Agenda Item 10

Committee:	**Corporate Parenting Panel**
Date:	**18 October 2013**
By:	**Interim Director of Children's Services**
Title of Report:	**Future commissioning and needs assessment for health of children and young people in Lansdowne Secure Children's Home**
Purpose of Report:	**To inform the Panel of the final report by the Public Health Action Support Team CIC (PHAST) and actions taken to date**

Recommendation: **The Panel is recommended to:**
(1) note the PHAST final report and the summary; and
(2) endorse the continued linking with Health Service Commissioners and the planning in place for the delivery of health care to residents of Lansdowne Secure Children's Home.

1. Financial Appraisal

1.1 The commissioning of health services provided to children in Secure Children's Homes with welfare only places transferred from April 2013 to the (then) NHS Commissioning Board, now NHS England. The NHS England area team for Kent have the lead for health services in Secure Estate across Kent, Surrey and Sussex.

2. Supporting Information

2.1 A summary of the background to the assessment, and the subsequent actions and future commissioning arrangements, is attached at Appendix 1. The full report is attached as Annex 1.

3. Conclusion and Reason for Recommendation

3.1 Members are asked to note the full report and endorse the continued linking with Health Service Commissioners and the planning in place for the delivery of health care to residents of Lansdowne Secure Children's Home.

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Local Member(s): Councillor Bentley and Councillor Keeley
BACKGROUND DOCUMENTS: None

APPENDIX 1

Briefing Report to ESCC Corporate Parenting Panel – October 2013

Lansdowne Secure Children's Home

1. Introduction

At the end of April 2012, the Department of Health indicated to all NHS commissioning bodies that the responsibility for the commissioning of health services provided to children in Secure Children's Homes with welfare only places would transfer to the (then) NHS Commissioning Board – now NHS England from April 2013.

Primary Care Trusts were required to complete a health needs assessment of all such homes in partnership with the Local Authorities in order to disaggregate the health funding and agree the appropriate level of spend.

The Department of Health allocated £10,000 for the needs assessment to be undertaken and the strategic commissioner for health and the public health department engaged an organisation known as PHAST to complete the work. The final report was made available in December 2012 (attached)

2. Profile of Children and Young People who are resident in Lansdowne Secure Children's Home

Residents can be aged 10 years, but are more usually are between 13 and 17 years old and the higher number are female. The average length of stay for residents is 3.5 months.

Lansdowne previously could accommodate 5 young people and this has now increased to 6 with the capacity for 7. With 7 placements available, the home could host around 21 children and young people per year.

Those accommodated are generally young people who have displayed serious and extreme behaviours which have resulted in needing the placement for either their own protection or the protection of others in the community.

Residents often come from areas outside of East Sussex but most frequently from Hastings and Rother

The most common general physical health needs of the children are reported to be asthma; needs related to sexual health; diet and nutrition; eczema and dental care.

The most common mental health needs of the children are reported to be self-harm, acute anger, eating disorders, learning difficulties and attachment disorder.

3. Key messages and subsequent actions

In recognition of the need for parity of specialist health provision into the 7 SCHs across the country, the Department of Health made available in 2013 additional resources for mental health and substance misuse - £15,000 into CAMHS at £11,000 into Under 19 years Substance Misuse Services (Local Authority). This has resulted in increased hours of Psychology and the presence of a psychologist on site for at least 2 days per week.

An increase in Looked After Children nurse time to undertake health assessments in a more timely way was a recommendation and this has been achieved through additional East Sussex Clinical Commissioning Groups (CCGs) funding of £12,000. The nurse has been recently

recruited.

Improved links between the GP practice and the designated LAC doctor have been proposed as well as the engagement of the lead GP undertaking medical health assessments in support of improving the primary care knowledge and response. This is an area of work in progress.

The new Lansdowne facility has a designated “health” room and dental care, optician visits and the ability to have therapy input on the site has been planned and practical arrangements are yet to be taken forward. Once in place, the need for escorted trips to health care providers may be reduced.

4. The future commissioning arrangements

The NHS England area team for Kent have the lead for health services in Secure Estate across Kent, Surrey and Sussex. Their commissioner has recently completed a visit to Lansdowne SCH. The CCGs strategic commissioner for health will remain the local lead for day to day issues and will work with ESCC Assistant Director on arrangements.

Additional resources identified by the Department of Health and the CCGs will make up the components of the commissioning budget held by the NHS England area team. Plans for the spend will be reviewed on a regular basis by NHS England.

Future Commissioning and Needs Assessment for Health of Children and Young People in Lansdowne Secure Children's Home

Final Report

December 2012

Version:	03
Ref No:	P439-1
Date:	05.12.2012
Author:	Pyper
Commissioner:	Alison Smith Strategic Commissioning lead for Health for Children and Maternity in East Sussex

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1. Executive Summary

1.1.1 NHS Sussex and East Sussex County Council appointed the Public Health Action Support Team CIC (PHAST) to undertake a health needs assessment (HNA) into the current and future healthcare needs of 'looked after'[1] children at Lansdowne Secure Children's Home (SCH). The research was conducted between July and October 2012.

1.1.2 The results are intended to provide an evidence base that will assist in determining future health provision and appropriate funding allocation in light of the changes resulting from the transfer of commissioning responsibilities for the health services at SCHs with welfare placements, to NHS Commissioning Board (NCB) from April 2013. This report has been commissioned from a health service perspective to recommended levels of provision during future commissioning. The report does not aim to set or review performance against specific targets.

1.1.3 The research is based on a mix of qualitative and quantitative methods, including a review of existing data held for Lansdowne SCH, comparative analysis with other SCHs providing welfare placements, and interviews with key stakeholders, including staff, residents and health care providers. The recommendations are therefore based on a variety of sources.

1.1.4 Lansdowne Secure Children's Home is based at Lansdowne Children's Centre, Hailsham, East Sussex. It provides a regional resource for young people who are at significant risk of harming themselves or others and who cannot be cared for safely in open conditions. The core concepts for practice, within the SCH are based upon clear planning, appropriate interventions, evaluation and positive outcomes. Lansdowne SCH is currently undertaking construction work to expand the site. This will extend the number of placements from five to seven.

1.1.5 The demographic profile of children at Lansdowne SCH is as follows. Residents are aged between 10 and 17 years old, with approximately three quarters being female. The average length of stay is three and a half months. The residents typically have a history of constant moves from one place to another. In 75% of cases the main reason for admission is a high risk of absconding or significant harm. For girls this is usually linked to sexual exploitation. Drugs are often also involved as is self-harm. For boys, there is often a history of violence. The young people admitted to Lansdowne SCH typically have very complex emotional and behavioural needs, which invariably have led to multiple breakdowns in previous placements. A high proportion of residents require mental health and substance misuse support. Discharge is generally to foster care, home or another secure unit.

1.1.6 The most common general physical health needs of children are reported to be (in order of the most common first): asthma; sexual health issues; diet and nutrition; eczema; and dental health.

1.1.7 The most common mental health needs of children are reported to be (in order of the most common first): self-harm; acute anger; eating disorders; learning difficulties; and attachment disorder.

1.1.8 The HNA finds that generally Lansdowne SCH is providing a good level of care, which meets the majority of the health needs of the resident looked after children. The following sections provide a summary of the key health needs identified during the HNA that should be taken into consideration by commissioners in allocating funding for future health care sources to be provided to residents of Lansdowne SCH.

- The LAC nurse provides an important role; however the hours are insufficient to effectively meet the current demand on the nurse and it is recommended that these are extended when the number of placements is expanded. Similarly it is recommended that the psychologist and psychiatrist supporting the SCH receive extended hours once the number of placements is expanded.
- There is a good GP service supporting the SCH, however the registration and admission health check procedures could be improved to make full use of the opportunity for health care interventions for children who typically have very chaotic lives, but are temporarily in the stable environment of the SCH. It is therefore recommended that more GP time is allocated to undertake a wider spectrum of screening and health assessment activities at admission.

[1] The term 'looked after' refers to children who are under 18 and have been provided with care and accommodation by children's services. Looked after Children is abbreviated to 'LAC'.

- The lead GP reports that a better service could be provided, if there was improved communication with both key health and social care staff linked to the SCH and the wider multi-disciplinary team supporting the children. There is also a need to prioritise access to past NHS medical records and information regarding recent referrals. It is therefore recommended that protocols are agreed to enhance communication between the SCH and health care providers.
- There is currently a significant delay in arranging specialist mental health care for children from out of county at the SCH (such care can take between one and four months to arrange). This delay may potentially result in adverse mental health outcomes. The delay is due to funding negotiations with the Local Authority from which the child originates. It is therefore recommended that funding is agreed in advance, or provision made for bridging finance, to avoid these current delays in specialist mental health referrals.
- Discharge from the SCH is often at short notice and with immediate effect. This makes planning a complete and managed hand-over process very challenging. There is potential for improving the transition through earlier planning and greater involvement of the GP and LAC nurse. It is therefore recommended that SCH staff, the LAC nurse and the GP to have more time allocated to plan each child's discharge; this involves the confidential transfer of key health and social care information to the next professionals responsible for the on-going care of the child in order to ensure continuity of care.
- Due to the limited space on-site and the restrictions in mobility imposed by the SCH, there is limited opportunity for children to engage in a range of enjoyable modes of exercise. There is therefore a need for the exercise suite to be designed and maintained at a very high standard, as this is the main opportunity for physical activity.
- On arrival at the SCH the majority of children are smokers. The SCH operates a no smoking policy, requiring children to stop smoking immediately. Whilst a smoking cessation support service is available it currently can take up to three weeks to arrange; this results in the current smoking cessation service being ineffective and undersubscribed. Children are currently expected to manage withdrawal unsupported, during an already traumatic and stressful period; the majority will typically resume smoking as soon as they leave the SCH. It is therefore recommended that responsive smoking cessation support is provided, including Nicotine replacement if required, from the time of admission.
- Children often have need of non-urgent dental services; however as currently there are no on-site assessment facilities available, dental assessment is usually not available for several weeks. The delay means that for many children the opportunity is missed entirely and for others the course of treatment can then not be completed during their period of residence. Other SCHs offer onsite dental assessment to address this issue and this will be possible in the new building.
- Consideration needs to be given to the staffing impacts at the SCH when a child requires off-site care or appointments. It can take up to three members of staff to provide an escort if there are high risks of absconding. For inpatient care escorts need to be provided 24 hours. It is therefore recommended that support with resources for additional escorts is provided from the Local Authority.
- A large proportion of children arriving at the SCH have substance misuse problems. Whilst there is support from the local under 19's Substance Misuse Team, this can take several weeks to arrange. This delay means there is only limited support that staff can provide if detoxification is required on admission. It is therefore recommended that substance misuse support is made available from admission. However the Substance misuse team report that their normal response time to referrals is five days but Lansdowne is prioritised so visits can be undertaken the same day if required. The disparity in perception should be reviewed locally.

1.1.9 Recommendations to meet these and other less urgent needs are set out in the conclusion and recommendations section of this report (Section 7).

2. Introduction

2.1 Assessment context

2.1.1 This report was commissioned to provide evidence that would aid understanding of the current health needs of 'looked after' children at Lansdowne Secure Children's Home (SCH), Hailsham, East Sussex, and to inform future decisions on funding allocation of health services at this SCH. The health needs assessment has specifically investigated the health needs of the children filling the five placements for young people between the ages of 10 and 16. This health needs assessment has been commissioned by the East Sussex Public Health Directorate on behalf of NHS Sussex and East Sussex County Council. The health needs assessment has been carried out by the Public Health Action Support Team CIC (PHAST), a not-for-profit group of experienced public health professionals.

2.2 Assessment aims:

2.2.1 This report provides a body of evidence, supported by appropriate quantitative and qualitative data, about the health and healthcare needs of children at Lansdowne SCH. All main stakeholders are represented.

2.2.2 The HNA investigates the current state of health of this vulnerable group of children and examines the aspects of healthcare provision that are seen to provide the most effective support for maintaining a healthy lifestyle: being able to access convenient health services for both immediate needs and preventative measures; supporting any long-term or chronic conditions; and receiving appropriate support in maintaining good physical health and mental wellbeing.

2.2.3 The report fulfils the two main requirement objectives of:

- Identifying current provision and future anticipated need including any gaps or weaknesses in the current position.
- Providing a comparison of healthcare provision with the other 6 SCH's that provide placements on welfare grounds, including assessing whether standards and key performance areas can be measured against outcomes for health for the children and young people.

2.2.4 This report makes robust recommendations based on: analysis of data on current services and users; comparison with other similar SCHs; and consultation with users, providers and commissioners of healthcare services.

2.3 Background

Looked after children (LAC)[2]

2.3.1 The term 'looked after' refers to children who are under 18 and have been provided with care and accommodation by children's services. Often this will be with foster carers, but some looked after children might stay in a children's home or boarding school, or with another adult known to the parents and children's services. The looked after children that are the subject of this report are accommodated in specialist secure accommodation.

2.3.2 The aim is to ensure the health and safety of looked after children, who often come from families who have experienced extreme hardship and upheaval, whilst working as closely as possible with the birth parents.

2.3.3 Any disruption to home life often means that looked after children do not achieve their academic potential. Children's services therefore work to make sure the educational needs of each looked after child are met.

2.3.4 A large number of children coming into care will have a history of physical, sexual or emotional abuse. Some may have suffered the death of a parent, or have parents who can't look after them properly because of illness. Others may have disabilities and many different needs. A very small number are in care because of crimes they have committed.

[2] Summary based on: http://www.eastsussex.gov.uk/childrenandfamilies/childrenincare/lookedafterchildren/default01.htm

2.3.5 Children come into the SCH's care by two main routes – because the parents have asked for this help or because the child is in danger of being harmed.

- Under section 20 of the Children Act 1989[3]: where parents have asked for help, because for some reason their child can no longer stay at home, children's services will find suitable accommodation for the child. Parental responsibility remains with the parent/guardian.
- Under section 31 of the Children Act 1989: if the child is in danger of being harmed, a care order will be made by a court. The court will take all the circumstances into careful consideration before doing this. When a care order is made, children's services acquire parental responsibility and become a legal parent alongside the parent/guardian.

2.3.6 Young people may be placed in secure accommodation via the courts on welfare grounds under Section 25 of the Children Act 1989. A welfare placement for a child under the age of 13 requires the approval of the Secretary of State.

> *Section 25 of the Children's Act 1989 (as amended) states that with regard to the use of accommodation for restricting liberty:*
>
> *(1) Subject to the following provisions of this section, a child who is being looked after by a local authority may not be placed, and, if placed, may not be kept, in accommodation provided for the purpose of restricting liberty ("secure accommodation") unless it appears—*
>
> *(a) that—(i) he/she has a history of absconding and is likely to abscond from any other description of accommodation; and (ii) if he/she absconds, he/she is likely to suffer significant harm; or*
>
> *(b) that if he/she is kept in any other description of accommodation he/she is likely to injure him/herself or other persons.*

2.3.7 The placements provided by Lansdowne SCH are for such 'welfare' (as opposed to custodial) placements.

2.3.8 In addition to Lansdowne SCH there are six other SCH that provide placements solely on welfare grounds. This HNA includes a comparator analysis with these other SCHs:

- Atkinson Unit
- St Catherine's
- Clare Lodge
- Kyloe House
- Leverton Hall Secure Unit
- Beechfields Secure Unit

Commissioning context

2.3.9 The driver for the health needs assessment arises from a disparity in health care provision between Youth Justice Board (YJB) secure children's homes and purely welfare units like Lansdowne SCH. YJB units are generally for children who have been secured due to some criminal activity. Welfare only units detain children for non-criminal reasons. The beds at both types of unit are commercially managed and 'sold' either to Local Authorities (in the case of welfare beds) or to the YJB for use where there is criminal detention involved. YJB units may include welfare beds; however welfare only units will not include YJB beds. The YJB has a health funding arrangement with the Department of Health. As a result the health budget and quality of healthcare offered at YJB units is higher than at welfare only units. Two issues therefore arise. Firstly children at welfare only units are not getting as good

[3] Section 20 of the Children Act 1989 (as amended) concerns provision of accommodation for children: general. See: http://www.legislation.gov.uk/ukpga/1989/41/section/20

access to health services as those at welfare only units. Secondly because of the central funding of YJB health services the cost of YJB beds is cheaper (as it does not include charges to cover health care provision). This places welfare only units at a commercial disadvantage in selling bed spaces, which is the income generating basis for their continued operation.

2.3.10 Health and Social Care Act 2012 – Part 1 – The health services in England, Section 15, gives the Secretary of State power to require Commissioning Boards to commission certain health services:

> *(1) Regulations may require the Board to arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of… services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description.*

2.3.11 From April 2013 commissioning of the majority of health services for Offenders will transfer to the NHS Commissioning Board (NHS CB) under the provisions of the amended Health and Social Care Act (2012).

2.3.12 The NHS CB will be responsible for Prisons, Young Offender Institutes, Immigration Removals Centres, Secure Training Centres, Secure Children's Homes, Police Custody Suites, County Diversion Services and Sexual Assault Referral Centres.

2.3.13 The NHS CB will be responsible for commissioning health services (excluding emergency care) and public health services for those people in secure children's homes.

2.3.14 The functions which will underpin these responsibilities include:

- Planning – services must meet national standards and local ambitions to ensure the service needs of the population;
- Securing services – using relevant data to specify new service requirements and a robust contracting route to deliver best quality and outcomes for this population which promote continuity of care and integration of services; and
- Monitoring – assessing and challenging the quality of services.

2.3.15 In order to determine health funding needs for the 'welfare' SCH sector East Sussex PCT has been asked by the Departments of Health and Education to perform a health needs assessment in partnership with the Local Authority, with one aim being to identify the funding required for the future health service provision. This health needs assessment supports this objective.

3. Methods and approach

3.1 About health needs assessment

3.1.1 Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities[4].

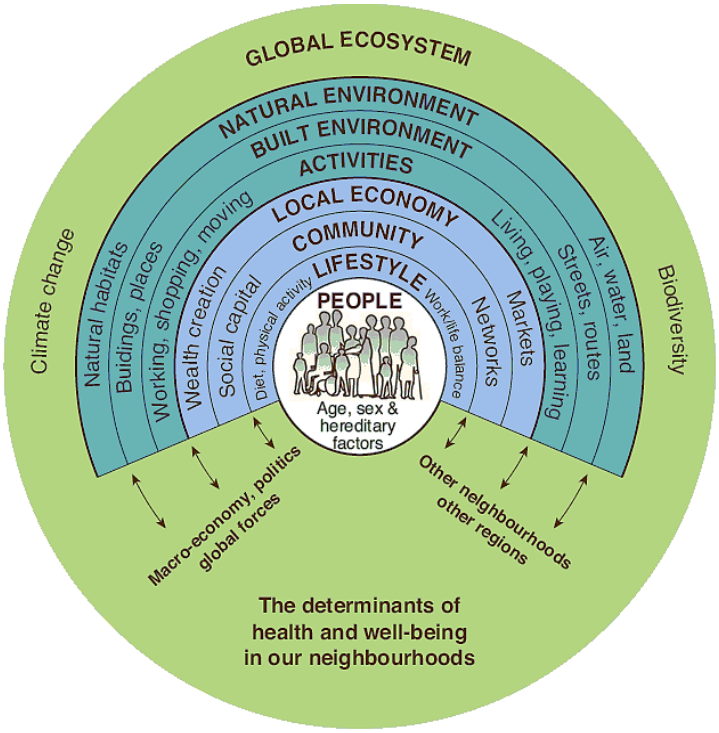
3.1.2 HNA compares and balances the different needs of stakeholders in order to select priorities. The different types of need may include: perceptions and expectations of the profiled population (felt and expressed needs); perceptions of professionals providing the services; perceptions of managers of commissioner/ provider organisations (normative needs); and priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (corporate needs).

3.1.3 This HNA uses the World Health Organization's (WHO) definition of health[5]: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'

3.1.4 Health inequalities are also an important consideration in HNA and can be defined as differences in health status or in the distribution of health determinants between different population groups[6].

3.1.5 There are a number of factors, as illustrated in Figure 3.1 which affect health directly or indirectly. These are called determinants of health and include diet, learning, physical activity, housing etc. These can improve and protect health as well as potentially cause harm. This HNA will consider only the most relevant of these in detail; however it is important to place the HNA within a wider context of there being many influences on health outcomes and health needs.

Figure 3.1: the main determinants of health and well-being



[4] National Institute of Health and Clinical Excellence (NICE), Health needs assessment: A practical guide. 8 June 2005. Available at: http://www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf

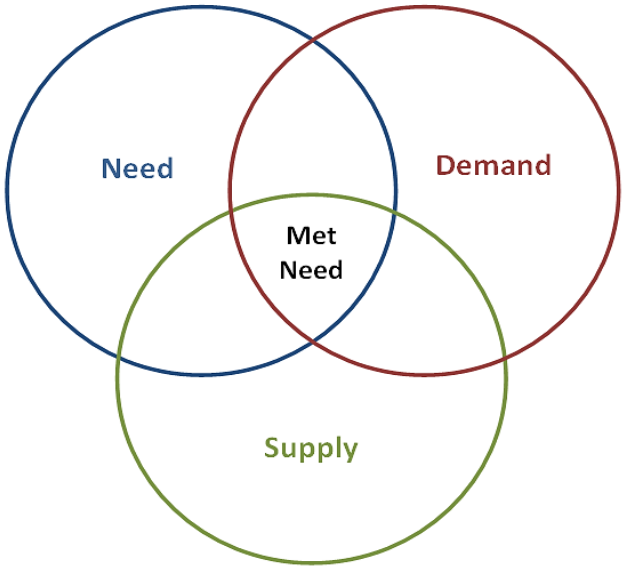
[5] World Health Organization (WHO). Preamble to the Constitution of the World Health Organization; signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. Official Records of the World Health Organization, no. 2, p.100. 1948 New York. Available at www.who.int/about/definition/en/print.html

[6] World Health Organization (WHO) glossary. Available at: http://www.who.int/hia/about/glos/en/index1.html

3.1.6 There are three drivers behind establishing met and unmet health need for health services, that is, need, demand and supply:

- Need arises where there is a demonstrated capacity for health gain, i.e. where further interventions or treatments would be effective in improving people's health.
- Demand for healthcare services is the expression of felt need, i.e. the services that people ask for or attend.
- Supply (or use) concerns the utilisation of health services, i.e. the actual uptake of provided services.

Figure 3.2: Representation of the intersection of need, demand and supply



3.1.7 Figure 3.2 provides a visual representation of the interactions between need, demand and supply. Only where a genuine need exists, services are in demand and services are provided and used, will health needs have been effectively met.

3.1.8 This report deals primarily with establishing need and demand. The report will inform strategies for future supply of services.

3.2 HNA Framework

3.2.1 PHAST bases its methodology for Health Needs Assessments on the process and priorities identified by Stevens and Rafferty (1994) and refined in to a working framework by the National Institute for Health and Clinical Excellence (NICE)[7].

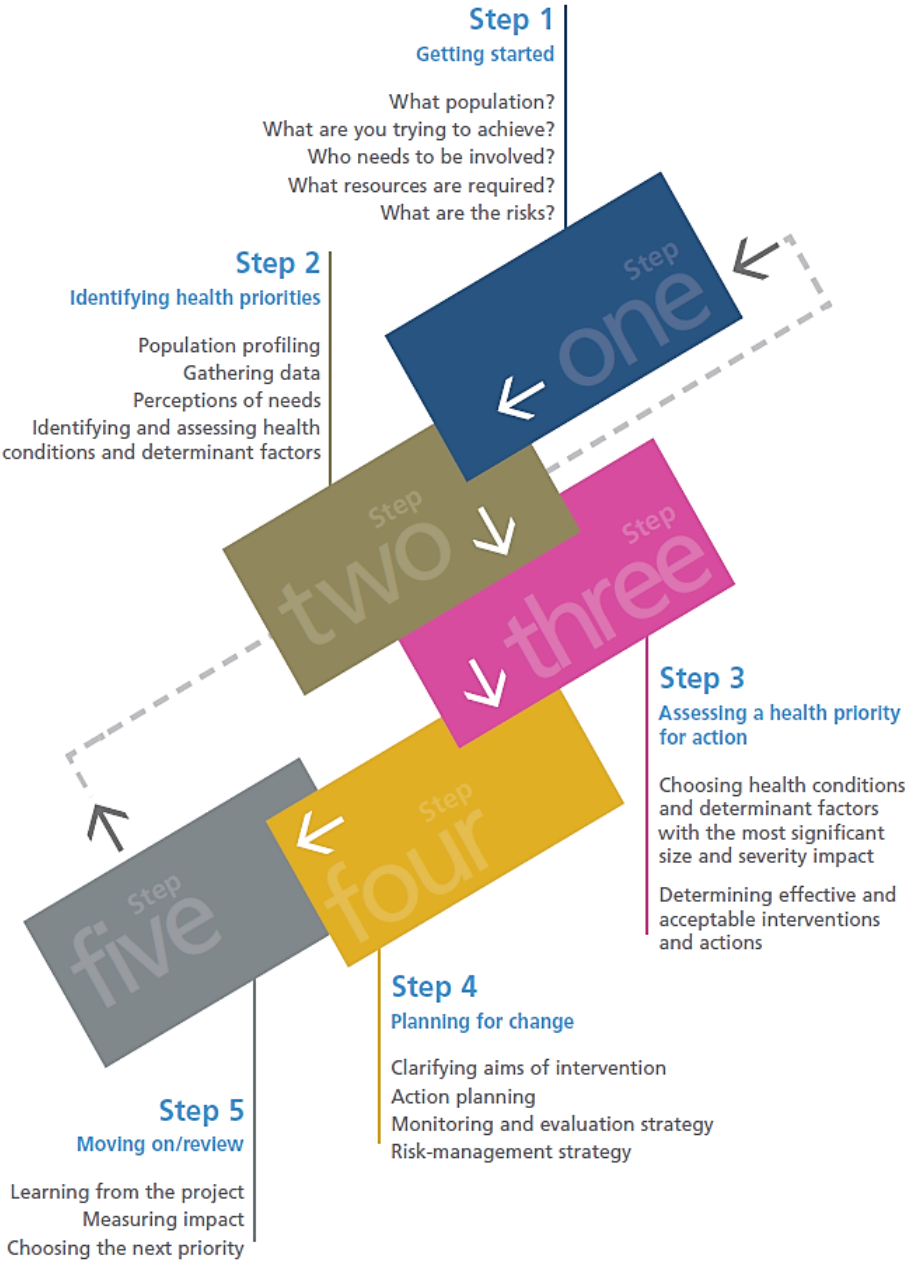
3.2.2 Figure 3.3sets out the HNA framework.

3.2.3 The framework involves five steps or stages:

- Getting started: where relevant populations are identified; objectives are set; stakeholders are identified; resources are allocated; and project risks are assessed.
- Identifying health priorities: where populations are profiled; data is collected; stakeholders are interviewed; and infrastructure is assessed.
- Assessing health priorities for action: where the most significant determining factors for the population's health are identified; and appropriate recommendations are made in the HNA report.
- Planning for change: where commissioners review the outcomes of the HNA report and produce an action or monitoring strategy.
- Moving on/review: where commissioners review any lessons learnt and prioritise next steps.

[7] National Institute of Health and Clinical Excellence (NICE), Health needs assessment: A practical guide. 8 June 2005.

Figure 3.3: HNA



framework

3.3 Data collection and analysis methods

3.3.1 Anonymised data was requested from Lansdowne SCH to support population profiling.

3.3.2 A stakeholder survey was run electronically using email contact and telephone contact. Respondents were contacted with a brief explanatory email and hyperlink to the online survey. The results of the stakeholder survey informed and guided the stakeholder semi-structured interviews.

3.4 Stakeholder interview methods

3.4.1 The stakeholder interviews involved conducting confidential in-depth interviews with a small number of key individuals to explore their perspectives regarding the provision of health services to Lansdowne SCH. Stakeholders

were asked to respond to a semi-structured questionnaire that addressed their experiences of healthcare provision for the looked after children.

3.4.2 It is noted that, because of the small numbers of interviews, the results must be interpreted with caution. Not all stakeholders contacted agreed to take part, and those interviewed were asked to reflect on their perspectives on these issues, which will be informed by their role and involvement.

3.5 Provider interviews

3.5.1 A list of thirteen stakeholders was supplied by the commissioner. A topic guide was constructed with the intended outcome of identifying information about each interviewee, treatment and care services, health and wellbeing needs, resource allocation, comparative information, reflection on child protection and some additional questions specific to particular professionals. An email was sent to all stakeholders asking for an appointment to conduct a telephone interview. Four appointments were made immediately and the respondents sent the topic guide. A follow up email produced two further interviews. Further telephone calls failed to elicit further response. A social worker declined an interview as her client had left the unit and another had passed his case on to a new social worker with whom contact was unsuccessful. Appointments were made with the Independent panel member for secure reviews, the designated LAC Nurse, the CAMHS psychologist, CAMHS psychiatrist, the Operational Manager for Residential LAC Services, the designated nurse commissioner supervisor for LAC nurses, a social worker, the Independent Reviewing Officer and the Under 19's Substance Misuse Team.

3.5.2 Interviews were also held with the GP for Lansdowne SCH, as well as the SCH manager and deputy manager.

3.6 Resident interviews

3.6.1 An interview framework was constructed to allow discussion of topics relevant to the HNA but also broad enough to allow the young people to offer their own contributions to discussion. The conversation had the potential to be quite free as the numbers were small.

3.6.2 Permission was gained to meet the residents who had agreed to be interviewed. Two young people of three who were resident at the time had agreed to the meeting. The interviews took place in the open lounge area as the visitors room was being used by the third resident. Two staff members were present with the young people, and other staff walked through the room and chatted with the residents as they were passing. The two girls aged thirteen and fifteen dealt with the questions between them, reminding each other and bringing in each other's experiences. The staff also contributed their views to the discussion, but the focus of the interviews was constantly brought back to the residents.

3.7 Recommendations

3.7.1 Recommendations are made throughout the report and summarised in the conclusions.

4. Demographic profile

4.1.1 The following section provides a profile of Lansdowne SCH and the resident population.

4.2 Lansdowne Secure Children's Home[8]

4.2.1 Lansdowne SCH aims to provide a safe and controlled environment in domestic surroundings, for young people whose vulnerability and/or behaviour places them and others at particular risk. Admissions take place only if there is genuinely no alternative to the use of secure accommodation and placement is viewed as a positive opportunity to focus on the particular problems that the young people have, with a view to an early return to the community.

4.2.2 Lansdowne Secure Children's Home accommodates up to five young people of either gender aged 13-17 years (and from the age of 10 years with Secretary of State's approval) in a physically secure environment. The client group comprises of young people who have displayed serious and extreme behaviours which have resulted in them needing to be placed in a secure children's home for their own protection or protection of others in the community.

4.2.3 Lansdowne SCH is currently the smallest of the SCHs that provide placements purely on welfare grounds. As a result the staff to child ratio is relatively high.

4.2.4 Typically with five placements available Lansdowne is host to 15 children per year. It is projected that with seven placements this would increase to around 21 children per year.

4.2.5 Lansdowne SCH is currently undertaking construction work to expand the site. There is the potential for future expansion of the number of child placements up to a maximum of 10.

4.2.6 The young people admitted to Lansdowne SCH typically have very complex emotional and behavioural needs, which invariably have led to multiple breakdowns in previous placements. Lansdowne SCH aim to meet their psychological, social, emotional, health and educational needs within the safety and security of the home.

4.2.7 Lansdowne SCH is registered with Ofsted and is required to adhere to the Children's Homes National Minimum Standards 2011. It operates within the Children's Homes Regulations 2001 and the Children Act 1989. Alongside this, the home complies with the operational policies, guidance and instructions governing the provision of safe residential care.

4.2.8 Lansdowne Secure Children's Home is based at Lansdowne Children's Centre, Hailsham. It provides a regional resource for young people who are at significant risk of harming themselves or others and who cannot be cared for safely in open conditions. It is an important component in the range of accommodation services of East Sussex Children's Services Department providing services to young people and families across the county. The Department sees restricting the liberty of young people as a serious step, which must be taken only when there is no alternative. It is seen as a 'last resort' in the sense that all else has been comprehensively considered and rejected as inappropriate.

4.2.9 The Home operates within the statutory framework for secure accommodation and as such operates a rigorous gate-keeping process to protect young people from unnecessary and inappropriate placement. It ensures that all admissions comply with legal criteria as defined under Section 25 of the Children Act (1989)[9] and, on occasion, the Children and Young Persons Act 1969 (Section 23) as updated by the Crime and Disorder Act 1998[10].

[8] Summary based on: Lansdowne SCH Statement of Purpose 2012

[9] Section 25 of the Children Act 1989 (as amended) concerns use of accommodation for restricting liberty. See: http://www.legislation.gov.uk/ukpga/1989/41/section/25

[10] Section 23 of the Children and Young Persons Act 1969 (as amended) concerns remands and committals to local authority accommodation. See: http://www.legislation.gov.uk/ukpga/1969/54

4.2.10 The core concepts for practice within the Home are based upon clear planning, evaluation, appropriate interventions, and positive outcomes. All young people admitted to the home have their needs and risks assessed and are participants within this process, which provides the foundation for individual care planning at all stages of their period of accommodation.

4.2.11 The ethos at Lansdowne is one in which children can thrive within a safe, secure but homely environment. A strong emphasis on recognition and reward for achievement encourages self-esteem and confidence to enjoy the benefits of group living. Well trained and experienced staff use a variety of therapeutic approaches. Life at Lansdowne revolves around a system of behaviour modification which rewards good behaviour. Cognitive behaviour therapy is also widely used allowing a child to look seriously at past experiences. It is important for children to work hard at the issues set out in their care plans and to take every opportunity to improve their education, but alongside this the staff want the children to enjoy their leisure time and have fun.

- The health of a young person is considered of paramount importance and to support this, the services of a Consultant Child and Adolescent Psychiatrist, Psychologist, the local health centre and the services of a named nurse are available to the home to support staff, young people and their families and contribute to effective and cohesive teamwork.

4.2.12 There are three members of staff working with the children at all times. In addition, a member of management will be in the building to respond to emergencies. Outside office hours and at weekends, a fourth member of staff is on a duty roster.

- One waking Night Care Officer is on duty in the home whose responsibility it is to ensure that the regular checks on young people are carried out. There are two other members of staff who sleep in and support where necessary.
- All staff at Lansdowne SCH are trained in the signs and indicators of abuse. It is recognised that residential staff have a key role in identifying abuse and follow clear guidelines as set out in the Sussex Child Protection and Safeguarding Procedures. Every member of staff has access to the Sussex Child Protection and Safeguarding Procedure which are regularly updated on the East Sussex Intranet. All staff are required to attend regular refreshers to keep up-to-date with new legislation and changes to practice.
- For each young person admitted to Lansdowne SCH, assessment and placement plans are progressed through the establishment of time-limited contracts linked to individual programme planning, which includes education on a daily basis. No one method or system is employed. However, it is expected that care packages will include individual and group work in the home, working with carers, social work colleagues, psychiatrists, psychologists and other agencies.
- Referrals to Lansdowne Secure Children's Home which fall solely under the 'welfare' category are received nation-wide though preference is given to neighbouring counties to ensure that a young person is able to maintain links with their Social Worker and families/carers. The very nature of the service necessitates emergency admissions in order to secure a young person's safety.

4.2.13 To facilitate the decision making process a written report is required covering, inter alia: a summary case history, including psychiatric and any other reports; a chronology of contact with the Children's Services Departments; all information relevant to Looked After Children reviews; medical information; reasons for seeking admission; a history of any self-harm or violence to others; an assessment of the length of time the young person is likely to remain in the home; a summary of what is hoped to be achieved by this placement; and future plans for the young person on leaving the home.

4.2.14 On admission a young person needs time to adjust gradually to life in the home without undue pressure from staff to participate in activities. Admission arrangements are particularly important in allaying some of the worst anxieties and fears which the young person may be experiencing. It is also important that the existing group of young people is prepared for a newcomer. Emphasis on making unhurried introductions to staff and other young people, with clear expectations and sufficient information to enable the young person to settle into the home is considered important.

4.2.15 Where a young person is admitted in an extremely distressed condition or where they are behaving violently, staff may be required to remain with them for a substantial period of time, with the objective of calming them until they are able to be introduced to others in the home.

4.2.16 The service of a Clinical Psychologist (CAMHS) is available one half day a week in an advisory, supervisory and training capacity to the staff group. She plays a key role in contributing to the planning of work to be undertaken with young people, as well as working with their families.

4.2.17 Additional services which could form part of a young person's care plan include: psychiatric and psychological assessment through local agreement with C.A.H.M.S. and education; counselling; group work; family work; full-time education; therapeutic art and play; joint work with Drug and Alcohol Treatment Service; joint work with the Virtual School; joint work with the Youth Offending Teams; joint work with the Fostering Teams; joint work with the 'Safe Around Sex' Team; joint work with the Leaving Care Team; leisure and recreational activities; outreach work; and missing from Care – N.M.P.H.

4.2.18 Young people admitted to Lansdowne are particularly vulnerable, as they frequently have not received continuity of health care. In view of this, staff play an active role promoting all aspects of a young person's health by encouraging residents to take a responsible attitude towards their body and their general fitness.

4.2.19 Attention is given to hygiene, personal care, exercise, fresh air and recreation on a daily basis. Education on specific issues including smoking (the home and its grounds are a non-smoking environment), HIV AIDS, drugs, solvent abuse and use of alcohol is considered important. Contact with specialist clinics help in this process. The SCH aims to maintain a gender balance in the staff team in order that individual needs are met in a sensitive manner.

4.2.20 All young people have access to a local doctor who provides a specific service to the centre; where possible the SCH endeavours to retain a child's own GP. Strong emphasis is placed on ensuring that each young person has regular medical, dental and optical examinations and that immunisations are up-to-date. The SCH engages the services of a named nurse who writes individual Health Care Plans following assessment. Monthly reviews of individual Health Care Plans enable managers to monitor progress in all aspects.

4.2.21 The services of a Consultant Child and Adolescent Psychiatrist and Clinical Psychologist are available to Lansdowne Children's Home to help support staff, young people and their families, contributing to effective and cohesive teamwork. This provision ensures that a young person's physical, mental and emotional well-being is given high priority. Specific therapeutic techniques are carried out by qualified people only and supervised by an external qualified therapist in that field.

- Lansdowne recognises that many young people in care underachieve in education due in part to the way their lives are characterised by instability, too much time out of school and insufficient help with their education in terms of support and encouragement. The SCH acknowledges that educational outcomes are strongly influenced by a young person's emotional, mental or physical health and wellbeing.
- A full-time education programme is offered in the SCH, as well as a rolling programme of drugs awareness, diet and nutrition, sexual health education and self-esteem during term time.

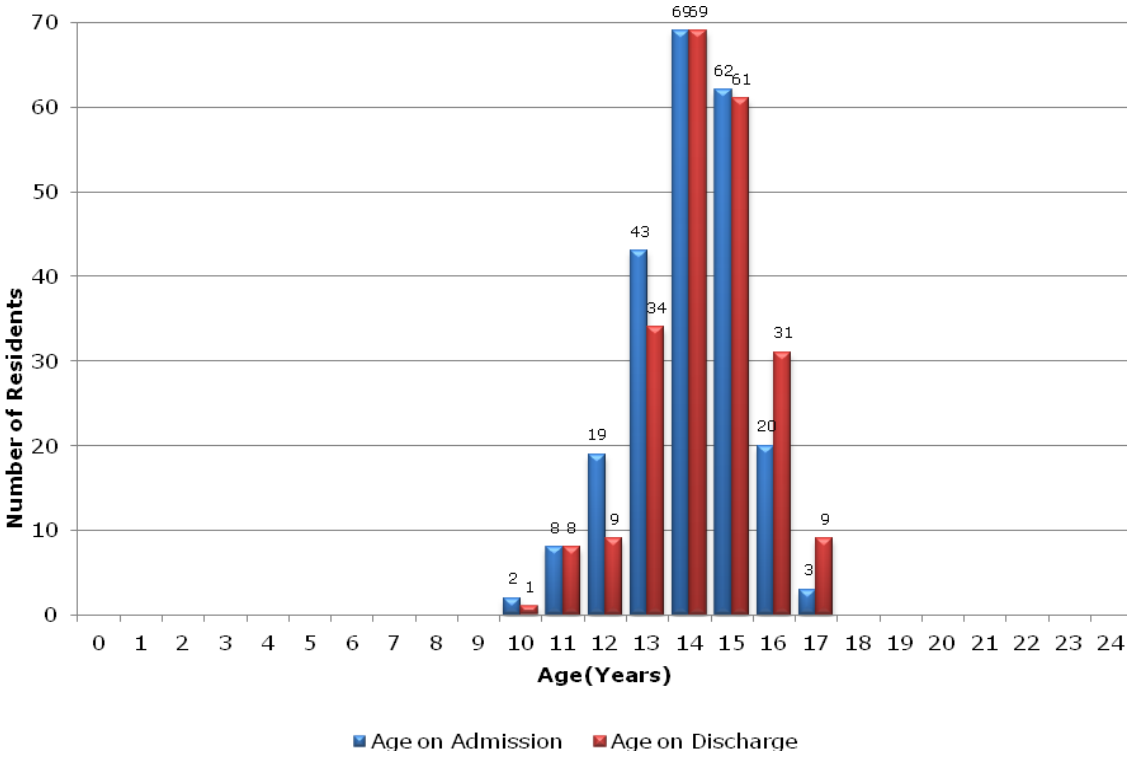
4.3 Resident profile

4.3.1 Lansdowne SCH's manager made the following observation with regard to the children who reside at the SCH.

Children's care history is typically of constant moves from one place to another, resulting in frequent absconding which places them at risk of harm. For girls this is usually absconding with an older man, ending in sexual exploitation. Drugs are often also involved as is self-harm. For boys, occasionally they are so violent they can't be held anywhere other than a secure facility. Our experience is that the system tends to criminalise boys, often the criminalising offence is assault related. Some young men have concerns over their sexually and some are self-harmers. They typically have a profile for being involved in gangs, guns or knives.

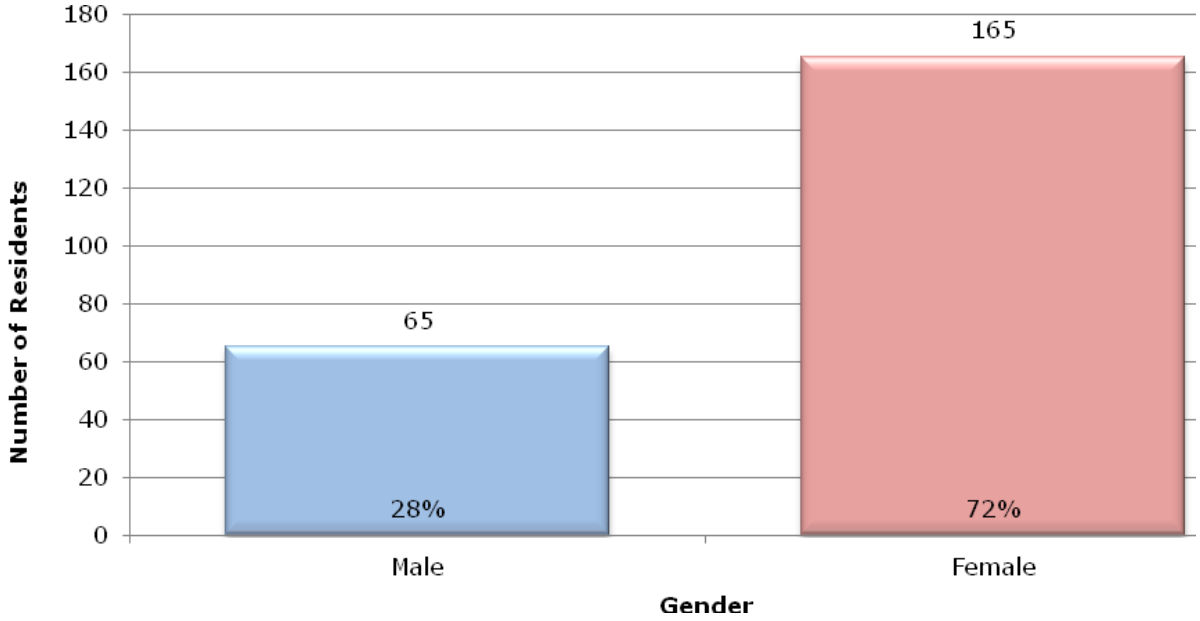
4.3.2 The following figures present the results of the analysis of the anonymised data provided by Lansdowne SCH. The data covers the period from 2001 to 2012.

Figure 4.1: Age of residents



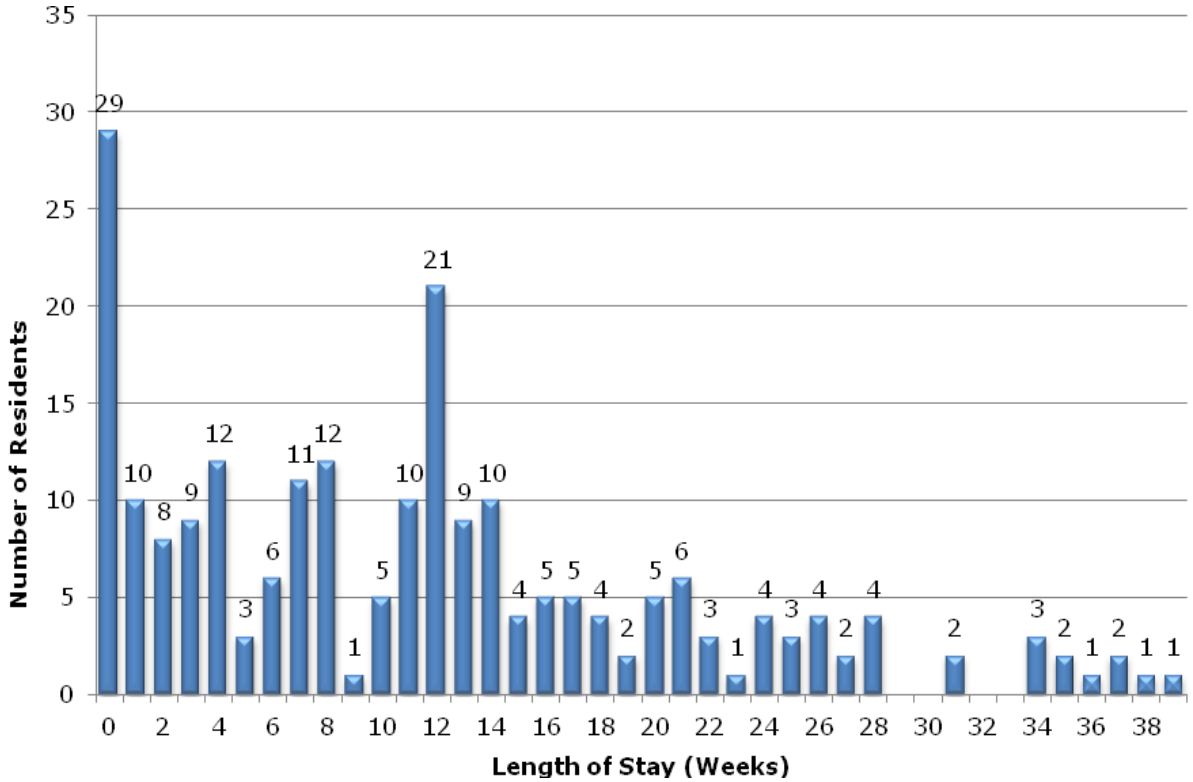
4.3.3 Figure 4.1 shows that the average age of children at Lansdowne SCH is 14 years old. All the of children are aged 10 to 17 years.

Figure 4.2: Gender of residents



4.3.4 Figure 4.2 shows that almost three quarters of children at Lansdowne SCH are female.

Figure 4.3: Length of stay at Lansdowne SCH in weeks

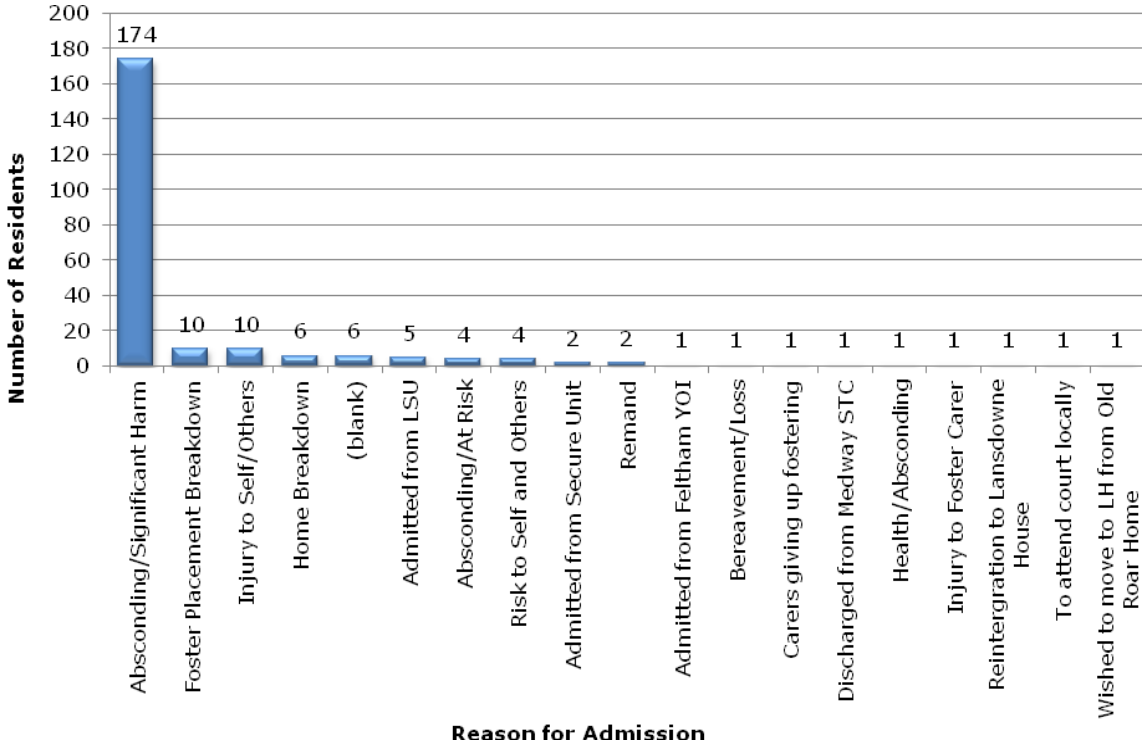


4.3.5 Figure 4.3 shows that a large number of children stay less than a week at Lansdowne SCH (12%). A quarter of children stay less than one month. The average length of stay is 3.5 months. Less than 3% of children stay for more than a year.

4.3.6 The data shows that for a large proportion of children there is a very limited time within which the opportunity exists to assess and influence health outcomes.

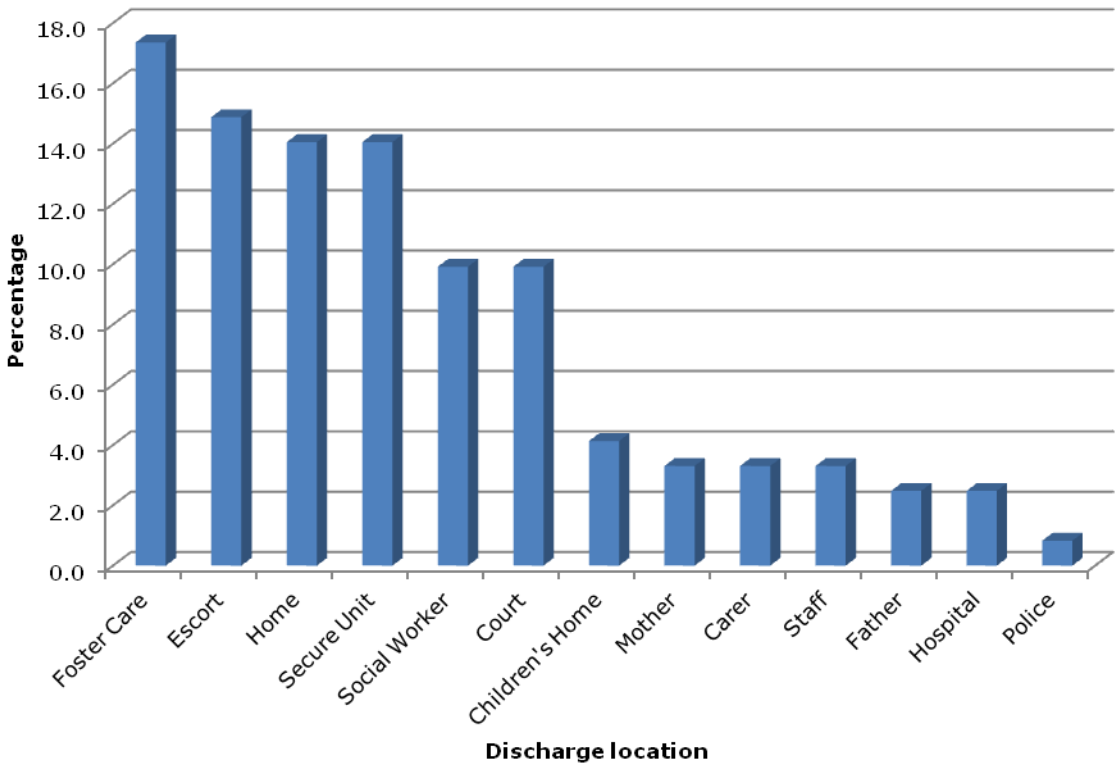
4.3.7 It is recommended that health assessments and health care plans are prioritised as soon as children arrive, so that as a minimum they leave with a health check having been completed and a health care plan for any urgent referrals or treatment.

Figure 4.4: Reason for admission (fields are not mutually exclusive)



4.3.8 Figure 4.4 shows that by far the greatest reason for admission to Lansdowne SCH is a risk of absconding or significant harm (75%). For this reason health appointments outside of the SCH environment are problematic and require close supervision. In many cases the level of trust required for external appointments will take time to establish.

Figure 4.5: Discharge location



4.3.9 Figure 4.5 shows that the most common discharge locations are to foster care, home, to a secure unit or to a Court. Discharge is also frequently to an individual such as an escort or social worker. In only 20% of cases is discharge to a parent or to the child's home.

4.3.10 Data was also supplied on the originating area of the child. The results show that the most frequent location is Hastings and Rother (16%), followed by: Eastbourne; Lewes and Wealden (each 6.5%); and Oxfordshire County Council (2.6%). There are a further 102 other originating areas, 7 with four originating children, 7 with 3 originating children, 20 with two originating children and the other 68 having only one originating child. The results show the diverse locations from which children originate and is consistent with reported workloads in tracking down medical histories and notes.

5. Summary of current service provision

5.1.1 The following section summarise the main health care services provided for children at Lansdowne SCH.

5.2 GP

5.2.1 The SCH uses a local GP, The Quentin Medical Surgery. Dr Grey is the lead GP and primarily responsible for supporting the SCH. There are both male and female GPs available.

5.2.2 Out of hours services are managed by SeaDoc. The service is generally advice based, but will visit the SCH if required.

5.2.3 In an emergency the SCH uses the normal 999 ambulance service. However this will often require 3 members of staff to provide an escort.

5.3 Induction health assessment

5.3.1 Within 2 to 3 days the GP undertakes a fairly basic health assessment, this takes about 20 min. The screening involves lots of questions and answers. A basic physical exam is performed and a medical history is taken.

5.3.2 The assessment is considered mandatory, but is dependent on having appropriate signed permission from the child's parent, guardian or LA case holder.

5.3.3 The GP screening is followed by a visit from LAC nurse attached to the SCH unit. The LAC nurse is contracted for 7 hours per week, but the time is allocation flexibly so that her support is available when needed. The SCH manager reports that the current level of provision seems to work out right for the role the nurse performs. The LAC nurse writes up a health care plan for each child and updates it as information comes through. A common update is for immunisations and vaccinations, which children have often missed.

5.3.4 Children have typically moved frequently before they arrive at Lansdowne SCH. The LAC nurse's job includes researching each child's previous history, which may involve tracing all over the UK and even aboard.

5.3.5 The SCH staff use a common sense approach to identifying immediate health issues, there is not a formal staff health screening process on reception.

5.3.6 Depending on confidentially results of the health assessment generally provided to the child over the phone to the GP or via a letter from the GP. If the child has provided permission, the SCH can be given the results to pass onto the child.

5.4 Dental services

5.4.1 The SCH use Sturton Place Dental Surgery (about 1 mile away). The service is available Mon – Fri and has an emergency out of hours service. It generally takes a few weeks for a child to see the dentist. This can be affected if the risk of the child absconding outweighs the need for a check-up.

5.5 Optician

5.5.1 The SCH uses a local optician, Sopers (about 1 mile away). The service is available Mon – Fri.

5.6 Asthma care

5.6.1 Asthma care is provided by the GP and LAC nurse, usually onsite at the SCH.

5.7 Counselling

5.7.1 Counselling services are provided on-site by the SCH's keyworkers, with advisory support from the CAMHS. One-to-one sessions are run with each child a minimum of three times a week. In addition to this a social worker or Local Authority may provide further professional counselling support.

5.8 Substance misuse and alcohol reduction care

5.8.1 The service is provided on-site by the local under 19's Substance Misuse Team. It will generally take a few weeks to arrange an appointment. Any emergency treatment is provided by the GP.

5.8.2 Under 19's Substance Misuse Team report that Lansdowne is always prioritized by the Team, and their normal response time of five days from referral can be much quicker, with same days response where necessary. They have a close working relationship with the GPs who will provide scripts for medication where the Substance misuse team recommend.

5.8.3 If detoxification is required (which is rare) the SCH offers 'cold turkey' with lots of support and close liaison with the GP and Under 19's Substance Misuse Team.

5.8.4 The Under 19's Substance Misuse Team provide a service for any resident at the home regardless of area of residence.

5.8.5 The Under 19's Substance Misuse Team provide training sessions twice a year on emerging topics, currently on "legal highs". This is also open to staff at Lansdowne.

5.9 Smoking cessation care

5.9.1 The service is provided on-site by the Smoking cessation team. The service is provided on an individual basis, as required. The service may take up to three weeks to arrange.

5.10 Physiotherapy

5.10.1 Referral to a physiotherapist is via the LAC Nurse or GP. The service is provided on an individual basis, as required (there is not high demand). The service may take weeks or even months to arrange.

5.11 GUM services

5.11.1 GUM services are provided by the local Sexual Health Clinic in Eastbourne (4 miles away). The SCH also has one trained staff member in Teenage pregnancy TP3. Any further support is provided by the GP.

5.12 Contraception

5.12.1 Contraception services are provided by the GP or local Sexual Health Clinic in Eastbourne.

5.13 Mental health service

5.13.1 There is a basic mental health assessment on admission at the SCH this is not equivalent to a CAMHS assessment. Further referral to specialist support is dependent on the Local Authority of origin for funding. Specialist mental health support can take between one and four months to arrange due to delay in arranging the funding. Any urgent care is provided by the local GP and CAMHS.

5.13.2 If inpatient mental health care is required a child would be discharged to an inpatient unit.

6. Evidence of future anticipated health needs

6.1 Interpretation

6.1.1 This section sets out the evidence for health needs and demand (expression of felt need). Needs and demand are explored through different avenues of inquiry in the following sections:

- Stakeholder interviews with key informants providing healthcare to Lansdowne SCH.
- Service user interviews with residents at Lansdowne SCH.
- Stakeholder interviews with the GP for Lansdowne SCH.
- Comparative analysis of healthcare provision at other SCHs.
- Stakeholder interviews with managers of Lansdowne SCH.

6.2 Stakeholder Interviews (Service Providers)

6.2.1 Many agencies supply diagnostic and therapeutic services to the children and young people at Lansdowne SCH. Whether these are supplied on a regular and frequent basis or occasionally, they all display a close interest and commitment to the SCH. Each has a slightly different focus and the interviews have added depth to understanding the health need and supply of the children and young people at Lansdowne.

6.2.2 Interviews were obtained with all staff groups except the Ofsted inspector, who declined to be interviewed.

Staffing

6.2.3 The LAC nurse has 7 hours a week which she provides flexibly to meet the needs of the residents and includes attending the monthly staff meeting. A new arrival requires more time in the early days and after that time is provided on an "as required" basis. She is a non-uniform staff member who aims to attract the trust and confidence of the young people. They can always ask to see her, and they do, but she lets them know that she has many other calls on her time and it may be a day or two before she can call in to see them. Her wider workload (she has responsibilities as part of a county-wide LAC nursing service) and the number of hours dedicated to Lansdowne mean that she may not be present every week. The service is currently provided by a Band 8a designated LAC nurse. The Designated nurse commissioner has a professional advisory role.

6.2.4 The Consultant Psychiatrist (the Lead Psychiatrist CAMHS, Sussex Partnership NHS Foundation Trust, CAMHS Ouse Valley) has no formal agreement for hours supplied to Lansdowne, and a remit for all children and young people in his area, not just looked after children. He is the clinical Lead for CAMHS for the Peacehaven area, not the whole county. But he has had a traditional role of providing a consultant psychiatric role to the SCH as required. He can be called for any child whatever the area of residence and assumes the CAMHS service manager charges his time when the service is to an out of area young person. He is called infrequently, generally for assessment and advice or to produce court reports.

6.2.5 The CAMHS psychologist has a contract for 3 ½ hours a week. She supplies a regular morning each week and she attends the staff meeting monthly. Her aim is that the young people know when she is available and she will chat to them during the morning coffee break when there is also a break from education.

6.2.6 The social worker interviewed had a role in placing one of the current children, and monitoring her stay at the Home. She was also able to advise on mobility allowances, and on counselling input which was provided by a Family Mediation Worker for the child's PCT area of residence (at the request of the child).

6.2.7 The Independent panel member for secure reviews and the Independent Reviewing Officer provides the statutory requirements of their monitoring roles, the former ensuring application of the legal requirements regarding the securing of individual young people and the latter regarding all aspects of the running of the SCH.

6.2.8 The Operations Manager for residential LAC services is new in her post and manages all residential homes for children in care homes in East Sussex. She anticipates spending a day a week at Lansdowne, a weekly meeting, monthly supervision and a monthly team meeting in addition to informal visits.

6.2.9 The Under 19's Substance Misuse Team provides for all children and young people in East Sussex and this includes all residents at Lansdowne. As it is part of the general provision to East Sussex, the service estimates that there should be no implications of an increase in number from five to seven residents.

The model of care

6.2.10 The LAC nurse provides written and verbal support for the staff, writes care plans and reports and provides direct care to the children and young people. She receives many calls from staff for advice which are often redirected to the GP. In this sense she provides triage.

6.2.11 The psychologist asses each new admission with self-administered psychology assessment forms (Becks tools to screen or diagnose depression, anxiety, hopelessness, and suicide ideation and Resiliency scales to theoretically and empirically provide sound assessment of core characteristics underlying personal resiliency in children and adolescents ages 9–18). This then forms part of the care plan. The self-administered measures are not a full clinical psychological assessment but provide a baseline from which to build. Some children arrive without prior CAMHS[11] contact or assessment.

6.2.12 CAMHS is commissioned for one session psychology consultation each week which includes scoring and writing reports for staff. Direct work can be provided for East Sussex children including assessments of learning difficulties but this is within the one session per week. They might be seen only once or twice to do the cognitive part of assessment or they might be seen a further time or more if there is also ADHD. For out of area children, time has to be commissioned by the PCT area of residence either from a visiting psychologist or from LAC CAMHS East Sussex. Because of the cost negotiation and management of appointments, this process can be very slow. The psychologist sees merit in it being provided locally though paid for by the sending PCT as there is a good evidence base that in treatment for psychological trauma the relationship with the therapist is important. The young person will have had the opportunity to get to know the LAC psychologist through her weekly visits at coffee time, which reduces suspicion, making it easier for the young person to engage.

6.2.13 The Independent Reviewing Officer expressed concern about the very slow process of introducing psychiatric help. He saw it as a challenge of timeliness and geography for individual psychology and psychiatric input, especially for self-harmers.

> "Why when there was a severe risk – e.g. ligatures round neck on regular basis - does it take so long to set up a specialist funded referral?"

6.2.14 In his view there should be specialist services plugged in alongside the staff providing daily care, both to provide treatment to the young person and to support the staff. Possible resolutions to this problem were to have a budget in place from savings in the SCH for private consultancy or agreement by the referrer to pay for specialist input as necessary, as part of the referral agreement and they accept financial responsibility. This can then be set up as need becomes apparent without time being taken to negotiate funding.

6.2.15 The Independent Reviewing Officer visits once a month for monitoring and reporting. He does speak with residents and offers an interview should they wish to raise any issues with him. However residents do not take up the offer of individual conversation. His time at Lansdowne is three hours a month. This is likely to double with the new build but has not yet been discussed.

6.2.16 The psychiatrist provides a consultant service fulfilling any needs the SCH presented to him. His role is not in direct therapeutic care of the young people, but in: diagnosis; assessment; prescribing treatment regimens (which would be carried out by other members of the CAMHS team or sought from the sending PCT); and in producing court reports. The psychiatrist was warm in his praise of the work done at Lansdowne:

[11] **Child and Adolescent Mental Health Services (CAMHS) are NHS-provided services for children in the mental health arena in the UK.**

"Children's mental health needs are met at Lansdowne. If they are struggling then they call for psychiatric assessment and advice. It very rarely happens that a young person's mental health needs are not met. There have been young people who have been at Chalk Hill adolescent psychiatric unit who gain benefit from being taken into Lansdowne. It is effective beyond what one might expect from such a unit in one-to-one supervision and containing very disruptive teenagers."

6.2.17 The social worker considered the model of care to be effective, mainly in terms of staff input. The social worker noted that staff were very accommodating in keeping parents and the social worker informed and developing a package suitable for this particular young person who was there for 6 months. A Key worker was assigned and provided regular sessions. Quality of care, communication, and information sharing was all reported to be excellent. For young people with difficulty in forming relationships the small number of places at Lansdowne SCH was reported to be a much better environment than other secure accommodation with a large number of young people. Consistency of staff was also greatly appreciated. It was reported that the key working staff were very balanced in their views and considered the young peoples' views and wellbeing all the time.

6.2.18 The Under 19's Substance Misuse Team will see young people who are referred, rather than routinely assessing all new arrivals. However they state that they do prioritise Lansdowne because of the high degree of need, and they will see people on a same day basis where they can.

Physical environment

6.2.19 The shortcomings of the current physical environment relevant to healthcare at Lansdowne SCH are largely overtaken by the new build project which is near completion. Currently the GP uses either the visitors' room or child's own room. In the future, there will be a medical room in the new build: fully equipped with couch, desk, there would be some minimal medical equipment on site and storage for GP if required.

6.2.20 For the social worker, compared with other homes the physical accommodation was not so good. Her client had previously been in secure accommodation at a much larger home. However although larger, that home had many young people and it was chaotic. By comparison Lansdowne with few young people was reported to be a calmer more intimate environment with greater structure.

6.2.21 Stakeholders report that there is a tension between the professional requirements of different staff and the ethos and management of the Home as a cohesive institution. The significant roles of the LAC nurse and the psychologist are not facilitated by the number of hours they can provide to the SCH nor by the physical support – rooms, storage, management of notes and records – available to them. An example is storage of notes in the child's case file, to which the admission report of the LAC nurse on a new arrival may not be added until two weeks after admission.

6.2.22 An issue raised by more than one respondent was the need for additional clinical support. The psychiatrist referred to making assessments and recommending therapeutic interventions, but there is currently little resource to meet such a recommendation. Gaining agreement from a sending PCT creates a quasi-waiting list whereby the children have to wait for support whilst the funding is agreed.

6.2.23 There is demand from the HNAs key informants for additional psychology hours and a dedicated nurse for Lansdowne, based there as a permanent member of staff. It is anticipated that the demand will increase with the anticipated growth in the new unit. An expansion in the hours of the psychologist and the nurse would allow:

- on-going dialogue including access after school hours
- greater support of children and staff a
- greater nurse support for health education and staff team meetings
- a nurse qualified as a nurse prescriber would also be able to minimise occasions when a GP is needed for common ailments. The difficulty is always where there is a need to take a young person out of the home, and this will increase in the enlarged premises.
- the staff often need professional advice for a resident's minor ailment, but they have to obtain professional advice and often this could come from the nurse and avoid GP appointments which can be disruptive.

6.2.24 The SCH staff note that the children often experience pain and have lots of time to think about it, or phantom pains and anxiety symptoms. In these cases delay whilst professional medical advice is sought only increases the level of distress.

6.2.25 An expanded nurse role would help meet OFSTED requirements to provide access to a health professional for a child within 24 hours of being restrained. Such access to a health professional needs to be provided onsite as the child has had a violent episode. The SCH currently meets this OFSTED requirement, but having a nurse present to support this would be a big improvement and this need is likely to increase with the expansion of the SCH.

6.2.26 The circumstances of a restraint and the practices and reporting by staff are stringently prescribed. The frequency of restraints varies, sometimes daily and at other times, weeks apart. It depends on the children and young people in the SCH; it is anticipated that the number of restraints will increase as Lansdowne grows.

6.2.27 The need for extra nursing had not been raised as an issue with the Independent Reviewing Officer but he did note that healthcare at Lansdowne is high profile and taken seriously.

Children as local residents - arrival

6.2.28 These are usually emergency admissions arriving on the day the SCH is notified. It can be very traumatic for the young person. It is reported that administrative systems are effective in notifying the LAC nurse and the psychologist by email of the admission. The GP will conduct the initial health assessment in the first week after arrival. After receiving the medical report from the GP, the LAC nurse writes an initial care plan. The care plan continues to be updated by the LAC nurse as more background information is obtained. The chaotic and transient nature of the children's lives can make this a formidable exercise. In one case the Red Cross helped with an asylum case to identify family genetic issues back in the Middle East. More often it requires tracking down previous addresses and provider organisations that then send paper based records. The process can be a time consuming exercise.

6.2.29 With regard to medication management. Children almost always arrive with medication that the LAC nurse can review to get repeat prescriptions for from the GP or from the original prescriber. Staff may also follow-up with original prescribers if medication is urgently required.

6.2.30 There are now red books[12] for children which the Lansdowne LAC nurse completes and gives to the child if they want it, forming their own personal health record. Notes obtained from other authorities are currently in paper format and do not include GP notes.

6.2.31 The SCH manager suggested the GP needs extra time for a more detailed screening process. This should be triangulated against a flat rate fee paid by the PCT for admission medicals and the interview with the GP.

Health Promotion

6.2.32 The Independent Reviewing Officer was very positive: "I think they are very good at health promotion". The IRO noted the gym, yard and educational curriculum which meant that the young people were out in fresh air almost every day. The IRO also noted the benefits to health promotion from support provided via the nurse and PHSE in the education syllabus. Despite generally good feedback on health promotion, most respondents spoke of the problem of weight gain amongst young people while at the SCH.

6.2.33 It is estimated by SCH staff that approximately 80% of children are smokers. With regard to smoking cessation, it is reported that the SCH stops smoking on admission. Although there was mention of the nurse holding a supply of nicotine patches to use at discretion, others spoke of "cold turkey". There is a smoking cessation team that can visit the SCH, however only around two children per year chose to take up this service.

6.2.34 More than one interviewee spoke of the healthy diet, of encouraging interest in food and of food being provided to take account of particular cultural sensitivities.

[12] Personal Child Health Record (PCHR) is provided in England with a red cover and is often called "the red book". This is a way of keeping track of a child's progress. A child's healthcare professional will use the red book to record a child's weight and other measurements, vaccinations and other important health information.

6.2.35 The social worker spoke of her client who was a persistent absconder. Although the Lansdowne staff wanted to put her on mobility (provide greater freedoms) the social worker could not agree. The young woman started to gain weight despite attempts by staff to provide more exercise within the unit. It was recognised that the new build greatly reduces the space available for exercise onsite. Off-site exercise is an option once appropriate levels of trust are established. For example one child was able to undertake supervised biking, bowling, and walking along a coastal path. A staff member even brought her dog to work and they went dog walking.

6.2.36 Sexual health problems are dealt with offsite at the GUM clinic on admission to the SCH.

6.2.37 The Under 19's Substance Misuse Team consider that a major need for the children and young people is an understanding of the danger of substance misuse. As they have often missed mainstream education they have little understanding of the dangers even of alcohol misuse.

Health needs of children and young people in secure accommodation.

6.2.38 Key informants report that the health needs of children at Lansdowne SCH are really little different from those of all 'looked after' children on admission to care, who haven't been accessing health services. It was noted that secure accommodation can be a way of making changes in a young person's life, but it is only as good as what comes next. For example some children arrive having been on the run, homeless, or missing from care. There is a need to set up appointments again. Screening reviews are needed for: sexual health, drug addiction, diet and nutrition, immunisations, smoking, self-harm, asthma, diabetes, pregnancy, and anything that might be ethnically associated e.g. sickle cell. Generally children entering the home do not have issues with TB. It is common for the children to display signs of chronic long term neglect and problems with mental and emotional health.

6.2.39 Occasionally a child arrives with immediate health concerns, usually a GU issue relating to recent sexual activity requiring a visit the GUM clinic in Eastbourne. There is no formal staff health screening process on reception and SCH staff use a common sense approach to identifying immediate health issues. A full time nurse role would provide additional professional screening capability at the SCH. When the health assessment is undertaken during the first week, children are one-on-one with the GP unless the child requests that a member of our staff is present.

Children as local residents - release

6.2.40 Discharge is meant to be a very clear process but is often unpredictable. Usually the court will make an order for a child to spend 28 days at the SCH. If after 28 days the local authority goes back to court the first application can be extended for a further 2 months, equal to 3 months in total. Then a new application is made. Discharge planning in this environment is very difficult.

6.2.41 Good practice would allow a transition period so that there is some thought and planning put into the next move. The transition should involve gradually meeting new carers, through them visiting the SCH, followed by the young person making visits to the new home, including staying overnight in the latter visits.

6.2.42 Stakeholders report that planning is easier for children from East Sussex, but is more difficult for out of area children. Lansdowne aims towards a very robust discharge procedure. However there are few placements for the challenging children in the programme; transition planning is limited where the next step is not known. A placement could be fostering, home to parents or into other secure accommodation. Some children may even be sectioned and discharged to a mental health institution.

6.2.43 The LAC nurse reports that repeated requests need to be made for a forwarding address to which to send notes and plans. The health care plan works towards what happens when a child leaves Lansdowne SCH and aims to provide joined up planning with the new placement e.g. child doesn't need to go to optician again. The transition and handover can be a difficult period and will often take around two weeks of the LAC nurse's time if there are secondary care appointments in place that need to be rebooked in a new locality.

6.2.44 For the clinical psychologist, her role is advisory to the Lansdowne SCH staff so once the child is discharged, no further follow-up is made.

6.2.45 The Under 19's Substance Misuse Team will continue to see young people in the community if they are residents of East Sussex. However where they are discharged out of county, records will be passed to the receiving social worker, but that is where the responsibility of the team is completed.

Step Down Period

6.2.46 A view was expressed that often children are discharged before the completion of therapeutic work. As soon as a child no longer meets the criteria for being held in secure accommodation, they may no longer be detained. There was little process in this, but instead it was very much black or white. Either a child is under a secure order or the order is ceased.

6.2.47 Some cases were cited which would have benefited from a less secure regime, in the environment where they have learned to trust. The Independent Panel Member for Secure Reviews reiterated that they could not continue at the SCH once the Panel had recommended their discharge. The social worker commented, "Step down for a young person not completely ready to return home would be a really useful addition. If they were still able to have a good level of intensive input as part of rehabilitation or mobility it would improve their future chances greatly".

Discussion arising from provider interviews

6.2.48 One of the benefits of this exercise is the opportunity to compare and contrast different professional perspectives of health need, care and supply relating to the residents of the Lansdowne SCH. However there was great congruence of focus on achieving the optimum benefit for the young people.

6.2.49 The different models of care practised by the nurse (7 hours a week) and the psychologist (3½ hours a week) were interesting. The psychologist provides one morning of care. The nurse provides time as it is needed. This still is not quite adequate and it is possible that the growth of Lansdowne to 7 and later to 10 young people will require the nurse full or nearly full time to meet the requirements of the post. The extended nurse role includes closer integration in the staff team to provide clinical support to the staff. This is not akin to a school nurse post as these young people have significant health needs, especially psychological and emotional but also physical and psychosomatic. The staff call frequently on the nurse for advice so it would be helpful to be able to attend the weekly staff meeting more often and it would be advantageous were she able to prescribe to settle minor ailments quickly in response to the anxiety of the young people. The nurse also has a significant task in tracking past medical histories and fulfilling the statutory requirement of the health care plan and she plays a significant part in discharge which can require much communication with the receiving authority and which usually means handing over a case very much in process on a number of issues. A comprehensive list of tasks for the LAC nurse is available in Appendix 4.

6.2.50 Speed of response is noted by more than one interviewee. As the children are extremely vulnerable and only likely to be resident for a few weeks or months, speed of diagnosis and response is needed to achieve the best outcome. Being secured is an opportunity to provide the maximum best care in the time given. But the very fragile nature of the children also requires swift response to self-harm and it makes no sense to spend weeks seeking agreement and funding for psychiatric input. A system should be in place for treatment to be provided as the need is diagnosed.

6.2.51 The time taken to settle into the system and the patient nature of the work that needs to be done also gave rise to the question of a step down arrangement. This cannot be provided within the secure unit as when the criteria are no longer met the child must be discharged. This is acknowledged and was underlined by the Independent Panel Member for Secure Reviews. But after all the input of high quality work, to leave the task unfinished is poor value for money and effort and leaves the young person with a much greater chance of returning to their previous lifestyle. Consideration could be given to including post-discharge follow-up by the expanded nurse role to assist where possible with any outstanding health referrals or appointments that were made whilst the child was at Lansdowne SCH. Responsibility would end once the course of treatment was complete or a clear and full handover had been achieved.

6.2.52 The model employed by the psychologist is reported to work well. The regularity of her attendance, her availability at the education break when she is there, her style of providing support to the young people by advising and supporting the staff is positive. She will need more hours in the new building because the extra number of young people will require increased interaction. The Independent Reviewing Officer, a very experienced manager in the secure homes sector, noted that although the policy at Lansdowne is one of "no bullying" and that young people are never left alone, bullying can be very subtle, transmitted by body language, a

look or a covert gesture. This will be much harder to monitor where there are more young people. He noted the near impossibility of eradicating bullying in larger homes. The growth of the Lansdowne is unlikely to lead to significant change, but it will change, and staff provision must be in line with the increased numbers and increasingly demanding situation. The value that has been expressed of this home is its intimacy, caring and calmness which should not be lost.

6.2.53 How many hours are needed for the nurse and the psychologist is a difficult question because of varying numbers of children at the home and the variability in their needs. There may be periods when restraint is required on a daily basis but others when it is a rare occurrence.

6.2.54 The elements of the psychologist's current role include:

- new entrant assessments, scoring and reporting, weekly brief observation of the children, advice on management to staff and attending team meetings.

6.2.55 Following completion of the new buildings, the psychology role should include:

- current practice;
- some additional time for staff support as they work in a closed community of children who may be suicidal, very violent, manipulative and damaged;
- direct therapeutic work with the children and young people (engendered by their own assessments, requirements of staff and direction by the prescription by the Consultant Psychiatrist); and
- additional time to manage new complexity brought by an increase in numbers, for example increased potential to bullying which is more difficult to contain amongst larger number of residents.

6.2.56 The increased input may mean that the young people less often reach discharge with current work on their development being unfinished.

6.2.57 The best estimate may therefore be that the psychologist would need three to four sessions in the new environment.

6.2.58 The actual hours currently worked by the LAC nurse are unknown. Her designated seven hours are spread flexibly and she has no record of actually how much time is provided. The current elements of her role include:

- New entrant assessments and writing care plans, obtaining information to enhance the fragmented histories of the children, updating care plans as more information is discovered, arranging health care appointments identified in the care plan (sexual health, drug addiction. immunisations, pregnancy testing and whatever else is needed to reverse chronic long term neglect), advising staff on current health problems as they occur, attending team meetings, managing discharge at short notice, outreach to new addresses with children, writing discharge referral letters where appointments have been set up in the locality of Eastbourne but may need to be made in the area of new residence.

6.2.59 Following completion of the new buildings, the nurse role should include:

- current practice;
- recognition of the increased need for support of staff in relation to a great number of children;
- availability to meet the Ofsted requirement of a clinical supervision within 24 hours of restraint which should be available onsite;
- training in sexual health management and prescribing;
- forming relationships with the young people to gain trust, and enable input to improve health status (reassurance on unidentified lumps and bumps, the authority of clinical advice on minor matters, and replication of the brief period when a GP visited frequently and added much stability to the young people in being on hand to deal with worries before they develop into greater anxiety);
- increased availability for staff support in advising on minor health needs which in an open community might be dealt with by consultation at the local pharmacist outlet; and

- post-departure follow-up to ensure an appropriate handover is achieved.

6.2.60 Increased input may mean that the young people less often reach discharge with current work on their development being unfinished.

6.2.61 The best estimate of hours required for a LAC nurse in the new environment might be maximum part time (nine sessions a fortnight). The nurse should be based at Lansdowne, being available five days a week, during school hours for non-contact duties and outside those hours for contact with children and staff. This might lessen the impact absence of cover for the post for sickness and holidays. Additional LAC duties outside Lansdowne could be undertaken for maybe one session a week to be reviewed after the enlarged Home is established.

6.2.62 The current arrangement with the Consultant Psychiatrist is unclear. He meets all requests for input and is unclear about charging arrangements. He does not have a LAC role but is the Lead Clinician for CAMHS for one part of East Sussex. Although the arrangement works well, it should be regularised for the enlarged SCH additional time would be required, particularly with the addition of a high dependency bed.

6.2.63 The Psychiatrist is comfortable about the new build and approves of increased capacity for East Sussex. It would be preferable to have sound arrangements in terms of psychiatric provision. The Psychiatrist reports that there have been "a couple" of instances when Lansdowne was not right environment as there was a need for forensic intervention. There have been cases where Lansdowne does not have capacity probably because places had been taken by young people placed on secure orders from out of area.

6.2.64 The new building should provide a better environment, for physical structure to support medical services in storage for notes, and a medical area to conduct interviews. The need for confidentiality and management of interviews will also expand.

6.2.65 Most interviewees mentioned the need for exercise when talking about health promotion. The view of the social worker is that the staff have been very creative in seeking to meet this need, but more is needed and should be a high priority in the new building. A sense of self-worth is fundamental and influenced by weight gain.

6.3 Service Users Interviews (Residents)

6.3.1 Lansdowne SCH has a maximum occupancy of five young people and it does not always reach full capacity. This section reflects the views of the two children resident at the date of the interviews**.**

Results

6.3.2 One girl had been at Lansdowne for three months, the other a bit longer. On arrival at Lansdowne each had health issues, requiring a visit to the GUM clinic. They spoke of being medically checked when they arrived, the examination taking place in the visitors room. They said they understood what they were being told. They did not speak as if it had been an ordeal. "They just checked your breathing and talked and asked questions."

6.3.3 The staff interjected: We ring the doctor to say there is an admission. If court day was on a Friday then Monday would be court again and sometimes they did not see the doctor for a month.

6.3.4 The children were asked if they felt the staff listened properly to your concerns. They were happy with the staff, and "some doctors listen properly" but sometimes they felt ignored. It was reported that the GP was not always prompt in responding to requests for advice.

6.3.5 One child reported that there were insufficient GP visits to the SCH. She described a time when she had felt very unwell and had been made to go to the GP surgery when she had requested that the doctor visit her at the SCH.

6.3.6 The children reported that if they were feeling unwell or had a health concern then they would tell staff, a coordinator or key worker, who would then arrange access to a health professional.

6.3.7 The Staff commented on how difficult that can be to provide sufficient escorts for healthcare appointments. It is reported that it can take three escorts (depends on level of "mobility"). If there is a high level of security then staff can request that the doctor visit the SCH.

6.3.8 It was reported that in June or July there was a lady GP who came to the SCH frequently. The staff explained that she would just call in. When she was there she was willing for staff or residents to ask her questions. The young people were enthusiastic that "it was good to have someone round that you could ask". The staff had also appreciated the ease of access at that time.

6.3.9 The staff commented that although they could request a lady GP there was no guarantee that one would be available.

6.3.10 They were asked if they could see the doctor alone if they wanted. This question was slightly rubbished as being silly. "The staff have to be there otherwise how do they know what is supposed to happen to you?"

6.3.11 They were asked about seeing the dentist. The older girl had seen the dentist but not on arrival. It had taken three months for her arrival dental inspection. She needed to go back for braces and fillings.

6.3.12 On the question of seeing other therapists and counsellors, the Staff noted that if a child was seeing a Psychiatrist or counsellors when they arrived, then that would continue if their local authority gave authorisation. Under 19s drug and alcohol service also visits. Social workers might visit to undertake assessments. It was reported that some social workers "only come when they have to although they are supposed to come every fortnight".

Discussion arising from resident interviews

6.3.13 Visits to the GUM clinic were regular for female residents at Lansdowne and well managed. There was a longer waiting period to see the optician and dentist. Given upcoming court appearances for the older resident it is unlikely that her dental work would even be started whilst at Lansdowne. Had there not been such an initial delay this it is likely treatment could have been completed.

6.3.14 The wait for an admission medical is of concern. During service provider stakeholder interviews the LAC nurse said she waits for the results of the admission medical before beginning to write the care plan. Early diagnosis of current problems at admission is very important and other processes are dependent on it, and time from admission to completion of the admission medical should be a quality indicator.

6.3.15 There was quite a mixed conversation going on at different levels. The younger girl was quite affronted that she should be taken out to see the GP when she was feeling very unwell. At an organisational level, given the secure facility and the problem of having to provide three escorts, the staff felt that the home should be given priority but that the doctors were not as ready to come out as they should have been. It is important that planning of health services take into account that as a secure facility there is a lack of the normal community health care support, such as pharmacists. It is likely that if there was additional nurse support at the SCH, rapid assessment and management of minor health issues could be improved.

6.3.16 The female children valued having a female doctor in the home on frequent occasions and the opportunity to ask about small things that were bothering them. It was being able just to ask because the doctor was present, without formality or waiting that they clearly appreciated. Appointments and waiting were not easy situations for them to accept.

6.3.17 The question of being able to see the doctor alone was checked with the LAC nurse. She would not accompany them, but staff would: "for the majority of young people they are present. However, if over 16 occasionally the GP has asked to see the young person on their own".

6.3.18 These were the views of just two individuals and had the interviews taken place with a different group of residents at another time, the responses might have been different. But the particular histories and response to authority of these two people, and their own deep experience of rejection may be representative of the wider community of young people at Lansdowne SCH.

6.3.19 There is a need to reconcile making efficient use of the GPs time when requesting visits to the SCH and making efficient use of the SCH staff's time if three escorts are required to accompany the child for a primary care visit off-site.

6.3.20 It is noted that because these children's history has assigned them to a secure place and because of the sense of rejection they often feel, there is a different value in having a clinician available with whom they can informally discuss the symptoms on which their fears are focused, than would normally be assigned to a home visit by a GP.

6.3.21 This theme was also pickup during the service provider stakeholder interviews: "The children have a desperate need for affirmation, including through being held and looked at. E.g. acknowledging a little lump that they keep talking about and nobody does anything about (not necessarily requiring medical intervention)".

6.4 Stakeholder Interview with Dr Gray Lead GP to Lansdowne SCH

6.4.1 Dr Gray has been attending Lansdowne secure children's home for the last 18 months. His general practice surgery - Quintin's Medical Centre is about three minutes car journey away from the home. He was invited to become the lead GP of the home following an OFSTED report which stated that because the previous general practitioner was a male single practitioner there was not sufficient choice to allow the children to see a female GP if preferred.

6.4.2 Dr Gray is the lead GP for Lansdowne's children's home there is one other male and four female GP's at Clinton's medical centre. The GPs are all willing to be involved with Lansdowne secure children's home except one of the female GP's who does not want to be involved. Dr Gray has previous experience working in deprived areas and has undertaken training addressing children at risk and drug and alcohol rehabilitation. All requests are initially referred to Dr Gray by the reception team and he decides whether either he or a number another member of the GP team will deal with it. Since joining the home Dr Gray and his team have not been offered any further training that addresses caring for children in secure units.

Contract to provide GP services to Lansdowne secure children's home

6.4.3 The GP practice holds a contract directly with the Lansdowne Secure Children's Home. He is paid a quarterly retainer. The total amount paid over one year is £1,200. Lansdowne Secure Children's Home have procured normal GP services and stated that they would prefer for the GP to visit for new assessments and routine care when possible. Dr Gray is not been given a clear guidelines or protocols regarding the Lansdowne secure home requirement of GP services.

GP workload

6.4.4 The workload is not onerous as the maximum number of children at the home is only five and often there are about 3 children resident. The GP practice considers this workload very manageable. The practice nurse is usually only involved if blood tests are required; however on one occasion a practice nurse was asked to give additional support to the home when the LAC nurse was not available. Most of the care of the children is carried out at the home including the GPs carrying out any necessary immunisations. The average waiting time for a child to see a GP for an admission visit is about 24 hours; the maximum time for a child to see the GP is around 3 to 4 days; the delays are usually due to the fact the child is spending a lot of time in court and is unavailable for an admission assessment.

Healthcare facilities within the home

6.4.5 There are no designated healthcare facilities within the current building; the room where the GPs see the children have no couch, they consider it is adequate for the majority of consultations; however it is not adequate for a full physical examination. If a full examination is required, they ask for the child to be brought to the GP surgery. Dr Gray has had no input into the design of the rooms in the new building and his knowledge there is no doctor's room being designed. This is an area that should be addressed while the new building is in development.

Communication across the multidisciplinary team linked to the home

6.4.6 Communication between the multidisciplinary team attending the care home and the GPs is not always coordinated well. Dr Gray is currently acting as a GP who provides GP services including the initial assessment. The GPs are not always informed about the health problems that are arising within the home. Dr Gray recognises that sometimes the LAC nurse and the social workers have a more important role in the day-to-day support and counselling of a child than the GP; however he would prefer to be kept informed about any significant event or referral made by other members of the team. Overall Dr Gray would like to improve both formal and informal communications between the multi-disciplinary team regarding the health and well-being of the resident children.

Initial health assessment of children admitted to the home

6.4.7 At the admission visit most children are cooperative and the history taking and examination is straightforward. If the child requests to see a female GP this is arranged. Some children have complex medical and psychosocial

problems. When a newly admitted child is able to communicate effectively about their past medical history and recent problems, the initial assessment visit is relatively straightforward; however problems arise when a child refuses to cooperate and there is very little documentation available. Sometimes it takes several weeks or even months for the NHS records of a child to be sent to the GP and it is only at this later time that the GP is able to review the past history of the child and sometimes discovers they have a significant medical or mental health history that were not reported at the time of admission. This is especially concerning when there is a history of self-harm or abuse and this has been denied by the child when directly asked at the admission visit.

6.4.8 Some children are only admitted to the home for 2 to 3 weeks this often results in the child's care healthcare being poorly coordinated. The GP is not involved in writing discharge letter to the next GP. Dr Gray recommends that there should be more efficient ways of accessing the past health history of the child and urgent requests for medical notes should be prioritised by NHS administration.

Sexual health services

6.4.9 Many of the children have seen sexual health services around the time they had been admitted. Sexual health service health professionals do not visit the home; a confidential referral is usually made by one of the members of the care team. Some children have required careful examination prior to their admission to the home this is especially in cases of physical abuse and rape. Communication with sexual health services is sometimes a problem and Dr Gray is not informed if a child has an STI. This is because sexual health clinics have a code of confidentiality. However this has created problems if a child needs on-going care. Sometimes the girls are pregnant when they are admitted to the home and on-going maternity care and support is arranged. Some girls require contraception especially long acting methods of contraception. When recommending this type contraception to girls it is important they are offered careful counselling. Sometimes the GPs are not informed; Dr Gray considers the GP's role is to support the girls in making an informed decision about the method of contraceptive choice.

Mental health services

6.4.10 Dr Grey reports that the most frequent mental health problems of the children resident at the home are those of self-harm, overdose, depression, anxiety and behavioural problems, (often linked to being in long-term care). It is rare for the any child to have severe mental illness. The referral system to mental health care services is often poorly co-ordinated and may be made by different members of the care team. Sometimes referrals are made by the LAC nurse or by the social worker and the GPs are not informed. This means that sometimes a child would be receiving mental health care services but not having regular updates being sent to the GP. Dr Gray is concerned that sometimes there is poor communication across the multi-disciplinary team and would like this addressed.

Secondary care services

6.4.11 Specialist services do not visit the home other than the mental health team. It is not often that referrals are made for secondary care services. When they are they are usually for ENT or dermatology.

Out of hours care and Accident and Emergency care

6.4.12 Dr Gray is not aware of any problems arising when the home has used out of hours care and accident and emergency care. He is not aware of any inappropriate use of these services.

Pharmacy

6.4.13 Currently the home users Seaforth Pharmacy for the residents' prescriptions which often take a long time to dispense, this creates problems in initiating therapy. Dr Gray would prefer that the home used the local pharmacy called Kempson's pharmacy. The GP practice has strong links with this pharmacy and considers they offer a better service and would be more convenient for the home.

Health promotion and well-being

6.4.14 Dr Gray mentioned that some of the children especially the girls are overweight and would benefit from dietary support. There is little scope within the current facilities of the home for exercise; access to exercise that is enjoyable for children within this age group is recommended.

Substance misuse

6.4.15 Many of the children who enter the home have a past history of drug abuse. Most of the children are not regular drug users and do not require a formal drug withdrawal programme. When drug and alcohol counselling and support are required the LAC nurse or staff at the Home refers them to the drug and alcohol team. If the child is an IV drug abuser they are recommended to have hepatitis B immunisations. Often the GPs will commence the course; however the child often leaves before completing the course of hepatitis B injections. The GPs are concerned about whether the child gets appropriate follow-up from their next GP**.**

Safe Guarding Children

6.4.16 Dr Gray is not usually involved with case conferences addressing safeguarding children. The GPs do not usually have the time to take a whole morning out to attend the case conferences. The GPs assume that most of the children are on an “at risk register” but they are currently not sent regular updates about the outcomes of any recent case conferences.

Discussion arising from GP interview

6.4.17 The GPs would like to have their role more clearly defined. They are willing to be more involved and take an active role within the multidisciplinary team, especially in supporting those children who are resident for longer lengths of time. The GPs at the practice would like to have a clear understanding about whether the home would like the GPs to get more involved with the children's care, or whether they require the GPs only to offer routine GP services and delegate the responsibility for the coordination of all other services including mental health services, sexual health services and social care to the LAC nurse shared with the child's own social worker.

6.4.18 Currently there are poor communications between the GP practice and the multi- disciplinary team at the care home. They find it especially difficult when there is confusion regarding who is referring the child for specialist services. This sometimes results in duplication of referrals occurring. This is creating frustration and concern within the GP practice team.

6.5 Comparison of Lansdowne Healthcare provision with other SCHs

6.5.1 There are six SCHs in addition to Lansdowne SCH that provide placements solely on welfare grounds. These are:

- Atkinson Unit SCH
- St Catherines SCH
- Clare Lodge SCH
- Kyloe House SCH
- Leverton Hall SCH
- Beechfields SCH

6.5.2 As part of the HNA for Lansdowne SCH these other six SCHs were contacted. Table 6.1 sets out an analysis of needs as assessed against the requirements of the National Minimum Standards (NMS) 2011 and Children Homes Regulations 2001 (as amended). Two of the six other SCHs that provide placements on welfare grounds agreed to contribute to this section. The sections following the table provide commentary and recommendations.

6.5.3 A full star indicates the requirement is fully met, half a star indicates almost met and a blank star indicates the requirement is not met.

Table 6.1: Needs assessed against the requirements of the National Minimum Standards (NMS) 2011 and Children Homes Regulations 2001 (as amended)

	Lansdowne SCH	Two compartor SCHs	
A variety of properly prepared, wholesome and nutritious food is served in adequate quantities and at appropriate intervals. And such food meets children's reasonable needs and preferences.	★	½	★
Fresh drinking water is available to children at all times.	★	★	★
All special dietary needs due to health, religious persuasion, racial origin or cultural background are met.	½	★	★
Children are provided with appropriate clothing, footwear and personal necessities, and such items meet children's reasonable preferences.	★	★	★
Each child is a registered patient with a general medical practitioner.	★	★	★
Each child has access to such medical treatment and other services, as they may require.	★	★	★
Each child has access to such dental treatment and other services, as they may require.	½	★	★
Each child has access to such nursing treatment and other services, as they may require.	½	★	½
Each child has access to such psychological and psychiatric advice, treatment and other services, as they may require.	☆	★	½
Each child is provided with such individual support, aids and equipment as they may require as a result of any particular health needs or disability.	½	★	★
Each child is provided with guidance, support and advice on health and personal care issues appropriate to their needs and wishes.	★	★	½
At all times, at least one person on duty at the children's home has a suitable first aid qualification.	★	★	★
Any person appointed to the position of nurse at the children's home is a registered nurse.	★	★	★
All parts of the home to which children have access are so far as reasonably practicable free from hazards to their health or safety.	★	★	★
Any activities in which children participate are so far as reasonably practicable free from avoidable risks.	★	★	★
The children's home's 'statement of purpose' includes arrangements made to protect and promote the health of the children accommodated at the home.	★	★	★
The children's home's 'case records' include any special dietary or health needs of the child and details of any health examination or developmental tests.	★	★	★
Children's physical and emotional and social development needs are promoted.	★	★	★
Children understand their health needs, how to maintain a healthy lifestyle and to make informed decisions about their own health.	½	★	½

Children are encouraged to participate in a range of positive activities that contribute to their physical and emotional health.	★	★	★
Children have access to doctors and other health professionals, including specialist services, when they need these services.	★	★	★
Children's health is promoted in accordance with their placement plan and staff are clear about what responsibilities and decisions are delegated to them and where consent for medical treatment needs to be obtained.	★	★	★
Children's wishes and feelings are sought and taken into account in their health care, according to their understanding, and staff advocate on behalf of children.	★	★	★
Staff have received sufficient training on health and hygiene issues and first aid with particular emphasis on health promotion and communicable diseases.	★	★	★
Staff receive guidance and training to provide appropriate care if looking after children with complex health needs.	★	★	★
The home has good links with health agencies, including specialist services where appropriate, such as CAMHS and sexual health services. The availability of such services is taken into account when deciding on admissions.	★	★	★
Staff involved in delivering therapeutic interventions have appropriate training and expertise and access to regular supervision.	★	★	★
Specific therapies are used only: where there is a clear and widely accepted theoretical or evidence base underpinning its effectiveness; and with the continuing agreement of the child's responsible authority or a person with parental responsibility and of the child concerned where the child is of sufficient understanding.	★	★	★
Each child's wishes and feelings are sought and taken into account in their health care, according to their understanding, and each child has someone in the home who can advocate these for them.	★	★	★
Medicines which are kept in the home are stored safely and are accessible only by those for whom they are intended.	★	★	★
Prescribed medication is only given to the child for whom it was prescribed, and in accordance with the prescription.	★	★	★
Children who are able and wish to keep and take their own medication, can do so safely.	★	★	★
There is a written record of all medication, treatment and first aid given to children during their placement.	★	★	★
The home has any physical adaptations or equipment needed to provide appropriate care for children.	★		
Staff are trained in resettlement issues in order to prepare young people effectively for leaving the secure children's home.	★		★
There are explicit policies and procedures that effectively identify and counter risks of self-harm and suicide.	★	★	★
The children's home has a clear written policy on managing behaviour, which includes supporting positive behaviour, de-escalation of conflicts, discipline, control and restraint, that all staff understand and apply at all times.	★	★	★
Staff are trained in appropriate safe-care practice, including skills to care for children who have been abused. For providers who offer placements to disabled children, this includes training specifically on issues affecting disabled children.	★	★	★
Children are able to enjoy their interests, develop confidence in their skills and are supported and encouraged by staff to engage in leisure activities.	★	★	★
Children are supported to achieve their educational potential.	★	★	★
Children live in well designed, safe and pleasant homes with adequate space in a suitable location where there is access to the necessary facilities for a range of activities which will promote their development.	★	★	★
Staff have sufficient numbers, qualifications and experience to meet the needs of the children.	★	★	★
Children are looked after by staff who are trained and competent to meet their needs; and staff receive high quality training to enhance their individual skills and to keep them up-to-date with professional and legal developments.	★	★	★
Monitoring includes consultation with children about their welfare.	★	★	★
Children know how to obtain support and make a complaint.	★	★	★
The health of children is assessed at regular intervals and the child's care plan includes an individual health plan.	★	★	★

Discussion arising from analysis of statutory requirements

6.5.4 With regard to special dietary requirements Lansdowne SCH does not fully meet the requirement, as it takes a few days to make the necessary changes. For comparison the two comparator SCHs both fully meet this requirement.

6.5.5 With regard to dental treatment Lansdowne SCH does not fully meet the requirement, as non-urgent cases are deferred till staff are satisfied that there is an appropriate level of trust to enable the children to be taken off-site for dental treatment. For comparison the two comparator SCHs both fully meet this requirement.

6.5.6 With regard to access to nursing treatment Lansdowne SCH does not fully meet the requirement, as the LAC nurse service is for 7hr a week and is based off site. As a result a nurse is not always easily accessible. For comparison one of the two comparator SCHs already fully meets this requirement and the other is about to appoint a full time Practice Nurse to replace the current twice weekly visits by a LAC Nurse.

6.5.7 With regard to access to psychological and psychiatric advice Lansdowne SCH does not meet the requirement, as a psychologist is only available one morning a week to guide staff interventions, but does no direct work with children. Psychiatrist input is commissioned as required. For comparison the comparator SCH that fully meets this requirement has an on-site clinical psychologist, with psychiatry commissioned on an individual basis.

6.5.8 With regard to providing children with support, aids and equipment for particular health needs or disability Lansdowne SCH does not fully meet the requirement, as such provision is dependent on a robust risk assessment. For comparison the two comparator SCHs both fully meet this requirement.

6.5.9 With regard to supporting children to maintain a healthy lifestyle and to make informed decisions about their own health Lansdowne SCH does not fully meet the requirement, as such work is often on-going, with the aim of only fully meeting the requirement by the point of discharge. For comparison a similar viewpoint is taken by one of the comparator SCHs.

6.5.10 With regard to access to doctors and other health professionals, including specialist services, Lansdowne SCH does not fully meet the requirement, as for specialist mental health services, the placing Local Authority will have to negotiate with CAMHS either from their own area of though our local office to provide a service with a cost attached. For comparison only one of the two comparator SCHs felt it fully met this requirement.

6.5.11 With regard to physical adaptations or equipment needed to provide appropriate care for children Lansdowne SCH does not meet the requirement, as the current buildings are not up to standard. However there is a significant new build in progress which is anticipated to meet this requirement.

6.5.12 With regard to staff training in resettlement issues in order to prepare young people effectively for leaving the secure children's home Lansdowne SCH does not fully meet the requirement, reporting that there is often not enough time available for a safe and supportive exit plan. For comparison only one of the two comparator SCHs felt it fully met this requirement.

6.5.13 With regard to staff training to support issues affecting disabled children Lansdowne SCH does not fully meet the requirement. For comparison only one of the two comparator SCHs felt it fully met this requirement.

6.5.14 With regard to the requirement for children to live in well designed, safe and pleasant homes with adequate space in a suitable location where there is access to the necessary facilities for a range of activities which will promote their development, both Lansdowne and the two comparator SCHs acknowledge that they do not fully meet this requirement, as there are limitation to what can be achieved with the resources provide.

6.5.15 Table 6.2 provides a comparison of key areas of health care provision at SCHs that provide placements on welfare grounds. Four of the six other SCHs contacted agreed to contribute to this section. The sections following the table provide commentary and recommendations.

Table 6.2: Comparison of key areas of health care provision at SCHs that provide placements on welfare grounds

	Lansdowne	Four comparator SCHs			
Onsite facilities used to support delivery	None at present, but a designated	Fully equipped medical room	The SCH has a medical room as	No data	Medical room for use of GP, LAC

of healthcare (e.g. an equipped room for the GP to use)	room for health care professionals will be in place in the new building	and dental suite	part of the secure unit – this is a fairly small room but is reasonably well equipped.		Nurse and future Practice Nurse.
Number of days after arrival for an induction health review to be conducted	Within one week.	Within one week.	Within 3 days.	Within 5 days.	Within 2 or 3 days
Who conducts induction health review and where are they undertaken	GP on-site	LAC Nurse on-site	LAC Nurse on-site.	GP and LAC nurse on-site.	LAC Nurse on-site
Whether there is onsite nurse supporting the children	No	Yes	Yes	No	No (but soon)
Number of hours per week by nurse.	7 hours per week	8.5 hours per week	30 hours per week	The LAC nurse attends weekly but will come in on request if necessary.	The Practice Nurse will work full time
How on-going health and wellbeing needs are communicated in resettlement plans	Usually with LAC nurse permission (confidentiality) all necessary information passed to new placement.	LAC nurse passes information to the social worker.	A health report is compiled by the site nurse which is passed on to the social worker and if appropriate the next placement.	The LAC nurse undertakes a discharge medical assessment which highlights any outstanding issues. A copy is forwarded to the next placement.	LAC Nurse sends on health records and the on-site clinical team liaise with the next placement.
The specialist health services available to children at the SCH	Dental, optician, physiotherapy and GUM services are provided off-site. Asthma care, diabetes care and contraceptive services are provided on-site. In addition PSHE sessions on Dental Hygiene, Healthy eating and Drugs awareness are also provided on-site	No data	On-site nurse who is a general registered nurse but also specialist sexual health and RMN. GP is a section 12 approved GP.	Dental (part), diabetes, physiotherapy and GUM services are provided off-site. Dental (part), optician, asthma care and contraceptive services are provided on-site.	Dental, optician, Gum and contraceptive services (part) are provided off-site. Asthma care, diabetes care, smoking cessation and contraceptive services (part) are provided on-site.
The most common physical health needs among the children	In order of the most common first: asthma; sexual health disorders; diet and nutrition; eczema; and dental issues.	No data available	Sexual health problems and nutritional issues are the most common but can present in different ways.	In order of the most common first: underweight; head lice; fungal infections; STI's; and skin conditions.	In order of the most common first: referral to GUM clinic; not sleeping; smoking cessation; education regarding abuse

					of alcohol / drugs; and physical effects of self-harm.
Whether the SCH has appropriate facilities and staff training to manage children with physical disabilities	No	Only mild to moderate disabilities.	Children with disabilities only accepted if staff have the resources to look after them.	No	No
Management of sexual health needs	Trained member of staff SAS (Safe Around Sex) and referral to GUM, PSHE and sexual health services.	Specialist input via SLA	The site nurse is a specialist in sexual health. The SCH also has good relationships with local services.	Management is via the LAC nurse.	With advice from LAC Nurse and referral to local GUM clinic. Also, as part of education and link work sessions with Care staff.
Management of inpatient care if needed	Inpatient care requires a risk assessment as to staffing levels and/or secure escorts.	Inpatient care is not supported.	If needed arrangements are made with the placing Local Authority.	Local Authorities provide 24 hour escorts.	Care staff will stay with young people.
Whether children receive training and encouragement in personal hygiene	Yes	Yes	Yes	Yes	Yes
Exercise spaces, facilities and incentives available	Two small yards and a fitness suite. Individual programmes of dance and aerobics.	Gym - Fitness suite - Outside sports area	Each unit has a secure garden area and a secure external activity area. There are also two activity halls within the secure complex.	A gym, two sports areas which young people are encouraged to use frequently.	Large courtyard for football etc.; Gym for indoor games, badminton etc.; Fitness suite; Indoor area with table tennis table and snooker / pool tables.
Health promotion activities	Drug and alcohol awareness; smoking cessation; dental hygiene; sexual health (age appropriate); and diet and nutrition	Through the school curriculum/ Terence Higgins Trust	All that are possible and appropriate. There are regular work sessions facilitated by the local Taz as well as other resources from the community.	The LAC nurse covers a variety of topics during sessions with the young people.	No data
Specialist mental health providers available for children at the SCH	Direct work with children only available through referral to CAMHS. A psychologist supports staff on-site, but does not	Psychiatrist and psychologist services are provided on-site.	Clinical psychologist and adolescent psychiatrist carry out an initial mental health risk assessment.	Psychiatrist; psychologist; mental health nurse; social worker; art therapist; and drama therapist services are provided on-site.	Counsellor, psychiatrist and psychologist services are provided on-site.

	work directly with children.		There is also access to a speech & language therapist and an educational psychologist.		
The most common mental health needs among the children	In order of the most common first: self-harm; acute anger; eating disorders; learning difficulties; and attachment disorder.	No data collected	ADHD; autism spectrum disorders; anxiety; post-traumatic stress; and attachment disorders.	In order of the most common first: self-harm; attachment issues; eating disorders; ADHD/mild autism/Asperger's; and anger management.	In order of the most common first: self-harm; managing anger; low moods; dealing with trauma; and poor attachment.
Whether the SCH has appropriate facilities and staff training to manage children with learning disabilities	Yes	Yes, for mild to moderate learning disabilities	Yes, dependant on the level of learning disabilities.	Yes, provided that the learning disabilities is low level.	No
Specialist services available for children at the SCH to help with alcohol and substance misuse	Substance misuse care is provided on-site.	Alcohol reduction care and substance misuse care service are accessed via a SLA.	Alcohol reduction care and substance misuse care are accessed via our GP and site nurse	Alcohol reduction care and substance misuse care are provided on-site.	Alcohol reduction care and substance misuse care are provided on-site.

Discussion arising from comparison of key healthcare issues between SCHs

6.5.16 Lansdowne's new building programme includes new facilities to support delivery of healthcare. This brings the SCH in line with other similar SCHs.

6.5.17 Lansdowne SCH undertakes an induction health review within one week. This is not dissimilar to some other SCHs, but could be improved to 2 or 3 days.

6.5.18 Lansdowne's induction health reviews are undertaken by the GP on-site. This is considered appropriate. Other SCH's use a LAC nurse to undertake this review, or to support the GP in doing so.

6.5.19 Lansdowne currently does not have a full-time nurse onsite. Compared to other SCHs this is not unusual, though more are opting for a full time nurse presence. The experience from other SCHs is that a full time nurse role is equivalent to approximately 30 hours per week.

6.5.20 The management of on-going care once a child leaves the SCH is the responsibility of the new placement and is supported though communication between the SCH's LAC nurse and the new placement. A similar process operates at other SCHs.

6.5.21 Lansdowne SCH provides a good range of specialist health services, either onsite or offsite. Compared to other SCHs the range of services is broadly similar.

6.5.22 Lansdowne SCH reports the most common physical health conditions to be: asthma; sexual health disorders; diet and nutrition; eczema; and dental issues. Other SCHs also find sexual health and nutritional issues to be common.

6.5.23 Lansdowne does not have the capability to manage children with all physical disabilities. Currently the SCH could manage sensory disability or minor physical disability, but will not have wheelchair access until the new build is

complete. With the opening of the new building Lansdowne is likely to be better equipped than most other SCHs for handling disabilities.

6.5.24 Sexual health needs at Lansdowne SCH are met by a trained member of staff SAS (Safe Around Sex) and referral to GUM, PSHE and sexual health services. This is consistent with most other SCHs.

6.5.25 Inpatient care (e.g. where a child has to stay overnight in hospital) requires additional staffing to ensure the child is safe and does not abscond. This is a challenge at all SCHs.

6.5.26 As with other SCHs, Lansdowne provides children with training and encouragement in personal hygiene.

6.5.27 There is some concern that there is very limited capacity for children at Lansdowne SCH to get sufficient exercise. This is an issue that is exacerbated by the additional land take of the new development.

6.5.28 Lansdowne SCH provides a good range of health promotion activities. This is consistent with other SCHs.

6.5.29 The specialist mental health services available to children at Lansdowne SCH are rather limited compared to other SCHs.

6.5.30 Lansdowne SCH reports the most common mental health conditions to be: self-harm; acute anger; eating disorders; learning difficulties; and attachment disorder. This range of conditions is consistent with other SCHs.

6.5.31 Lansdowne reports having appropriate facilities and staff training to manage children with learning disabilities. The majority of other SCHs also report having the capacity to manage low level learning disabilities.

6.5.32 Lansdowne SCH's on-site specialist alcohol and substance misuse care is similar to that at other SCHs.

6.6 Stakeholder interview with the SCH management

Management of health information

6.6.1 Lansdowne SCH's manager reports that the arrival health assessment information is recorded by the GP on a GP form. The record goes onto the child's file. The results of any screening test results are generally back within a few days. The same process applies to the LAC nurse's assessment. However this generally takes a couple of weeks to come back.

6.6.2 Currently each resident's health records are stored at the SCH in hard copy in a locked office. The SCH manager reports that the SCH is moving to a computerised system, however the electronic system will have limitations as Local Authorities lack unified national health IT systems for sharing information. A key requirement for the SCH is demonstrating the required forms are complete. The SCH manager notes that this is really only possible with paper forms as they are consistent between Local Authorities (whilst electronic systems are not). By contrast the LAC nurse holds a copy of the medial record for each child in a computerised form, which is regularly updated with information from the SCH and the GP.

Referrals

6.6.3 The SCH manger estimates that 90% of the children require some referral on to specialist health teams. The majority are for substance misuse and mental health, with significant duel referrals. The SCH manager reports that the referral process works, though there may be some time delay in getting an appointment. This is due to availability of consultants. There is no preferential treatment. The delay may not meet the child's needs in the time they are there.

> *We attempt to bring our children as up to date as possible with any outstanding medical matters from booster vaccinations, sexual health and substance misuse advice or treatment to orthodontic treatment. We do however run into difficulties when a child is here for a short time, as many medical interventions require a waiting list for a referral to a consultant and then further waiting for treatment. Sometimes referrals are not done until a child moves to a more permanent placement. This can delay treatment for quite some time.*

6.6.4 To improve the current referral system, the SCH manager noted that preferential treatment would be ideal in order to make the most of the opportunity when a child is stable. The SCH often finds that a child is on a referral waiting list in a different area and that the change in location means that the process has to be started over again.

6.6.5 The SCH manager estimates that a small proportion (less than 5%) of children do not receive appropriate referrals due to missing or delayed information (largely due to the chaotic lives led prior to arriving at the SCH).

6.6.6 The Under 19's Substance Misuse Team report that the Team does prioritise referrals by Lansdowne which can be made by the GP, LAC nurse or staff at the Home.

Nurse support

6.6.7 Currently a relatively high grade LAC nurse provides a limited period of dedicated time to the SCH (7 hours per week). The SCH manager suggested that it may be more appropriate to have a lower grad nurse who had the capacity to do more types of nursing, but who could still do health assessments. By reducing the nurse grade this would allow more time to be allocated to supporting the SCH. The SCH manager estimates that there is a need for the nurse to be on-site daily, with an allocation of approximately 20 hours per week (all daytime).

GP support

6.6.8 The SCH manager reports being very satisfied with the current GP. To improve the health assessment the SCH manger noted that the GP could be provided with additional resources to perform a more detailed assessment,

which would assist the nurse in developing a care plan without so much time spend chasing for previous medical records and notes.

Pharmacy support

6.6.9 The SCH manager notes that there have not been any problems with the pharmacy. They deliver medication and manage it using blister packs.

Departure handover process

6.6.10 The SCH manager reports that on departure the child's health care plan is offered to them. If the child does not what the health care plan, it is sent onto the LAC nurse for the next placement. The health care plan is only send on to parents with the child's permission. If the child is moving onto another looked after children placement then it would be automatically sent on by our LAC nurse to that placement.

6.6.11 The SCH manger described how ideally the staff at Lansdowne SCH would make contact with the placement and arrange for an appropriate person from the new placement to visit Lansdowne SCH. The young person would thus meet people from the new placement whilst at Lansdowne, then visit the new placement and do a trial overnight stay. The process should also involve discussion between the current and future placement on any medical issues or appointments so that there is a proper handover before a child's departure. However the Lansdowne SCH's manager noted that in practice there was rarely enough warning to make such a complete and managed transition a viable option.

6.6.12 At the point of discharge the SCH contacts the GP and dental practices by fax to discharge the registration of the child. Any medication held by the SCH is handed over at departure.

6.6.13 The SCH management recognise that the departure process can often be made more difficult by discharge happening unexpectedly, for example: poor Care Plans put in place late by the Local Authority; the child not meeting Secure Criteria at their Independent Review; or failing to obtain a further Secure Accommodation Order via the courts. The SCH management noted:

> *The best handovers are done in a planned way with time to organise and collate information. However this isn't always possible for reasons outside of our control and we have to do the best we can to prepare the child for a sudden move. No-one finds these situations acceptable, but we may well have to manage it.*

Counselling

6.6.14 The SCH management explains that counselling work done within the unit by the SCH staff begins straight away unless there are any reasons a young person is not up to it. The work aims to build relationships with the young people and offer them support at every juncture of their stay. It was noted that the admission can be a very traumatic time for the children, so key workers attempt to put them at ease and explain what is going on.

> *All our young people receive a therapeutic way of working within our setting. Their lives have been difficult in so many different ways and we aim for them to gain some understanding of this and how it has led them to Secure Accommodation. We do not allow them to see this period in their lives as any form of punishment but as an opportunity to progress and have a safer and better future.*

6.6.15 Any external counselling put in place by the Social Worker can take a while to arrange. This is often due to delay in identifying a worker either in their locality or close geographically to the SCH.

Dental services

6.6.16 The SCH management notes that generally the service is extremely good; however problems arise if orthodontic treatment or longer term treatment is required. Often the dental practice will not start something they themselves cannot finish within the time a young person is residing with us and so it can delay treatment until a child is permanently settled.

Opticians

6.6.17 It is reported that the opticians generally provide a very good service. There are a range of glasses for children to choose from (contacts are not recommended for under 16 year olds). Although there is a good choice of glasses, in reality the range is often limited to the free options as the Local Authority does not subsidise payments for glasses.

Substance misuse

6.6.18 The SCH management note that there is no admission service for substance misuse issues, which is often when support is most needed. It will generally take a few weeks to arrange an appointment with the local under 19's Substance Misuse Team. Any emergency treatment is provided by the GP.

6.6.19 If a child requires detoxification it may take several weeks to get sufficient support from the under 19's Substance Misuse Team. This means that there are difficulties if detoxification is needed on admission. The SCH can only monitor and support the child with their symptoms.

6.6.20 However the Under 19s Substance Misuse Service states that it is a response service, and is called by staff at the Home or other professionals. Their normal response time of five days can be shortened where need is more immediate, that Lansdowne is prioritised and that young people can be seen there on a same day basis. It seems therefore that young people can be seen at admission, if the referral is made quickly. Children and young people will be seen on average for a six week period with sessions of one hour once a week or more frequently if needed.

6.6.21 This difference in perception of the Under 19's Substance Misuse Team needs local discussion for a common understanding to be formed.

Smoking cessation care

6.6.22 The SCH management explains that the SCH operates a no smoking unit policy. This means that many of the children require immediate support with smoking cessation and do not get any till the smoking cessation team visit, which could be three weeks after admission. Consequently the children suffer with initial withdrawal with no substitute.

6.6.23 It is reported that many of the children only want to manage their symptoms and return to smoking after they leave the SCH. This may be a reflection that the current system is not effective. There appears to be a missed opportunity to provide a well-structured smoking cessation intervention during this period of relative stability in the child's life. As the adverse health outcomes associated with smoking are well documented, providing support and education that will lead to sustained reductions in smoking should be a priority.

Staff training

6.6.24 Staff at the SCH have NVQ Level 3 Caring for children (Or equivalent now QFC). The SCH management report that there are a variety of training courses available to staff and a strong team ethos of always striving for the best care and outcomes for the children.

6.6.25 Other than the support provided by the LAC nurse, the SCH staff do not have any medical training.

7. Conclusions and recommendations

7.1.1 The findings of this HNA identify that generally Lansdowne SCH is providing a good level of care which meets the majority of health needs of the resident looked after children. The report's recommendations address those areas where there is opportunity for improvement, as well as where provision will need to be scaled up following completion of the new facilities and the increase in placements that this entails. This information should be used by commissioners to make an appropriate financial allocation for the future health care of children at Lansdowne SCH.

7.1.2 The following section sets out the recommendations of this report. The recommendations are arranged by the source of evidence that supports this need. It is recognised that there is some repetition of common themes.

7.2 Primary care recommendations

7.2.1 It is recommended that on arrival at the SCH induction health assessments should be carried out as a priority and should be completed as a minimum within a week of arrival.

7.2.2 It is recommended that a discharge medical assessment is undertaken for all children prior to their leaving the SCH and a supporting health report (highlighting any future appointments or referrals) is passed to the next placement (subject to appropriate issues of confidentiality).

7.2.3 As the GP has expressed the view that there is capacity for health improvement with an additional GP time allocation per resident, it is recommended that additional time is made available for: more detailed admission medicals, including a prioritised GP lead detailed screening process; and better liaison between the GP and the East Sussex LAC GP (who is supported by a consultant paediatrician). Current time allocations are estimated to be approximately 20 minutes per resident for the admission appointment. It is recommended that this is extended to 30 minutes, with a further 10 minutes allocated to liaison with the LAC GP.

7.2.4 It is recommended that a more structured and supported smoking cessation program is available from admission. Such a service should reflect the stressful circumstances in which a child arrives at the SCH, including Nicotine replacement therapy where needed. It is recommended that the service provides a protocol for quick one-to-one advice and support including nicotine replacement therapy. Options should be considered for appropriate nicotine replacement methods including mints/patches via the local pharmacy. Provision should also cover weekends.

7.2.5 It is recognised that there are barriers to early off-site visits for induction dental care. It is therefore recommended that onsite dental assessment is undertaken (in line with some other SCHs) using the new onsite health room as soon after arrival as feasible. It is also recommended that provision is made for the additional escorts required to support offsite dental treatment, as required.

7.2.6 It is recommended that further discussion is held with the dental practice to explore ways in which more complex treatments could be started and then handed over to other dental practices should a child be discharged from the SCH.

7.2.7 It is recommended that induction optician visit should be carried out as soon after arrival as feasible. Such eye exams should include an assessment of eye health as well as visual acuity. It is noted that as with offsite dental visits there are resource implications for escorts to optician visits.

7.2.8 It is recommended that financial provision is made for subsidising glasses that meet the reasonable preferences of the child.

7.2.9 It is recommended that a revised approach to GP visits is developed that considers options to: increase staffing to provide escorts; increase the frequency of GP visits for non-urgent care and advice; or meet a greater proportion of onsite minor health care needs though an expanded nurse role (onsite daily), thus reducing the burden on GPs.

7.2.10 It is recommended that the practice continues to offer the option of a female GP if requested (the SCH typically has approximately 75% female residents).

7.2.11 It is noted that the new facilities will provide a sports hall, fitness suite and a larger outside exercise space. It is recommended that these are used to provide greater opportunities for exercise. In particular the quality and

diversity of the fitness suite equipment should reflect that, given the sites space constraints, it is the main opportunity for these children to get their daily recommended levels of exercise. The SCH should provide and encourage participation in daily 'fun' exercise classes as part of health promotion as well as social and educational activities.

7.2.12 It is recommended that there is improved support for healthy eating to reduce weight in overweight children at the SCH.

7.3 LAC system recommendations

7.3.1 It is recommended that the LAC nurse's hours are extended. Current hours per child are 1.4 hours per week (equivalent to two 3.5 hour sessions). Based on an estimate that demand for nurse time is closer to 2.5 hours per child per week: it is recommended that current nurse hours should increase to 12.5 hours per week or three and a half sessions (based on 5 children); and hours once the new facilities are open and the number of children increases to 7 should be 17.5 hours per week or approximately five sessions. This would allow a nurse to be onsite for one session each weekday. Sessions should be planned to ensure that there are daily periods when the nurse is available outside of education hours to see the residents. When not seeing residents the nurse should undertake other functions of the role, including inter alia: advising/supporting staff; liaising with other health professionals regarding treatment plans; and reviewing health or discharge plans. These recommended nurse hours would represent an approximate mid-point between the levels of nurse hours reported by other SCHs which range from 8.5 to 30 hours per week. The role could be provided by a Band 6 or 7 nurse (prescribing, and sexual health additional training would be an advantage). The time allocation could be split between more than one type/grade of nurse. However an important consideration is continuity and familiarity with residents.

7.3.2 It is recommended that the nurse position at Lansdowne SCH includes a lead in sexual health. It is also recommended that sexual health continues to be supported though other staff training specialties (GUM) and educational components in the curriculum.

7.4 Specialist recommendations

7.4.1 It is recommended that the psychologist's sessions are extended. Further time is required in addition to the current role of supporting staff, for a formal CAMHS mental health assessment of each child (i.e. to carry out mental health risk assessments, including interviews with each child, rather than just reviewing case notes). Such assessments should facilitate the timely access to treatment if any mental health care need is identified. A CAMHS assessment is estimated to take between one and two hours per resident. Current hours per child are 0.7 hours per week (equivalent to one 3.5 hour session). Based on an estimate that the additional mental health assessment time would be approximately double this requirement, it is recommended that: current psychologist hours should increase to 7 hours per week or two sessions (based on 5 children); and hours once the new facilities are open and the number of children increases to 7 should be approximately 10 hours per week or approximately three sessions. The additional time allocation needs to be planned flexibly with a large proportion of the average additional allocation per resident being used for an early assessment as soon after admission as possible.

7.4.2 It is recommended that the allocation of Consultant Psychiatrist time is described in a formal agreement. Current usage is estimated to be equivalent to approximately four two hour visits per year or eight hours (assuming two residents require two visits of two hours each). As this allocation appears to meet demand for a capacity of 5 residents, an increase to approximately 11 hours per year would be appropriate for a capacity of 7 residents. Added to this should be a provision for additional need associated with the high dependency bed in the new unit. The additional allocation this will generate is hard to estimate. It is therefore recommended that in formalising the Consultant Psychiatrist's time, a provisional allocation of 16 hours per year is made and this is reviewed after two years. However as the requirement for attendance by the Consultant Psychiatrist is usually an emergency, where there is requirement beyond the proposed hours, the visit should be made first and the contract reviewed afterwards.

7.4.3 It is recommended that as an urgent requirement, referral agreements are made with sending PCTs to allow for the possibility of psychiatric input or other specialist mental health care being made prior to funding agreement

being finalised. Provision should be made for interim funding to bridge any delay in financial agreements with the originating area authority to avoid adverse treatment outcomes for the children.

7.4.4 It is also recommended that for those residents where a need for additional mental health care is identified by the initial assessment, a greater range of therapists are available on-site as required, e.g. speech and language therapist; educational psychologist; mental health nurse; art therapist; drama therapist.

7.4.5 It is recommended that as a minimum Lansdowne provide facilities and staff training to support at least one child who requires use of a wheelchair (ground floor bedroom and ramp/lift access).

7.4.6 It is recommended that prior to Lansdowne SCH accepting any children with disabilities, it is confirmed that staff have the appropriate specialist training to safely manage their specific care needs.

7.4.7 Any need for the involvement of the Under 19s Substance Misuse Team should be referred immediately, with improved communication protocols being put in place to minimise any delay.

7.4.8 It is recommended that funding is provided for improved admission support to children with substance misuse issues, including immediate support with detoxification if required. It is recommended that an immediate care protocol and a treatment protocol are developed for managing residents with substance misuse issues, including alcohol. It is recommended that there is additional staff training to support such treatment and care. It is recommended that local mental health and substance misuse specialist services prioritise referrals from the SCH.

7.5 Process recommendations

7.5.1 Although all new arrivals are fully registered with the GP and a fast-track process is supposed to be in place for accessing previous medical notes of residents of SCHs, the fast-tracking of notes is not working effectively. It is recommended that on registration with the GP requests for children's notes should be fast tracked effectively. It is noted that this would support but not replace the current system of inquiries by the LAC nurse.

7.5.2 It is recommended that more efficient ways of accessing the past health history of vulnerable children within the NHS records system are developed, including prioritising by NHS administration of urgent requests for medical records of vulnerable children.

7.5.3 It is recommended that a method should be sought of supplying a better handover system to maximise value for money from the interventions achieved whilst at Lansdowne SCH. It is recommended that all health care arrangements put in place should be followed through on discharge. It is noted that where such future health care arrangement are within the health plan it is the social workers responsibility, however in some cases it may be appropriate for the LAC nurse to take responsibility for some arrangements. It is recommended that a clear allocation of responsibility is made between the SCH, LAC nurse and Social Worker for each health plan follow-up issue on discharge.

7.5.4 It is recommended that staff provide on-going encouragement and innovative solutions to providing the children with opportunities for exercise and a healthy balance diet. It is recommended that the responsibilities for health improvement are incorporated with the public health plans so that health improvement is a part of everyday exposure at the SCH. This should be supported by appropriate funding allocation by the Local Authority.

7.5.5 It is recommended that formal and informal communications between the multi-disciplinary team regarding the health and well-being of the resident children is improved.

7.5.6 It is recommended that there are improvements in communications about all the referrals made and that the GP practice is formally copied in on all communications when appropriate.

7.5.7 It is recommended that the GP practice is provided with a short social worker report about each child at admission; the information would include special needs especially educational requirements, mental health issues, and information about recent abuse including rape. The GPs are aware that sometimes there is no history and the child was just picked up in the Park or collected from accident and emergency following an overdose; however even having this history is useful when carrying out the initial assessment.

7.5.8 It is recommended that when a visit is requested by the home the GPs are given a clear understanding about how many children the home would like to have reviewed. Often the request is for one child; however when they arrive

they are asked to assess one or two other children; this creates time constraints as GP would not have planned this time allocation as part of their visit. In addition the doctors are unprepared; they could be better prepared if informed in advance including bringing all the NHS records of the relevant children with them.

7.5.9 It is recommended that prior to discharge the updated health plan, including the summary that the LAC nurse sends to the next placement, should also be sent to the resident's current GP (usually the SCH's GP) to be inserted into patient notes prior to any onward transfer of notes. Such notes should include a letter addressed to the future GP highlighting important follow-up care. For example any immunisations still required should be carefully documented to optimise the course being completed.

7.5.10 It is recommended that Dr Grey is directly involved in the planning of furnishing for the new health care facilities in the new building at Lansdowne SCH.

7.5.11 It is recommended that consideration be given to how the arrival period could be managed appropriately so that a variety of culturally appropriate meal options can be produced at short notice.

7.5.12 It is recommended that all children at Lansdowne SCH are always provided with such individual support, aids and equipment as they may require as a result of any particular health needs or disability. It is anticipated this requirement will be met through the facilities and equipment available in the new building.

7.5.13 It is recommended that departure planning is integrated into each child's care plan from the outset; as although the timing of a rapid departure cannot be predicted, the likelihood that this may occur is foreseeable. It is recommended that to support this, staff training for exit plans is revised to meet the challenge of having only limited time available to prepare children and to ensure appropriate handover of care. For example exit planning should be an on-going process that is initiated at arrival and continually reviewed and updated thereafter.

7.6 Implications for the Local Authority

7.6.1 It is recommended that a protocol is put in place with the Local Authority to manage arrangements for 24hr escorts should the need arise (so that negotiations do not delay urgent inpatient care). This may include financial provision for escorts during inpatient hospital care. It is estimated that approximately three weeks per year of such escorts are required.

8. Appendix 1: Lansdowne SCH Staff

Registered Provider and Managers Qualifications

Registered provider	Liz Rugg	BA in French/Italian MSW (Social Work) CQSW MSc in Family Therapy Advanced Award in Social Work MA in Public Service Management
Registered manager	Martin Sutcliffe	Registered Homes Managers Award NVQ Level 4 Management NVQ Level 3 Caring for Children and Young People RSA Qualified Youth Worker 27 years' experience working with adolescents 17 years residential experience

Staff Qualifications - Experience

Deputy Manager	Jane Sambrook	29 Years Residential Experience 1989 City and Guilds in Community Care Practice 1992 DipSW 1992 Diploma in Higher Education 2000 Certificate in Play Therapy 2000 Diploma in Play Therapy 2000 Post Qualification in Social Work Certificate in Management (Chartered Management Institute) Level 4
Group Workers	Carol Barrett	Internal Verifier Award A1 Assessors Award NVQ Level 3 Caring for Children and Young People 11 years residential experience
	Alison Berry	14 years residential experience NVQ Level 3 - Caring for Children and Young People.
	John Bowman	QP Certificate in Youth Work 4 years experience as a Youth Worker 12 years residential experience NVQ Level 3 Caring for Children and Young People

	Cherie Clarke	12 years residential experience Previous experience in working with addictive behaviours NVQ 3 Caring for Children and Young People
	Mary Collins	NVQ Level 3 Caring for Children and Young People TP3 – Teenage Pregnancy Advisor 10 years residential experience
	Mark Evans	NVQ Level 3 Caring for Children and Young People 16 years residential experience
	Carley Field	Skills for Care Induction/Foundation NVQ Level 3 Caring for Children and Young People 5 years residential experience
	Lee Hine	NVQ Level 3 Caring for Children and Young People 17 years residential experience 10 years attached to YOT 2 years project with NCH
	Susan Maycock	BA (Hons) Social Science A Level Sociology NVQ Level 3 Caring for Children and Young People 18 years residential experience
	Robert Phillips	NVQ Level 3 Caring for Children and Young People 20 years residential experience Therapeutic Crisis Intervention
	Susan Piercy	18 year's residential experience 5 years foster carer – adolescence and learning difficulties BA Hons Social Administration University of Sussex Diploma in Therapeutic Child Care – Caldecott College OCR/NVQ Aerobics Instructor with nutrition & healthy lifestyle planning
	Christine Rush	NNEB (nursery nurse) 14 years residential experience NVQ Level 3 Caring for Children and Young People
	Debbie Sutton	8 years residential experience NVQ Level 3 Caring for Children and Young People
	Nick McIvor	NVQ3 Health & Social Care for Children and Young People 5 year experience working with young people
	Roxanne Ghani	Diploma in Sports Psychology 9 years experience working with adolescents in custodial settings.

Teachers	Jean Long	B Ed 20 years experience working with young people with special needs
	Ed Godfrey	Sussex University - QTS BA (Hons) Canterbury Christ Church University - Diploma for Connexions Personal Advisor Sussex Connexions - Solution Focused Therapy East Sussex Youth Service - IQP Youth Work 3 years residential experience
	Tina Marie Bacon	BTEC - Diploma in Early Years Level 3 (Teaching Assistant) AS Psychology Grade B TA Induction Induction to Counselling TA3 2 years 6 years residential experience
	Holly Oddie	BSC Psychology 2:1 (Teaching Assistant) Specialises in Autism and Prada Willie Syndrome)
Night care officers	Lisa Coleman	NVQ Level 3 Caring for Children and Young People 10 years residential experience
	Michel Thorpe	NVQ3 Caring for Children and Young People 12 years care work experience 8 years working in a secure setting 3 years working with younger children 6 years residential experience
	Beverley Akinleye-Duffy	NVQ Level 3 Caring for Children and Young People NVQ Assessor 6 years residential experience
Admin. Staff	Donna Wilde	London Chamber of Commerce – Secretarial Studies Certificate London Chamber of Commerce - Shorthand RSA II Typewriting NVQ 2 - Youth & Community
Support Staff	Laurie Brian-Davis	Handyman
	Sheree Ellwood	Cook
	Linda Izzard	Domestic

Social workers	A pool of Sessional Workers, all of whom have undertaken the Warner recruitment process, are available as necessary.

9. Appendix 2: Review of standards and key performance areas

9.1.1 The following review was undertaken to inform the needs assessment. The outcomes of this review framed the comparative analysis of different SCHs that provide placements on welfare grounds.

9.1.2 The Children's Homes National Minimum Standards 2011, Department of Education, ISBN: 978-1-84775-868-2, together with the regulations such as the Children Homes Regulations 2001 as amended in 2011 form the basis of the regulatory framework under the Care Standards Act 2000 (CSA) for the conduct of children's home providers, including Secure Children's Homes.

9.1.3 The National Minimum Standards (NMS) 2011 and Children Homes Regulations 2001 (as amended) have been reviewed to identify the standards and key performance areas against which health outcomes for children and young people can be measured and compared with the other six secure children' homes.

9.2 Children's Homes Regulations 2001

9.2.1 The following section summarises the most relevant regulations from the Children's Homes Regulations 2001 as amended by the Children's Homes (Amendment) Regulations 2011.

9.2.2 Food: Regulation 13 requires appropriate provision of food which is: served in adequate quantities and at appropriate intervals; is properly prepared, wholesome and nutritious; is suitable for their needs and meets their reasonable preferences; and is sufficiently varied. Furthermore the regulations require access to fresh drinking water at all times and that any special dietary need due to health, religious persuasion, racial origin or cultural background is met.

9.2.3 Clothing: Regulation 14 requires the needs and reasonable preferences of each child accommodated in the home for clothing including footwear and personal necessities are met.

9.2.4 Health needs: Regulation 20 requires the promotion and protection of the physical, emotional and mental health of the children accommodated in a children's home. Specific requirements include:

- each child is a registered patient with a general medical practitioner;
- each child has access to such medical, dental, nursing, psychological and psychiatric advice, treatment and other services, as he may require;
- each child is provided with such individual support, aids and equipment as he may require as a result of any particular health needs or disability he may have;
- each child is provided with guidance, support and advice on health and personal care issues appropriate to his needs and wishes;
- at all times, at least one person on duty at the children's home has a suitable first aid qualification;
- any person appointed to the position of nurse at the children's home is a registered nurse.

9.2.5 Medicines: Regulation 21 requires suitable arrangements are made for the recording, handling, safekeeping, safe administration and disposal of any medicines received into the children's home.

9.2.6 Hazards and safety: Regulation 23 requires that all parts of the home to which children have access are so far as reasonably practicable free from hazards to their health or safety; and any activities in which children participate are so far as reasonably practicable free from avoidable risks.

9.2.7 Schedule 1 requires that the children's home's statement of purpose include arrangements made to protect and promote the health of the children accommodated at the home.

9.2.8 Schedule 3 requires that the children's home's case records include: any special dietary or health needs of the child; details of any health examination or developmental tests.

9.3 The Children's Homes National Minimum Standards 2011

9.3.1 The following section summarises the most relevant regulations from the Children's Homes National Minimum Standards 2011.

9.3.2 The main health requirements are set out in Standard 6: Promoting good health and wellbeing. This standard has the desired outcomes that: children live in a healthy environment where their physical, emotional and psychological health is promoted and where they are able to access the services to meet their health needs. The standard requires that:

- Children's physical and emotional and social development needs are promoted.
- Children understand their health needs, how to maintain a healthy lifestyle and to make informed decisions about their own health.
- Children are encouraged to participate in a range of positive activities that contribute to their physical and emotional health.
- Children have access to doctors and other health professionals, including specialist services, when they need these services.
- Children's health is promoted in accordance with their placement plan and staff are clear about what responsibilities and decisions are delegated to them and where consent for medical treatment needs to be obtained.
- Children's wishes and feelings are sought and taken into account in their health care, according to their understanding, and staff advocate on behalf of children.
- Staff have received sufficient training on health and hygiene issues and first aid with particular emphasis on health promotion and communicable diseases.
- Staff receive guidance and training to provide appropriate care if looking after children with complex health needs.
- The home has good links with health agencies, including specialist services where appropriate, such as CAMHS and sexual health services. The availability of such services is taken into account when deciding on admissions.
- Staff involved in delivering therapeutic interventions have appropriate training and expertise and access to regular supervision.
- Specific therapies are used only: where there is a clear and widely accepted theoretical or evidence base underpinning its effectiveness; and with the continuing agreement of the child's responsible authority or a person with parental responsibility and of the child concerned where the child is of sufficient understanding.
- Each child's wishes and feelings are sought and taken into account in their health care, according to their understanding, and each child has someone in the home who can advocate these for them.
- Medicines which are kept in the home are stored safely and are accessible only by those for whom they are intended.
- Prescribed medication is only given to the child for whom it was prescribed, and in accordance with the prescription. Children who are able and wish to keep and take their own medication, can do so safely.
- There is a written record of all medication, treatment and first aid given to children during their placement.
- The home has any physical adaptations or equipment needed to provide appropriate care for children.

9.3.3 In addition specific additional provisions are set out for secure children's homes in Standard 23: Secure accommodation and refuges. This standard has the desired outcomes that: Children living in a secure children's home experience positive support with their problems as well as security or refuge, and receive the same measures to safeguard and promote their rights and welfare as they should in other children's homes. The standard includes the requirements that:

- staff are trained in resettlement issues in order to prepare young people effectively for leaving the secure children's home; and
- there are explicit policies and procedures that effectively identify and counter risks of self-harm and suicide.

9.3.4 Other standards cover issues that have a bearing on the wider determinants of health, these include:

9.3.5 Standard 1: The child's wishes and feelings and the views of those significant to them. This standard has the desired outcomes that: Children know that their views, wishes and feelings are taken into account in all aspects of their care; are helped to understand why it may not be possible to act upon their wishes in all circumstances; and know how to obtain support and make a complaint.

9.3.6 Standard 2: Promoting diversity, a positive identity and potential through individualised care. This standard has the desired outcomes that: Children develop a positive self-view, emotional resilience and knowledge and understanding of their background. The standard includes the requirement that children are able to exercise choice in the food they eat and the cloths they ware (within reasonable limits).

9.3.7 Standard 3: Promoting positive behaviour and relationships. This standard has the desired outcomes that: Children enjoy sound relationships, interact positively with others and behave appropriately. The standard includes the requirement that the home has a clear written policy on managing behaviour, which includes supporting positive behaviour, de-escalation of conflicts, discipline, control and restraint, that all staff understand and apply at all times.

9.3.8 Standard 4: Safeguarding children. This standard has the desired outcomes that: Children feel safe and are safe. Children understand how to protect themselves; and feel protected and are protected from significant harm including neglect, abuse and accident. The standard includes the requirement that staff are trained in appropriate safe-care practice, including skills to care for children who have been abused. For providers who offer placements to disabled children, this includes training specifically on issues affecting disabled children.

9.3.9 Standard 7: Leisure activities. This standard has the desired outcomes that: Children are able to enjoy their interests, develop confidence in their skills and are supported and encouraged by staff to engage in leisure activities.

9.3.10 Standard 8: Promoting educational achievement. This standard has the desired outcomes that: The education and achievement of children is actively promoted as valuable in itself and as part of their preparation for adulthood. Children are supported to achieve their educational potential.

9.3.11 Standard 9: Promoting and supporting contact. This standard has the desired outcomes that: Children have, where appropriate, constructive contact with their parents, grandparents, siblings, half-siblings, families, friends and other people who play a significant role in their lives.

9.3.12 Standard 10: Providing a suitable physical environment for the child. This standard has the desired outcomes that: Children live in well designed, safe and pleasant homes with adequate space in a suitable location where there is access to the necessary facilities for a range of activities which will promote their development.

9.3.13 Standard 17: Sufficient staffing of the home. This standard has the desired outcomes that: Staff have sufficient numbers, qualifications and experience to meet the needs of the children.

9.3.14 Standard 18: Training, development and qualification of staff. This standard has the desired outcomes that: Children are looked after by staff who are trained and competent to meet their needs; and staff receive high quality training to enhance their individual skills and to keep them up-to-date with professional and legal developments.

9.3.15 Standard 21: Managing effectively and efficiently and monitoring the home. This standard includes the desired outcomes that: monitoring includes consultation with children about their welfare.

9.3.16 [The Children Act 1989 (Guidance and Regulations Volume 5) also sets out the requirement at paragraph 2.43 that the health of looked after children must be assessed at regular intervals and the child's care plan must include an individual health plan].

10. Appendix 3: Assessment of current NHS Funding Dec 2012 (approximate only)

	AREA	CURRENT ESTIMATE – DEC 2012	FUTURE ESTIMATE 2013	ANNUAL TOTAL 2013/14 £
1.	General Practitioner Health assessment	20 minutes - £21 per new resident 15-17 per annum	40 minutes - £42 per new resident 20 -24 per annum	1,008.00
2.	Primary Care – General	GP Practice retained - £100 per month	……..continued…….. Plus additional residents Plus Practice Nurse & increased GP time	1,200.00 (Local Authority) 480.00 3,972.00
3.	Health Improvement	Ad hoc + PHSE	TBC (included in Public Health plans) £100 per month	1,200.00
4.	LAC specialist nurse	Band 7 midpoint £550 per month 7 hours per week	Increase in hours to include restraint health check Band 7 - 3 sessions per week	6,600.00 12,900.00
5.	CAMHS Consultant psychiatrist	Ad hoc £100 per month	To include the High Dependency = £125 per month	1,500.00
6.	CAMHS Psychologist	Band 9, one session £205 per week (advice only)	……continued……. Plus Therapeutic Intervention for additional 2 sessions per month	10,660.00 21,320.00
7.	CAMHS Nurse	Band 7 , midpoint Ad hoc	One session per week (3 ½ hours)	6,600.00
8.	U 19 years substance misuse		Regular input plus increase (YJB to advise)	5,000.00
				72,440.00

Note - Not included: Dental and Optometric Services and smoking cessation

11. Appendix 4: Tasks and Functions of the LAC Nurse.

11.1.1 The SCH engages the services of a nurse from the Looked After Children's Team. The model employed is that a specified member of the LAC team provides on average seven hours a week to Lansdowne. This is distributed flexibly according to the needs of the Home but means there is not a regular session of attendance for example, to attend staff meetings or other information sharing.

11.1.2 The key tasks provided by the nurse are:

- New entrant assessments
- A new arrival requires more time in the early days and after that time is provided on an "as required" basis.
- writing care plans
- obtaining information to enhance the fragmented histories of the children
- updating care plans as more information is discovered,
- Monthly reviews of individual Health Care Plans to enable managers to monitor progress in all aspects.
- arranging health care appointments identified in the care plan (sexual health, drug addiction, vaccinations and immunisations, pregnancy testing and whatever else is needed to reverse chronic long term neglect),
- advising staff on current health problems as they occur, especially minor ailments and providing "triage"
- The LAC nurse is familiar with and can address the pain experienced by the children, or phantom pains and anxiety symptoms. In these cases delay whilst professional medical advice is sought, only increases the level of distress.
- Availability to meet the Ofsted requirement of a clinical supervision within 24 hours of restraint which should be available onsite;
- Referral for physiotherapy is via the LAC Nurse or GP
- Asthma care is provided on site jointly by the LAC nurse with the GP
- attending team meetings,
- managing discharge at short notice,
- outreach to new addresses with children,
- writing discharge referral letters where appointments have been set up in the locality of Eastbourne but may need to be made in the area of new residence.

11.1.3 Potential additional tasks for a larger residential group:

- training in sexual health management and prescribing;
- forming relationships with the young people to gain trust, and enable input to improve health status. This provides reassurance on unidentified lumps and bumps, the authority of clinical advice on minor matters, and the replication of the brief period when a GP visited frequently and added much stability to the young people in being on hand to deal with worries before they develop into greater anxiety;
- increased availability for staff support in advising on minor health needs which in an open community might be dealt with by consultation at the local pharmacist outlet;
- greater nurse support for health education and staff team meetings, and post-departure follow-up to ensure an appropriate handover is achieved.

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