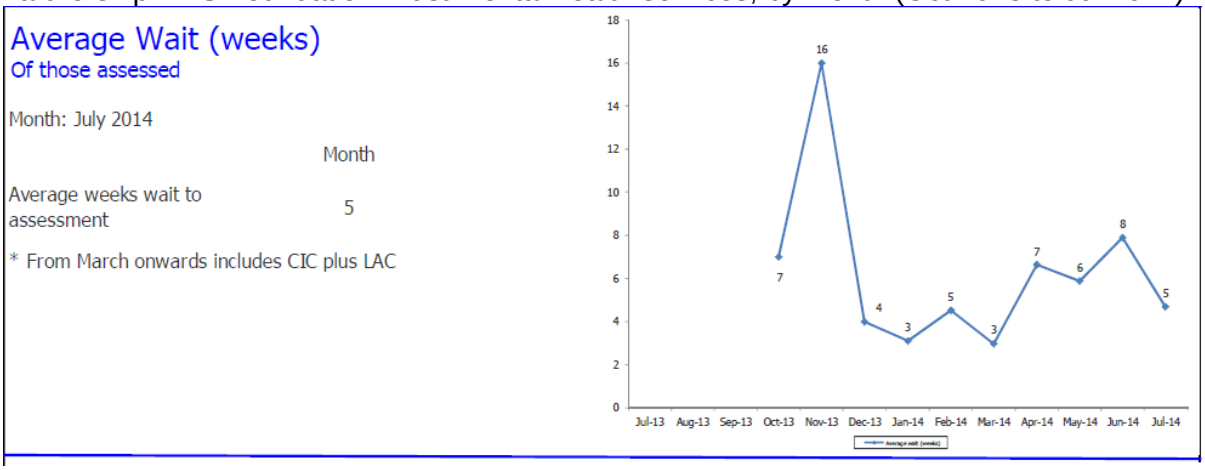
Source: KCHT N=174

Graph 87 Number of new referrals (Kent children in care) to Sussex Partnership NHS Foundation Trust mental health services by month (Oct 2013 to Jul 2014)



Source: Sussex Partnership NHS Foundation Trust

Graph 88 Average waiting time to assessment for Kent children in care referred to Sussex Partnership NHS Foundation Trust mental health services, by month (Oct 2013 to Jul 2014)



Source: Sussex Partnership NHS Foundation Trust

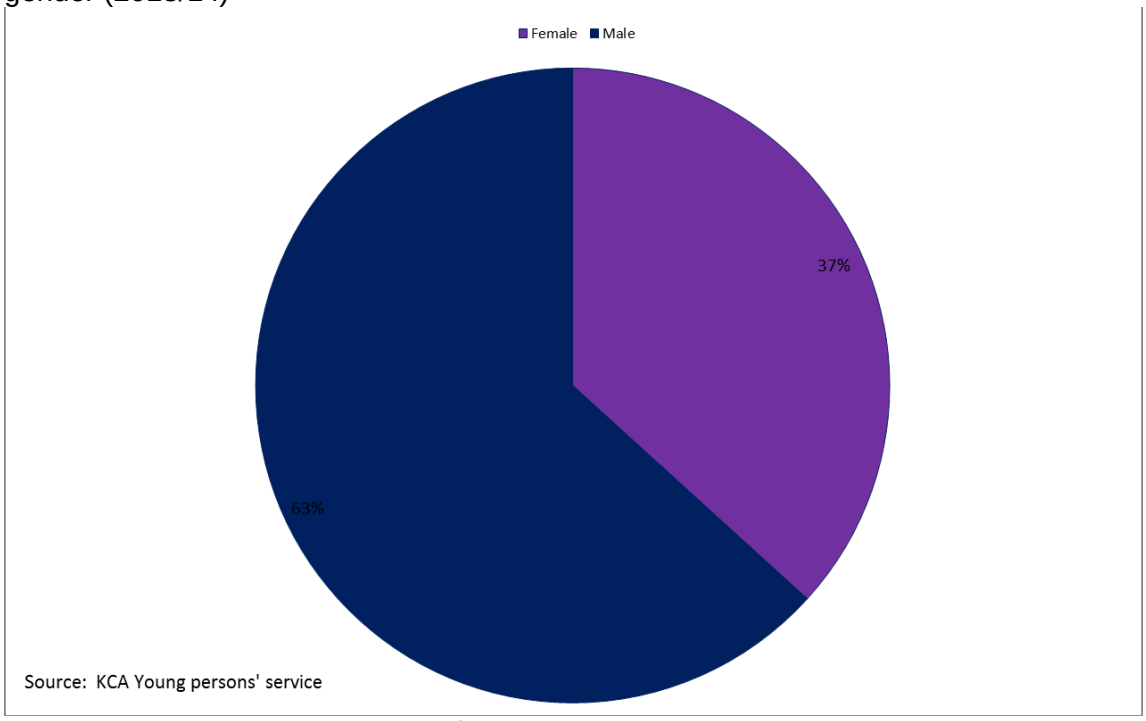
Graph 89 Number of cases (Kent children in care) managed by Sussex Partnership NHS Foundation Trust mental health services by CCG (Oct 2013 to July 2014)

Caseload - Performance Analysis - by CCG

Children in Care in Kent - Caseload										
CCG	Ashford	Canterbury & Coastal	Dartford, Gravesham & Swanley	Medway	South Kent Coast	Swale	Thanet	West Kent	Out-of-area CCG	Kent & Medway Total
Cases open at end of July 2014	36	84	51	59	77	62	93	56	12	530
Cases closed during July 2014	4	6	8	5	8	6	7	9	2	55

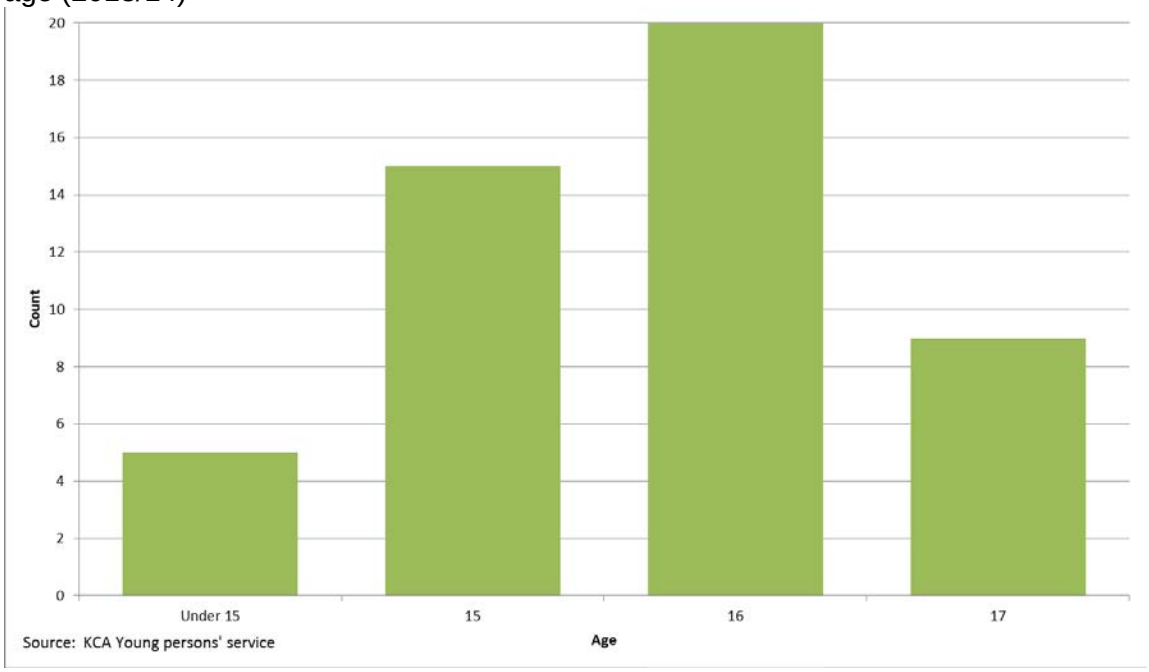
Source: Sussex Partnership NHS Foundation Trust

Graph 90 Number of Kent children in care starting specialist substance misuse treatment by gender (2013/14)



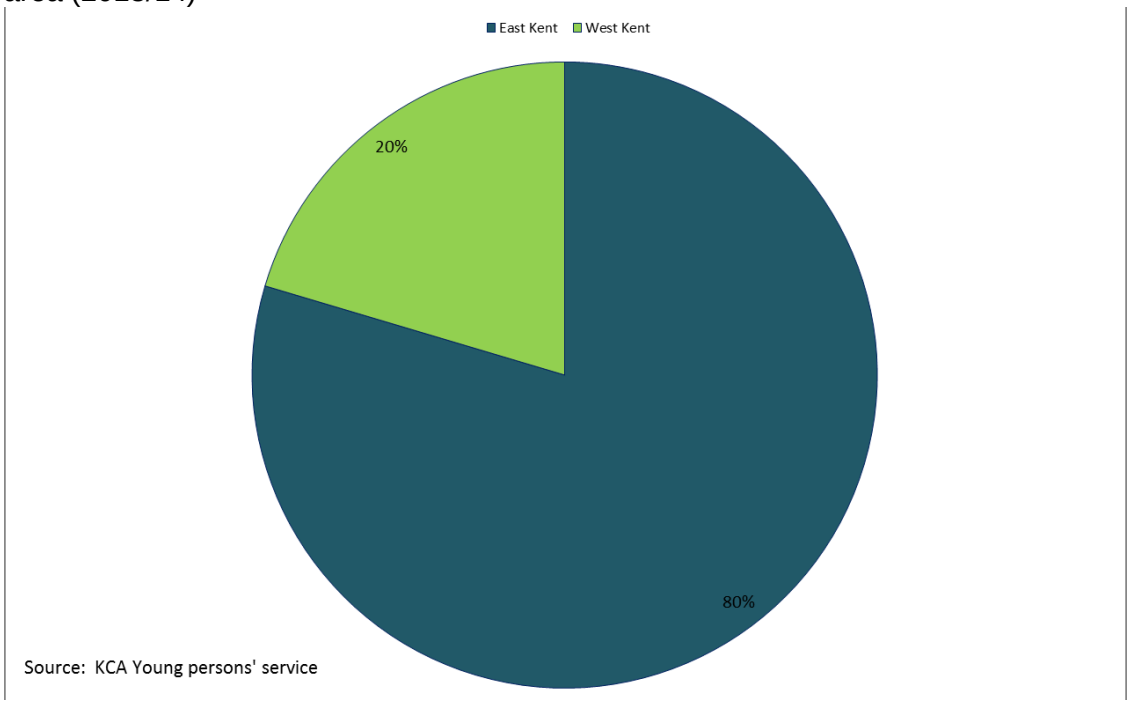
Source: KCA Young Persons' Service

Graph 91 Number of Kent children in care starting specialist substance misuse treatment by age (2013/14)



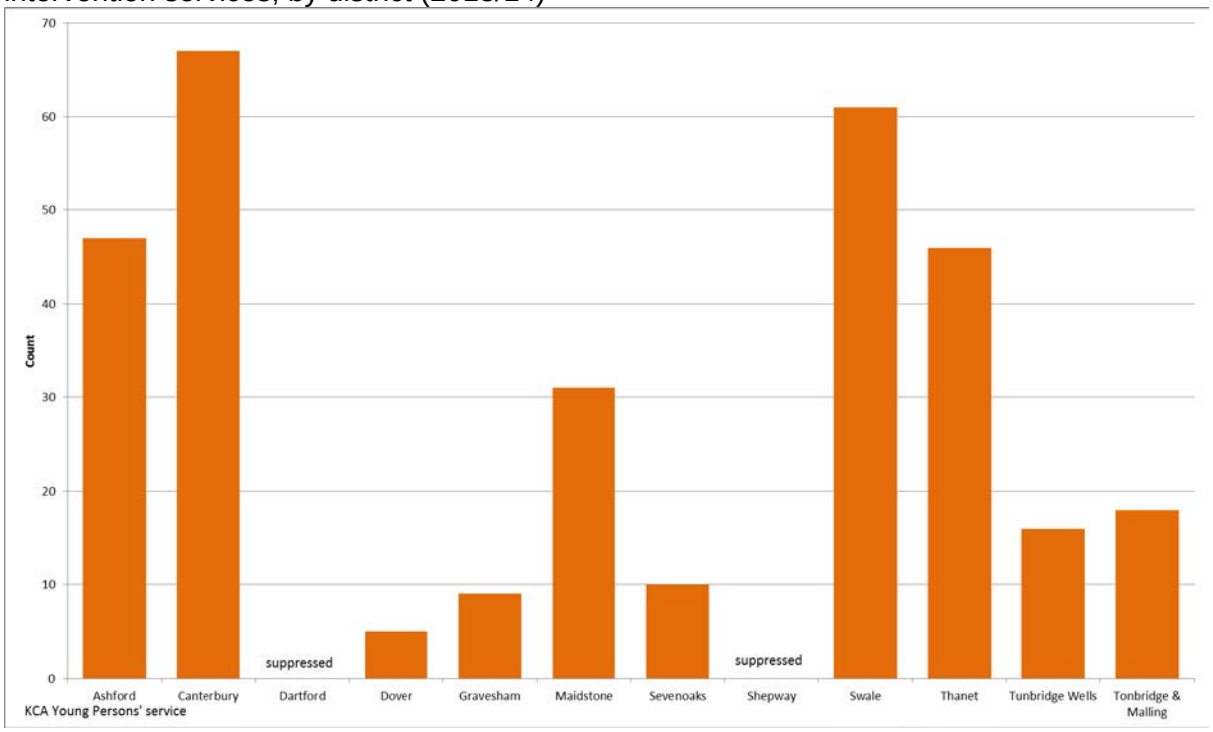
Source: KCA Young Persons' Service

Graph 92 Number of Kent children in care starting specialist substance misuse treatment by area (2013/14)



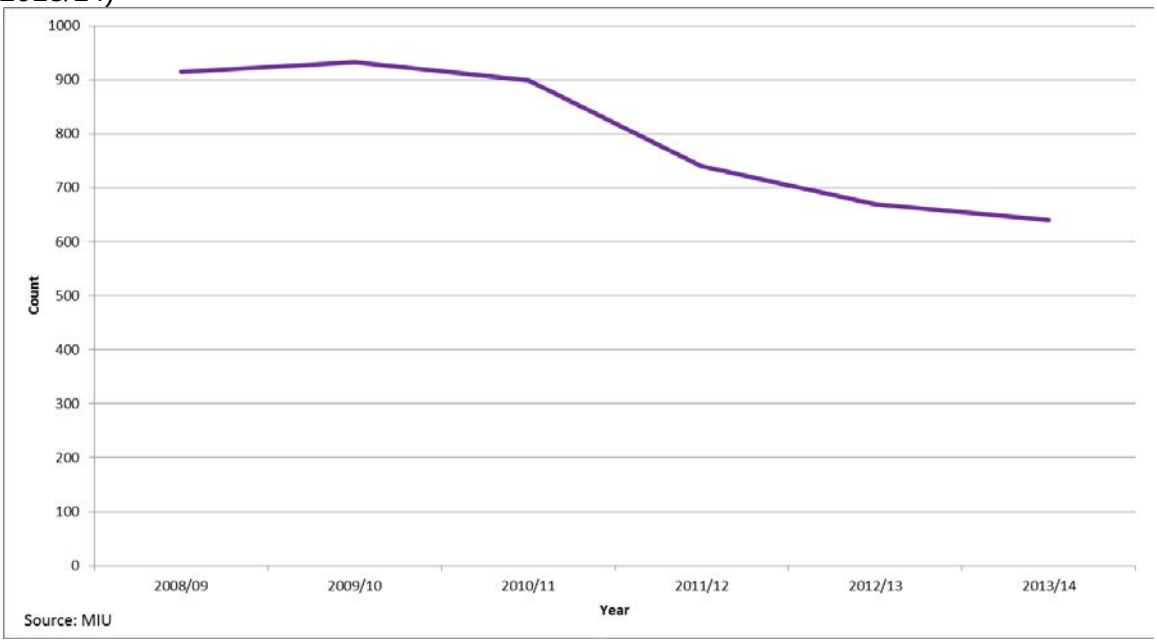
Source: KCA Young Persons' Service

Graph 93 Number of Kent children in care managed by KCA substance misuse early intervention services, by district (2013/14)



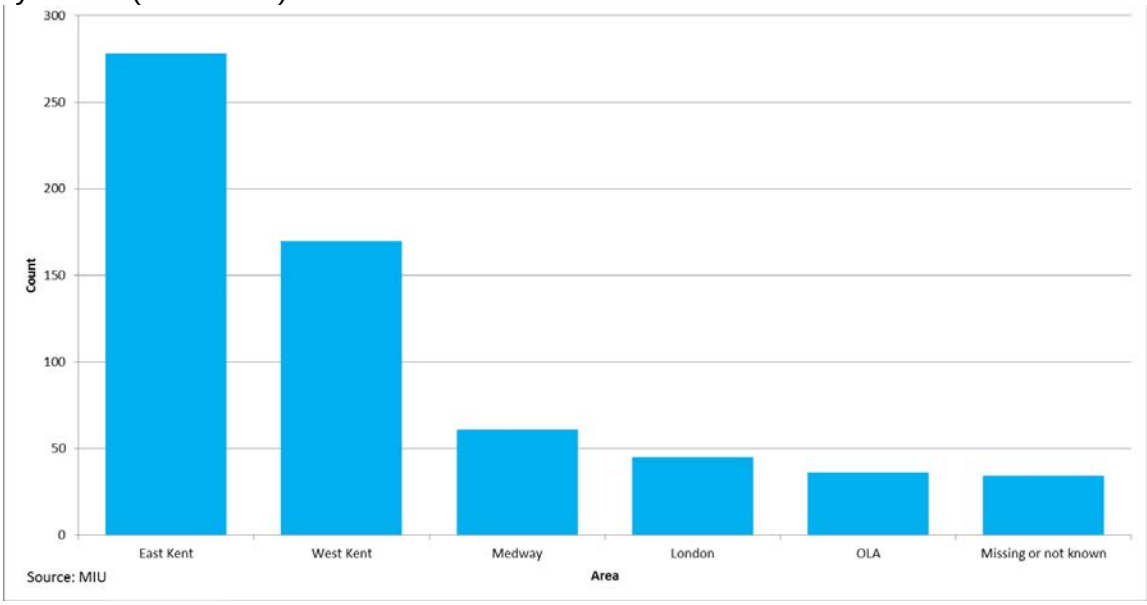
Source: KCA Young Persons' Service

Graph 94 Number of UASCs (children in care and care leavers) in Kent (2008/09 to 2013/14)



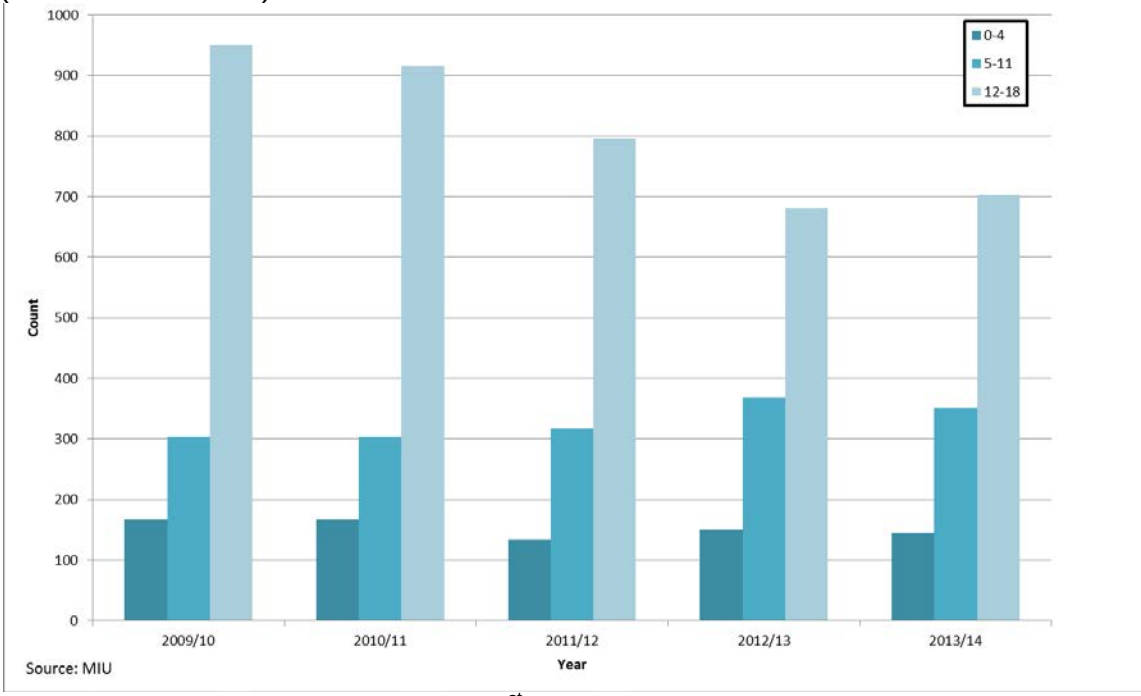
Source: Kent MIU

Graph 95 Number of Kent children in care that are unaccompanied asylum seeking children by district (June 2014)



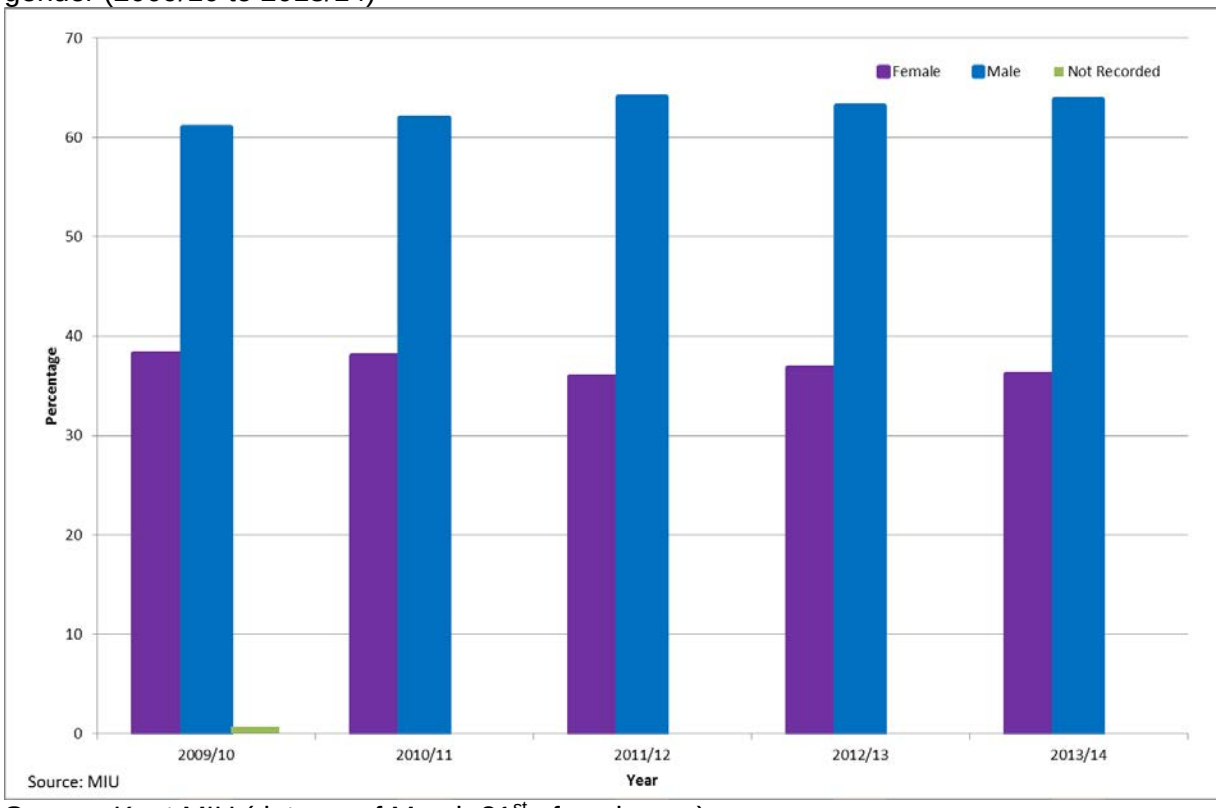
Source: Kent MIU

Graph 96 Number of children in care placed in Kent by other local authorities (OLAs) by age (2009/10 to 2013/14)



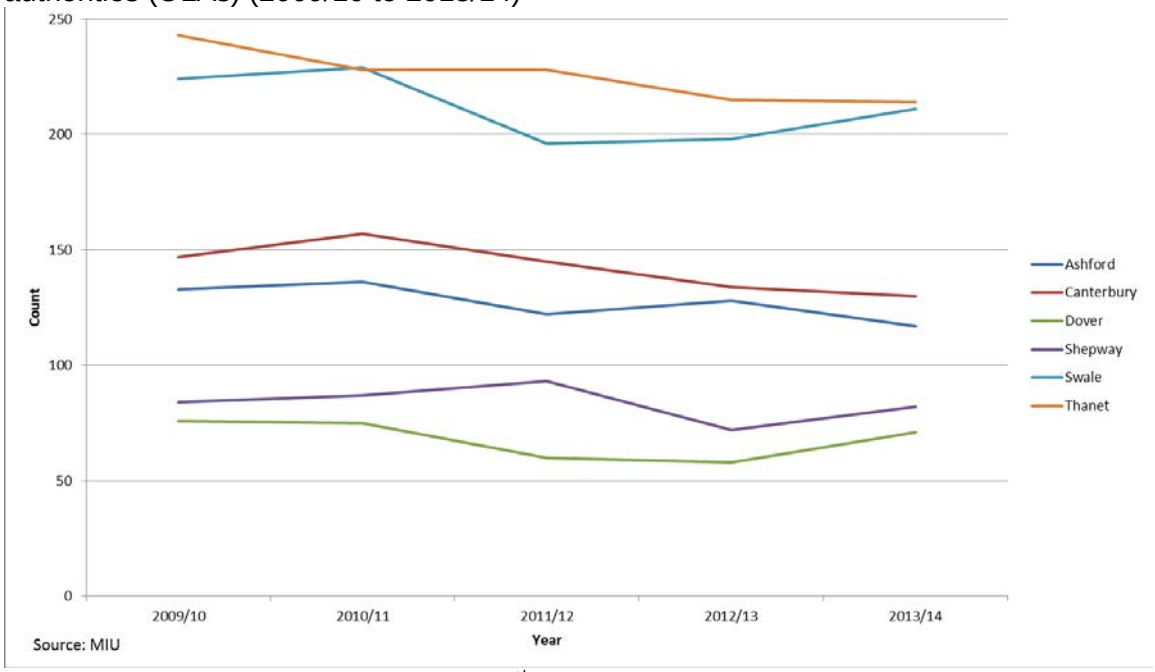
Source: Kent MIU (data as of March 31st of each year)

Graph 97 Number of children in care placed in Kent by other local authorities (OLAs) by gender (2009/10 to 2013/14)



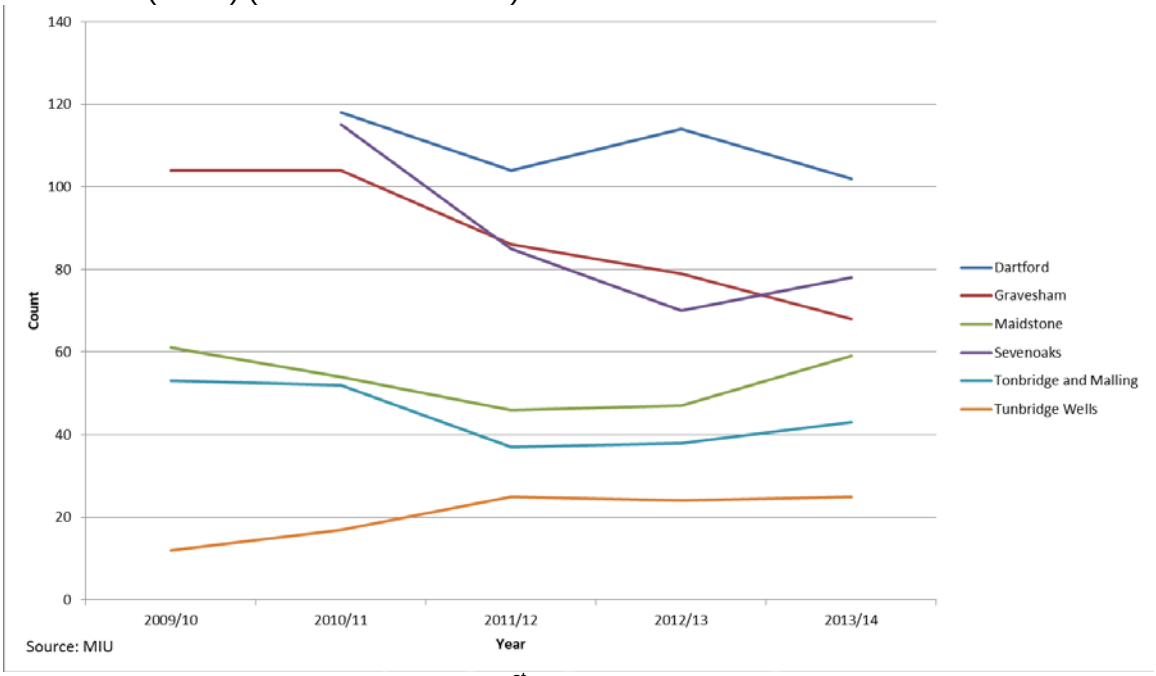
Source: Kent MIU (data as of March 31st of each year)

Graph 98 Number of children in care placed in East and South Kent districts by other local authorities (OLAs) (2009/10 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

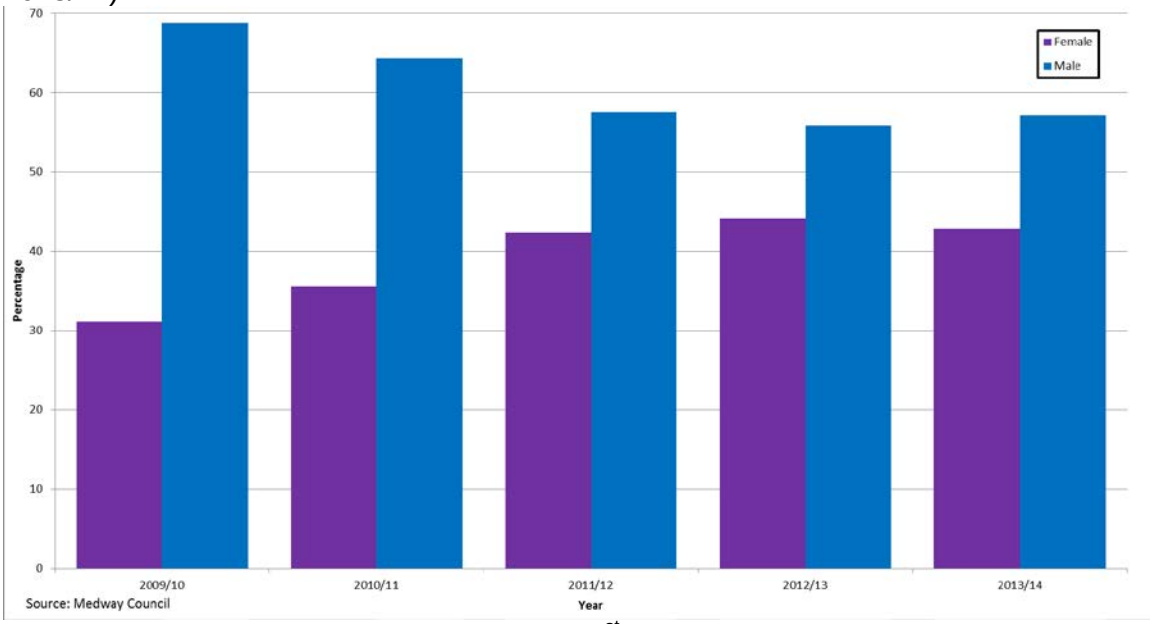
Graph 99 Number of children in care placed in West and North Kent districts by other local authorities (OLAs) (2009/10 to 2013/14)



Source: Kent MIU (data as of March 31st of each year)

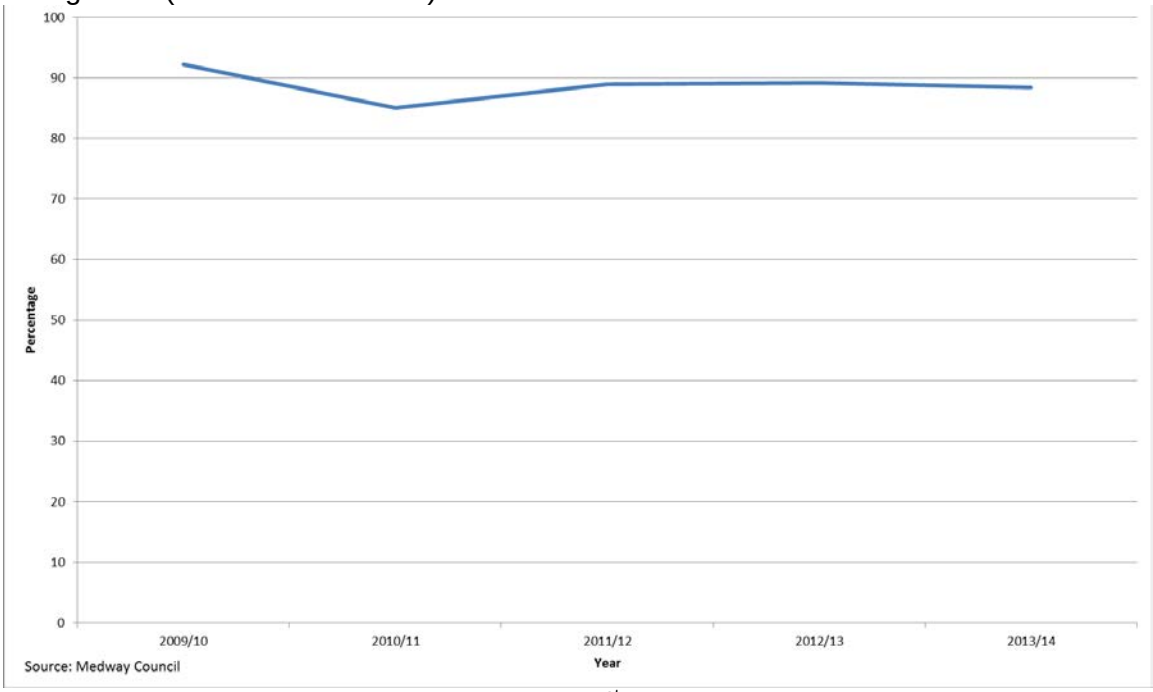
* Dartford and Sevenoaks OLA children in care (235) were recorded together for the year 2009/10

Graph 100 Number of Medway children in care placed in Kent, by gender (2009/10 to 2013/14)



Source: Medway Council (data as of March 31st of each year)

Graph 101 Medway children in care placed in Kent (%) recorded as having white British background (2009/10 to 2013/14)



Source: Medway Council (data as of March 31st of each year)