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In 2013, the RCN held several networking events for nurses working with looked after children.

Nurses who attended the October 2013 event raised numerous issues and concerns related to changes in NHS structures, commissioning of services, workload and capacity, roles and responsibilities, as well as the potential perverse impact of the introduction of a Payment by Results (PbR) tariff and unsafe working practices.

A survey of RCN members working with looked after children was undertaken during December 2013 and January 2014 which explored caseloads, ways of working and information about designated and named nurses' roles and responsibilities.

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158 members responded to the survey advising they worked with looked after children/children in care. Respondents were represented equitably across all RCN regions/boards, although there was a slightly greater percentage from London and the South East.

The comments included within this publication have been edited for readability without losing context.

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The majority of respondents did not know the total child (0-18years) population for their county/borough. Some of those responding indicated that the number of children and young people equalled 23 per cent of the total population, and in a specific area could be anything from 30,000 to over two million. In some areas it was acknowledged that this was expected to increase even more by 2020. Many respondents stated that they knew the number of children and young people on their individual caseload but did not know the total child population for their area.

In terms of the number of looked after children and young people, 50.4 per cent of respondents stated there were between one and six hundred looked after children in their area. A further 17.1 per cent stated there were between six hundred and one thousand, and a further 16.2 per cent stated that looked after children were between one thousand and five thousand. 1.7 per cent stated that there were in excess of five thousand (see Figure 1). The findings highlight that respondents covered varied geographical areas.

We have seen a 50 per cent increase in the numbers over the last three years. My organisation has provided no additional nurses to support this work.

The number of looked after children has decreased significantly over the last 18 months, seeing a month on month reduction in numbers. As of 18 months ago we

Over 61.5 per cent of respondents advised that 100 to 200 looked after children were placed out of the county/borough in the previous year. 13.8 per cent stated that between 200 and 400, and a further 1.8 per cent that between 600 and 800 children were placed out of the county/borough. 3.7 per cent stated that between 1,000 and 3,000 were placed out of the county/borough in the previous year (see Figure 2).

Most infants are placed locally at first but there is

65.7 per cent of respondents stated that they were responsible for between 100 and 200 care leavers. 5.6 per cent advised they had between 201 to 400 on their caseload, 4.6 per cent have between 401 and 600, 2.8 per cent have between 601 and 800, and 0.9 per cent have between 801 and 1,000 (see Figure 4).

Several respondents added comments which included:

> I have a team member take a lead with this cohort of looked after children as they have very specific and at times complex needs. I also have a GP who has developed a special interest who conducts the initial health assessment.

> We do not have a reception centre for asylum seekers locally anymore so we have very low numbers and these are young people who have been in the system a few years.

> The numbers of unaccompanied asylum seeks within our county is very small. I do not think there are many members of staff that fully understand their possible needs.

> We currently provide a full service for those young people on care orders but service is expanding to facilitate a service provision for all care leavers under the care of the 16+ team.

Several issues are illustrated by the above comments. There is a need to clarify and define the term care leavers so that all areas are looking at the same age range. In addition, the above statements show that some areas provide services to care leavers, but others are not commissioned or do not have the capacity to do so. These issues should be clarified in order to standardise, support and meet the health needs of this group of young people as per the Care leaver strategy

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4.4 per cent of respondents highlighted that more than 50 per cent of their caseload had learning difficulties, while 44.2 per cent stated that up to 20 per cent of looked after children on their caseload had learning difficulties (see Figure 6).

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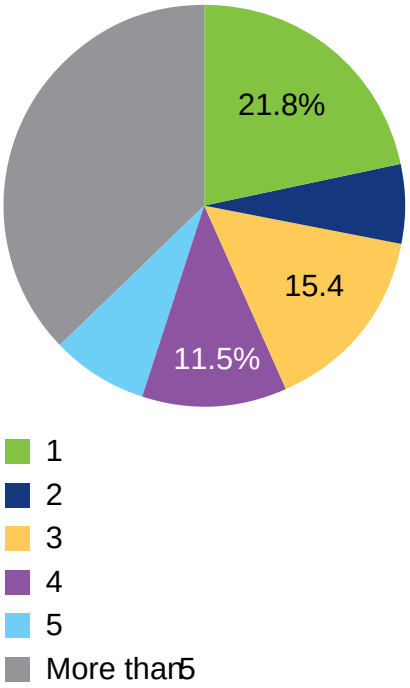
The school advertises a service which addresses mental health issues and draws a lot of funding for this, but then accesses local child and adolescent mental health services (CAMHS) when a crisis occurs, expecting local

This is a clear unmet need; young people are misplaced in open children's home/CAMHS Tier 4/secure provision because there is no secure children's home.

We are aware of at least three smaller independent units being used as secure children's units.

Currently in the process of commissioning a pilot retained remand foster care scheme through independent fostering providers.

The National minimum standards for children's homes (DfE, 2011) states that apart from the measures essential to the home's status as a secure children's home or refuge, children resident in secure units or approved refuges should receive the same care services, rights and protections as they should in other children's homes. These survey comments highlight practice models demonstrating how different interpretations of practise can lead to a significant variance in services for looked after children and young people.



81.1 per cent of respondents highlighted that there were independent companies providing care for looked after children in their county/borough. 37.2 per cent advised there were more than six such companies in their area (see Figure 10).

These facilities are not thought through. They are used in an emergency and driven by profit. The young people who reach this point have complex needs or are difficult to engage and highly risky. Staff are not skilled or trained to manage them in these settings.

Several of these independent companies accept looked after children with complex needs eg at risk/subject to child sexual exploitation. There are increased demands on health practitioners.

It is not always clear what health facilities or therapeutic interventions are being offered in these establishments or what the placing local authority has contracted with the home.

Concerns around cost, qualifications of therapeutic staff and staff in general in some placements, others however are excellent. All now have to apply to be part of the area and recommended for use to the local authorities within our area.

We send a letter with the child's details on it to the LAC health team where the child is placed requesting for the health assessment to be completed. When the form agreeing funding for this to take place is completed by the designated nurse and sent off, the health assessment is completed and returned to us.

We do not currently have funding to travel outside of area to complete RHA's so we would contact the LAC team where the child is placed to request this.

When we are notified by our local authority of an LAC movement out of county we would send a notification letter to the receiving LAC team which includes a copy of the last health assessment so any outstanding health issues are flagged up. The notification letter also includes information on any risk factors ie if child has history of self harm, frequent absconding etc. We

When a child is placed out of county, notification goes to the designated nurse for children in care (CIC) for the receiving area. This includes a copy of the child's most recent health assessment and health care plan. Health assessments are requested via the same route. The specialist CIC nurse will continue to maintain contact with that child/young person and their carers and liaise with their colleagues in the area that the child is placed in, and with the care provider to monitor the implementation of the health plan and ensure access to appropriate local services. This will be reported at the child's reviews.

When a child returns to the area the designated nurse for the other area is notified.

The responses above indicate the need for revision to the statutory guidance, to give clear direction on the commissioning arrangements for the health provision for

This post is part commissioning and part provider. The designated nurse manages the specialist children in care nurses. This split role has compromised the strategic function.

The comments reflect the current disparity in the interpretation of the designated nurse role for looked after children. Many of these role variations are based on historical arrangements and have not altered in line with changes to NHS structures. In many instances participants reported problems resulting from failure to separate the commissioning and provider functions. It had compromised the strategic function of the designated nurse for looked after children and their ability to provide impartial advice to commissioners or to represent looked after children's issy6(e)-8k2emmooked alic fdc tn5r(d n)12.ve son o(i)-4.1(g)-23.3o0 (r c8-)2.9T le def ti6(s)-66y ft h4(d)7(k.1(r)-2s.2

Some respondents provided a detailed outline in respect of the role and function of the named nurse.

Co-ordinate health care for the child, provide training for own staff and, in partnership with other provider teams, for foster carers. Monitor and audit service delivery. Lead service development within own organisation and in partnership with a designated nurse to ensure consistency across the whole health economy.

Manage a team of LAC nurses. Design policy and enhance standards. Undertake health reviews. Advice, training, immunisation and research.

Provide a comprehensive health service to looked after children and to care leavers. Promote positive physical and emotional health. Undertake health assessments of children looked after both in county and out of county where possible. Facilitate training courses for foster carers and other professionals about the health needs of LAC and care leavers including sexual health. Is the medical adviser to the foster panel. Is a member of the corporate parenting board. Attends skills to foster course. Promotes the health and wellbeing of looked after and children care leavers to all health professionals and a wider audience. Attends the area's LAC nurses group. Monitor health assessments of LAC placed outside of the area, monitor SDQs, delegate health reviews to be undertaken for children looked after by other local areas to trained school nurses/ health visitors and audits these to ensure quality. Undertake internal audits, write policies. Work closely with the designated nurse for LAC within the CCG.

Monitor mental health and risk. Attend LAC reviews and update all professionals involved. Is an advocate and a voice for young people. Is the core contact for all the professionals involved.

It is a new role so is being developed at present but supports the lead/designated nurse. Provides supervision for LAC nurses.

	The named nurse will carry out health assessments, work 1:1 with children/young people, carers and other professionals. Foster carer training and training for other professionals. Support for the acute trust on understanding the needs of LAC and the consent issues for LAC who need treatment. We have a range of skills in the team including a mental health nurse and a learning disability nurse.
	Co-ordination, leadership, champion, trainer, innovator and advocate, ensures the profile of children and young people who are looked after is raised.
	The designated nurse works in CCG. The named nurse provides the training, consultation, ensures systems are in place for HAs, monitors quality and cost, delivers the annual report to CCG/LA and works with the local area, but the designated nurse for LAC should be the health lead in ts raised. lea.7(e)-8.9(s t)-29.7(h)4.7(3.8(a)-26.3(n)4.Tc 0.003 Tw T*(.1(l)3.2(t)8T*)4.6(m8.8

They organise annual health assessments (or six monthly for under five year olds), provide foster carer training, have a named nurse against individual children's homes, sit on the foster panel, attend LAC reviews, check the health needs of looked after children are being met, liaise with professionals, and provide training for school nurses and health visitors.

This role is shared with one WTE RGN. They undertake health assessments; support young people living semi and [fully] independently; provide training and support to foster carers/county council staff and young people; provide health promotion advice; train and provide support for health professionals; liaise with designated nurse in commissioning; and provide data and information for the organisation board.

They undertake the statutory health assessments and monitor the implementation of health plans including signposting or referral to other services and liaison; advice, support and supervise a range of professionals and carers; training for a range of professionals and carers; CSE forums; resource and care panels, and professional meetings and safeguarding.

Co-ordinate all health assessments, lead professional responsibilities for children over 16, and those not in mainstream education. Liaise and train health and social care staff, CYP and carers on health needs of LAC and are a source of expert advice that ensure audit etc is

the country. This results in a wide variation of service depending on the area in which the child is looked after. Some LAC health teams travel to wherever their looked after child is placed, some have a larger team than others, some teams sit within safeguarding services. One person commented that it is a bit fragmented.

From this report, it is clear that the variation in service provision means that in some areas looked after children receive a poor or limited service in comparison to others. Although service models can differ to reflect local need, it is imperative that standardisation of services for this vulnerable group is in place to ensure high quality health care and to promote positive health outcomes for looked after children, no matter where they come into care.

Nurses also provided information ret(2 3.1(t s)-3(t)-1)-22.4(f3)-10.8(d)s .4(a)4.1(t)-

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Department of Health (2013) Payment by results 2013-14,

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