Health Needs Assessment of Children in Care

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EXECUTIVE SUMMARY

There is strong evidence that children in care are at a higher risk of poor health, education and social outcomes than their peers who are not in care and these disadvantages persist into adulthood.¹

This needs assessment relates to the health and wellbeing needs of children in care (aged 0-17 years) including unaccompanied asylum-seeking children (UASC) and care leavers. The primary aim is to assess whether current services are meeting the health and wellbeing needs of this group of children.

The needs assessment presents the profile of children in care (CiC) in Suffolk and the wider indicators that local authorities are required to report to the Department of Education, followed by an analysis of their health and wellbeing needs, the current established services and service use.

The available evidence base on why children enter care, their risk factors, and their needs has been presented, however due to inclusion criteria of rigorously evaluated optimal models only, a notable lack of models were identified.

The views of professionals (n=31) and children (n=6) have also been sought as part of the process. Despite a small size, they provide valuable insight and have been presented to give further context to what works well, support the review of current service provision and highlight any further gaps which need to be addressed.

Key findings

Profile and characteristics

1. The numbers of children in care in England continue to increase and this same pattern is reflected in Suffolk. As of 31st March 2018, a total of 861 children were looked after by Suffolk County Council, (comprising of 790 non-UASC and 71 UASC children), at a rate of 56.3 per 10,000 children under 18 years.
2. The absolute number of children in care (excluding UASC) has increased by 11% (712-790) between March 2014 and March 2018. This increase is statistically significant.
3. The profile and characteristics of children in care and care leavers has changed considerably over the last few years, in terms of age, sex and need. This is highly influenced by UASC, who tend to be of a non-white ethnicity, to be older, and to have a main category of need relating to absent parenting.²
4. In the last five years, the proportion of children in care (including UASC) aged 15-17 years has increased by 10% (27% to 37%). This increase was 6% when excluding UASC. In contrast, the proportion of those aged 0-4 and 5-9 years have reduced by 6% and 3% respectively.
5. There is a strong correlation between the numbers of children in care and deprivation. Higher rates of children in care and children on protection plans (CPP) (excluding UASC) are seen in the 10% most deprived areas of the county.
6. The number of children in care in Suffolk are expected to increase slightly in the next twenty years, as the number of adolescents rises over time, particularly in Forest Health, Ipswich and Waveney.
7. The Social Mobility Index combines factors associated with the chances of someone from a disadvantaged background experiencing upward social mobility. Analysis shows Ipswich, Forest Heath, Babergh and Waveney fall into the lowest social mobility
category nationally. A gradual increase in the numbers of their adolescent populations are also expected in these areas, therefore this should be taken into consideration when focusing on improving outcomes for children and young people (CYP).

8. The main needs of children entering care are reported to be due to abuse or neglect, family dysfunction, family stress and absent parenting. In 2016/17 family dysfunction as a primary need was higher among Suffolk children (26%) compared with the national average (15%). Parental issues as reasons why children become ‘at the edge of care’ or come into care have also been highlighted. However, it must be noted, interpretation of these categories can vary, due to limited consistency in the reporting, therefore direct comparisons may not be valid.

9. The number of children in care who were adopted has decreased by almost 50% over the last five years (from 81 to 44).

10. As of 31st March 2018, the most prevalent placement type is in foster placements at approximately 56%, followed by those fostered with friends or family at 14%, indicating the bulk of placements (~80%) are in family settings.

11. The numbers of children placed in secure units/children’s homes/ hostels has decreased by 18.6% in Suffolk between March 2016 and 2017.

12. In 2016/17, 18% of Suffolk’s children in care were placed out of the county, reducing to 11% as of 31st March 2018. This is significantly better than national average (38%) and statistical neighbours average (17.6%) for 2016/17, highlighting Suffolk’s improved local provision. More episodes of out of county placements were accounted for in the adolescent age groups.

13. As of 31st March 2018, one in five children (20.4%) placed in the county were more than 20 miles from home which is significantly higher than the England average (4%) and statistical neighbours (15%) for 2016/17. Suffolk is a large county; however, it would be useful to review the local provision in areas where children in care live, to see if they meet their needs.

14. Suffolk has had high levels of placement stability over the last five years. Long term stability was 70.0% in 2017/18 similar to 67.7% in 2013/14. The proportion of children in care who had three or more placements in the previous year has also remained relatively stable, currently at 9.5%.

15. In 2016/17, 57.1% of children in care had a special educational need or disability (SEND) of any level and 29.3% of CiC had an EHC plan or statement. Analysis has further shown that the numbers of children with SEN may increase up to 18% in the next three years. In addition, nationally, 1 in 5 school children reported having a long-term condition or disability which affected their day to day activities. It can be assumed this prevalence would be higher among the CiC cohort as well as the wider children in need (CIN) cohort, therefore this is an area which may warrant prioritisation in the coming years.

16. The educational progress of Suffolk’s children in care has improved and is now better than national average in all areas except for Key Stage 2 Maths.

UASC

17. In Suffolk, from the month of April 2016 to March 2018, the numbers of UASC have increased 65% from 43 to 71.

18. Currently, UASC represent 8.2% of the whole CiC cohort, at a rate of 4.6 UASC per 10,000 children under 18 years, the highest compared to its statistical neighbours.

19. There are a significantly higher number of male adolescent UASC compared to females. Two females have recently joined this cohort, presenting different needs and challenges.
Health and wellbeing

Suffolk has made substantial progress on a number of indicators regarding the health and wellbeing of children in care. There have been marked improvements on the overall completion of initial health assessments (IHAs) for children in care as well as timely completion within 28 days (15.9% at the end of March 2018 compared to 2.3% end of March 2017). The recording of immunisation status and undertaking of dental checks are also statistically similar compared to national and regional averages.

However, there is a lack of information around the health behaviours and some health status of children in care. Therefore, the report uses national level research and locally undertaken work to estimate the health behaviour and health status for children in care. There are certain caveats associated with the data, which have been highlighted in the main report.

20. Referral information from IHAs show that those entering care have various health needs with high numbers of children presenting with emotional and mental health difficulties, incomplete immunisations, special educational needs with some requiring screening for vision tests.

21. Vulnerability to and harm from substance misuse is increasing. Using estimates reported in the Young People and Substance Misuse in Suffolk needs assessment, applied to the Suffolk children in care population, an estimated 30-50 children may have substance misuse problems. However, many young people may not perceive themselves to have a substance misuse problem, and thus do not access treatment. Therefore, this may be an area of potential unmet need with further work required, especially as prevalence could be higher amongst older age groups including UASC.

22. In Suffolk, between March 2017 and March 2018, nearly half of all children (47%) screened using the Strength and Difficulty Questionnaire (SDQ) were identified as having ‘a concern for their mental health needs. NICE estimates that around 45% of all CiC in the UK have a diagnosable mental health disorder and that 70-80% have mental health problems that are recognisable, applying this prevalence estimate to Suffolk, 388 children (356 children in care and 32 UASC) may have mental ill health.

23. Smoking, drinking and drunkenness are reported to have reduced amongst school age children, along with early sexual activity. However there has been a decline in adolescents meeting Chief Medical Officer recommended physical activity levels.

24. The England, Health Behaviour in School aged Children Study found:
   - Up to 65% of young people reported experiencing at least one health complaint on a weekly basis and this increased with age increase. Irritability, sleeping difficulties and feeling nervous were reported as the top three complaints.
   - One in five young people were reported to have a long-term condition or disability which affected their daily life, of which asthma (49%), other disability (36%) followed by ADHD (6%) were the highest conditions. Despite caveats, it can be assumed that school aged children in care would suffer from a number of these problems and that care leavers would report a higher prevalence compared to children in care, if these conditions were not picked up and addressed at early stages.

25. Self-harm is on the rise and is particularly an area of concern for teenage girls: around one third of 15-year-old girls reported having self-harmed nationally, equating to an estimated 11, fifteen-year-old female looked after children in Suffolk. Additionally, 13% of emergency admissions in Suffolk (for an accident/injury from 2009 to 2016) were due to a primary cause of ‘intentional self-harm’ in those aged 15-17 years old. Applying this estimate to the CiC population, would show an estimated 27 males and 14 females
aged 15-17 years. It must be noted that due to recording differences and data quality, the accuracy of these numbers may not be valid, however they highlight the notable prevalence of self-harm amongst young people.

26. UASC health needs are different from the indigenous children in care population. The main health issues reported are:
   - Communicable diseases (Tuberculosis, Hepatitis B, scabies, sexual health issues) and a need for catch-up preventive immunisations and screening.
   - Emotional and mental health issues (most commonly post-traumatic stress disorder (PTSD), anxiety and depression).

Local services

Challenges that children and young people’s services face in looking after young people, can range from substance misuse, missing episodes, child exploitation, disengagement with education, poor social skills, self-harming, gang related activity, and attachment disorders. To address these common issues, agencies in Suffolk are working jointly to support children and prevent further exposure or deterioration:

27. Children’s homes have developed close working links with main partners and services through:
   - **Child and Adolescent Mental Health Services (CAMHS)**: which cover all services working with CYP who have difficulties with their emotional or behavioral wellbeing.
   - **Connect Service**: the countywide service for children in care, which specialises in working with trauma, complex care or parenting issues, and offers specialist assessments, consultation, and a wide range of therapeutic interventions.
   - **Turning Point**: the dedicated drug and alcohol service for young people with a substance misuse problem.
   - **The Police**: working to prevent children’s involvement in crime.
   - **Make a Change team**: the countywide service for CYP who are at risk or are victims of child exploitation.

28. Data shows that Family Solutions, the edge of care service, have had high success rates of CIN and CPP avoiding the need for care at over 80%. Given such success rates it would be useful to explore further opportunities to expand their capacity working with CIN and their families. Similarly, Home Start Suffolk is a good example of provision working with vulnerable families through well trained and experienced befriending volunteers.

29. Applying NICE’s prevalence estimate of 45%, it is estimated that 388 CiC may have a diagnosable mental health disorder. When comparing this estimate to the 117 new referrals that were made to the Connect Service in 2017/18, it falls short. However, an average of 67 children per month received support from Connect and 11% of children assessed were referred to further specialist mental health services. Additionally, over 800 contacts attended face to face or telephone support. Therefore, indicating an adequate number of children being referred, assessed and receiving intervention by the Connect Service in 2017/18.

30. However, young people, professionals and service providers have raised concern about the difficulties of accessing mental health services, mainly referring to CAMHS. A principal challenge for CAMHS is the management and treatment of children in care who are not quite meeting the criteria for diagnosis of a ‘mental health condition’. Emotional and conduct issues may defy a psychiatric diagnosis yet are perceived by other stakeholders to be an issue where mental health services could be productively
involved. We were unable to access CAMHS activity data in view of assessing unmet needs. It would be useful to further review this to determine any unmet needs.

31. New innovative provisions have been developed to support UASC including:
   a. A Drama Therapist pilot service (commenced in June 2018) to support their emotional wellbeing and a translator service to meet language needs.
   b. The Grandmentors Scheme (whereby someone aged 50+ mentors a care leaver) is in the process of being tailored to meet the needs of UASC, as many lack adult/parenting figures in the UK. It is important to monitor the risk levels of these young people and their exposure to substance misuse, gang and sexual exploitation due to their living circumstances.

32. Mental health, accommodation and educational outcomes are some of the main challenges care leavers experience. The Leaving Care Service has made considerable steps to develop care leavers independence skills for transitioning into adulthood, however report the requirement of more close working with adult services and other partners.

33. New legislation in the Children and Social Work Act 2017, has extended the age eligibility to provide a care leaving service to those aged 25 years, suggesting the number of care leavers who could require support could be double the current cohort of 360 care leavers aged 18-21, therefore putting potential pressure on current resources.

Areas for improvement

1. In Suffolk, the completion of IHAs undergo a rigorous process, including a comprehensive assessment of a child’s physical and mental health and wellbeing, education, and parental information in order to provide a complete understanding of a child’s health and wider profile. IHA forms are additionally shared with professionals in health, social care, foster care as well as the young person and parents. There are some reported challenges in timely completion of IHAs, such as delays in social worker completion of paperwork due to limited capacity (delays in getting parent/carer consent and variable quality of completion of the forms). These areas require immediate actions from social workers.

2. Emotional and mental health issues (specifically access to services) were raised as a concern by children and professionals involved in stakeholder engagement, as well as accommodation and other service providers. As part of Suffolk’s Children and Young People’s Emotional Wellbeing Transformation Plan, the Emotional Wellbeing Hub, a newly developed provision, will improve access to this area. At the same time, a review of the current provisions and pathways to Connect, CAMHS and other wellbeing services would improve access to mental health support for children in care and care leavers.

3. The SDQ is an evidence-based tool for identifying children whose mental health needs should be investigated further, however it is not currently being used as effectively as it could be in Suffolk. Best practice is for completion of the SDQ at onset of care and then at twelve monthly intervals. Currently, a review of the SDQ process is being undertaken by CYPS to improve timely support and strengthen analysis of young people’s mental and emotional health and wellbeing. It is therefore recommended that the ongoing work to improve this process focuses on:
3.1. A review of the current process of sharing completed SDQs i.e. outcomes with other professionals, especially with mental health and wellbeing services.

3.2. Inclusion of SDQ outcomes when a child is referred to Connect and other wellbeing services.

4. Given the large number of adolescents displaying emotional and behavioural difficulties and mental health issues, developing a therapeutic service provision for adolescents to provide ongoing support for vulnerable groups of children is recommended.

5. Continued support for care leavers in the following key areas is recommended:

5.1. Access to services for emotional and behavioural difficulties still presents challenges- a review of the current provision for those requiring immediate support is recommended.

5.2. Further work is required to ensure adults services, foster carers, supported housing providers and other partners are supporting care leavers to develop independent skills to successfully transition to adulthood.

6. Suffolk should aim to collaborate with partners across the children in care system to collectively assess the extent to which the Suffolk system is adhering to the NICE ‘Looked-after children and young people [PH28]’ guidelines, to identify gaps in service provision and thus action to address this.

7. Suffolk should continue to provide high quality data to monitor outcomes and measure improvements through ongoing work to join data across different providers and services.
1.0 Main report

1.1 What is the issue and why is it important for Suffolk?

The aim of the Children in Care Health Needs Assessment (HNA) is to establish whether the current services relating to their health meet the needs of this group of children. Numbers of children in care (CiC) are increasing, therefore in light of increasing demand and changing characteristics a different approach and provision is now required. The Children’s Commissioner noted in the recently published report that “families with children have faced large cuts in benefit spending since 2010. This is likely to place severe pressure on a group who are already more likely to face relative poverty (almost one in three) than other demographic groups, such as pensioners (about a one-in-six chance)”.

The health and wellbeing of children in care encompasses their physical health but also their social and emotional wellbeing, and is influenced by multifactorial factors of the care they receive. There is strong evidence that children in care are at a higher risk of poor health, education and social outcomes than their peers who are not in care and these disadvantages persist into adulthood. Children and young people (CYP) who have experienced disrupted childhoods and inconsistent or broken attachments with their families, are also more likely to have mental health problems than their peers.

Research further highlights that parental issues (such as difficulties in relationships with parents and parental mental health) are reported to be one of the main reasons why children become ‘at the edge of care’ or come into care.

1.2 National and local context

In March 2015, the Department for Education (DfE) and the Department for Health published ‘Promoting the health and wellbeing of looked after children’. Key elements from the statutory guidance include:

- The corporate parenting responsibilities of local authorities which includes having a duty under the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, and the promotion of the child’s physical, emotional and mental health and acting on any early signs of health issues.
- The local authority that looks after the child must arrange for them to have a health assessment, and an up-to-date individual health plan, forming part of the child’s overall care plan.

Suffolk County Council’s (SCC), Children and Young People’s Services (CYPS) have been rated good in all areas in the most recent OFSTED pilot inspection (2017), putting the council in the top 25% of all Local Authorities (LAs). Relating to children in care specifically, the report mentioned that the LA makes “good use of its legal powers and acts decisively to protect children who are unable to continue to live at home safely and that social workers clearly understand the importance of achieving permanence for children in care”.

Due to this promising achievement, the council is dedicated to improving further, and as a result, one of the six transformational programmes for CYPS, is ‘CYP High Cost Demand-Children in Care’ which aims to reduce the need for children coming into care and ensure value for money of services for children in care.
1.3 Which population is this needs assessment about?

This needs assessment relates to the health and wellbeing needs of children in care aged 0-17 years including unaccompanied asylum-seeking children (UASC) and those leaving care. Children in care are also referred to as looked after children (LAC) and these terms are used interchangeably throughout this report. However, prior to discussing the health needs and outcomes, the report presents the detailed profile of children in care by the main indicators that all LAs are required to report to the Department of Education (DfE). Based on available information, it also attempts to provide a description of local provision, highlighting what works well and areas for further improvement.

The needs assessment is supplemented by a Literature Review on the available evidence base covering reasons why children enter care, their risk factors, and their needs. Of note is the National Institute for Health and Care Excellence (NICE) Looked After Children (LAC) guideline (2015)9 which covers how organisations, professionals and carers can work together to deliver high quality care, stable placements and nurturing relationships for children and young people (CYP) in care. However, it must be noted that due to explicit inclusion criteria in the literature review of only rigorously evaluated optimal service models for children in care, a notable lack of optimal models including best practice were identified.

As part of this needs assessment the views of professionals have been sought through online surveys, which were based on the main recommendations of the NICE guideline.9 In total 31 professionals responded (14 of which reported to work in care provision/face to face role, eight managers of services, four commissioners and another four working in primary care).

The views of young people in care and those leaving care have also been sought by the CYPS Engagement Hub. In total six young people were interviewed. Due to small numbers, views are not representative all young people in care and leaving care. However, they provide valuable insight and information to give context to what works well, as well as supporting the evaluation of current service provision and highlighting any further gaps which need to be addressed.

Multiple caveats are associated with certain data used in the report, due to small cohort sizes and non-uniformed coding of information across different sources, thus affecting their comparability. Where these sources have been used, it is explicitly mentioned.

2.0 Expected number, distribution and pattern by person, place and time

The term “children in care” includes all children being looked after by a local authority, including those subjects to care orders under section 31 of the Children's Act 1989 and those looked after on a voluntary basis through an agreement with their parents. Please note that throughout this report, unless stated/referenced otherwise, data from the DfE has been used, and to avoid the risk of disclosure the DfE has rounded numbers to the nearest five. Furthermore, please note that throughout the report national level and local level data of children in care from DfE is only available for the financial year ending March 2017, as data for 2017/18 is yet to be published. Where local data as of 31st March 2018 has been provided in the report, it is based on recording on local data systems.

2.1 Numbers and characteristics of children in care

The numbers of children in care in England continue to increase and this same pattern is reflected in Suffolk. In the year ending 31st March 2018, a total of 861 children were looked
after by SCC, (comprising of 790 non-UASC and 71 UASC children), at a rate of 56.3 per 10,000 children under 18 years.

The absolute number of children in care (excluding UASC) in Suffolk increased by 11% in the last five years from March 2014 to March 2018 (712-790) and this increase was statistically significant (Figure 1). This increase is in line with national trends.13

Figure 1: Numbers of children in care Suffolk, March 2014 to March 2018

Source: CYP IHUB, data and graphs for CiC Sufficiency Strategy, June 2018

2.2 Unaccompanied Asylum-Seeking Children (UASC)

Over the last few years, there have been observed changes in the characteristics of children in care. The profile of those becoming looked after and care leavers are highly influenced by the UASC cohort, who tend to be of non-white ethnicity, older age groups and with a main category of need relating to absent parenting.

After a large rise in numbers in 2016, the number of UASC continues to increase at the national level, now representing 6% of the looked after children population in England. Suffolk mirrors this trend. In Suffolk, between the month of April 2016 and March 2018, the numbers of UASC have increased 65% from 43 to 71. Currently, UASC represent 8.2% of the whole CiC cohort, at a rate 4.6 UASC per 10,000 children under 18 years, the highest compared to its statistical neighbours.

There are a significant higher number of male UASC compared to females. At the national level however, there has been a greater overall increase in female UASC – male UASC increased by 5% between 2015/16 to 2016/17, whereas females by 19%. Within Suffolk, all UASC are almost entirely all male, however recently Suffolk has taken on two female UASC.

The total number of children in care in Suffolk, once adjusted for the higher number of UASCs is mid-range compared to statistical neighbours.

2.3 Age

A good understanding of the age groups within the children in care population and the trends over time is essential for planning appropriate care placements. Figure 2 below shows the proportion of children in care by age group, over the last five years (2014 to 2018) including UASC.
In Suffolk, over the last five years, the proportion of those aged 15-17 years have seen an increase of 10% (27% to 37%). This increase was 6% when excluding the UASC. In contrast, the proportion of those aged 0-4 and 5-9 years have reduced by 6% and 3% respectively. However, the proportion those aged 10 to 14 years has remained stable over the last five years.

**Figure 2: Age group distribution of children in care as a % of total per year (inc. UASC)**

The trend in the age distribution of the UASC group, shows those aged 10-14 years have seen reductions in the last 5 years, from 10% to 4% during this period, however the overwhelming majority of UASC are aged 15-17 years. (See Appendix)

### 2.4 Sex

As of March 2018, 59% of children in care in Suffolk were male and 39% female.\(^4\) Over the last few years there have been greater increases in the numbers of children in care who were male –an increase of 9% in Suffolk between 2013-2017, compared to an increase of 4% at the national level. This difference has largely been driven by the increase in UASC over this period, majority of who are male. It must be noted that excluding UASCs, the profile of males in care have remained stable over the last five years.\(^6\)

### 2.5 Ethnicity

As of 31\(^{\text{st}}\) March 2018, data on the ethnic origin of children in care (including UASC) in Suffolk shows 75% of children in care are White British, compared with 88% of all children in the county. Over the last five years there have been small increases in the proportions of children in care of non-white ethnicity which is likely to reflect the increase in the number of UASC, who are predominantly from Eritrea, Sudan, Iran followed by Afghanistan.\(^2\)
2.6 Deprivation and inequalities
National level evidence shows a strong association between higher numbers of children in care and deprivation. CYPS and Public Health Suffolk undertook statistical analysis comparing children in care rates with the Index of Multiple Deprivation 2015 scores for Suffolk County and its statistical neighbours, with the aim of understanding the link between CiC numbers and deprivation. The results indicated a statistically significant, moderate positive correlation (r=0.37; P=0.1640). Indicating that in areas of Suffolk which fall in the 10% most deprived of the county, a significant increase in the numbers of children in care were seen. It must be noted that this increase cannot be attributable solely to deprivation and are most likely due to a combination of socio-economic factors that affect a child.

Additionally to provide background context to the importance of inequalities, the Social Mobility Index (SMI) sets out the differences between where children grow up and the chances they have of doing well in adult life. The index combines a collection of indicators (during early years, school years, youth and adulthood) that are associated with the chances of someone from a disadvantaged background experiencing upward social mobility. Out of 324 local authorities in England, any local authority ranking 260 or lower falls into the ‘cold spot’ (low social mobility category). Four out of seven Suffolk districts rank in the lowest category: Ipswich (261), Forest Heath (264), Babergh (270) and Waveney (314). As mentioned ahead these districts/boroughs are expecting gradual increase in the numbers of their adolescent population, therefore this should be taken into consideration when focusing on improving outcomes for children and young people.

2.7 Projection
The Office of National Statistics (ONS) data shows the number of all CYP aged 0-19 years is expected to increase by 3.5% in the next 20 years, with a notable increase in 10-14 and 15-19-year olds, therefore likely to place a higher demand on services such as secondary schools over the next two decades.

Projections for the number of children in care excluding UASC in Suffolk have been derived from ONS 2014-based population projections compared to mean annual age-specific rates of children in care. The number of children in care in Suffolk are expected to increase gradually as the number of adolescents rises over time, particularly in Forest Health, Ipswich and Waveney. It must be noted that this is the age that many children come into care including UASC. Furthermore, it is expected that the largest population increase will be for older people (aged 65+) living in Suffolk, which is likely to put further pressure on the LA and health and care budget, thus possibly affecting the resources available for children.

3.0 Children in the care system
3.1 Reason for entering the care system
The risk and protective factors for children in care are complex and their interaction is multi-levelled. However, the evidence on risk and protective factors is far from definitive and is limited in several ways.

When a child is assessed by children’s social care, their primary need is recorded. National level data from 2016/17, shows that 61% of children were looked after due to an initial need
of abuse or neglect, 15% due to family dysfunction, and 8% due to family in acute stress and 7% absent parenting.17

The proportion of children entering care due to family dysfunction and family in acute stress was higher among Suffolk children in this year compared with the national average accounting for 26% and 16% respectively. From several strands of work undertaken locally, parental issues as reasons why children become ‘at the edge of care’ or come into care have also been highlighted. Parental issues normally include difficulties in relationships with parents, parental mental health, substance misuse, parenting skills and parental history of abuse and trauma. However, it must be noted, interpretation of these categories can vary, due to limited consistency in the reporting, therefore direct comparisons may not be valid.

3.1.1 Link with Children in Need (CIN)

In March 2018 the DfE published a report on children in need of help and protection using 2015/16 data.18 Abuse or neglect was found to be the most prevalent primary need for children in need (CIN) analysed, found in around half of children assessed (50.6%). This was followed by needs relating to family dysfunction, identified in 17.4% of CIN, followed by acute stress at 8.7%. Suffolk children who received support from the designated edge of care service (who are predominantly CIN or CPP) had similar common features such as parental behavioural issues, families who have had previous (unresolved) referrals, long term neglect, emotional abuse and children who have had several moves in family life.

The two most prevalent factors associated with being a CIN, were domestic violence for half of the children assessed (49.6%) and mental health, (including both parental and child) in 36.6% of all assessments.18

Many characteristics of children in care overlap with CIN, as they form part of the CIN cohort, hence more preventative provision working with families and young people at an early stage is vital.

There is increasing evidence that children and families also feel that early intervention is crucial. For example, results from a consultation carried out in London, Liverpool and Newcastle reported that 43%(122) of children and young people who were in care or care leavers believed that they would be able to stay with their families if more support was available at an early stage.19 At the same time 36% of the children and young people thought that even if there had been more support to them and their families, they would still have needed to come into care.19

Furthermore, the National Foundation for Educational Research (NFER), conducted focus groups with parents seeking their views on entering care. Findings show that two thirds of parents stated that they would like help sooner, and both practitioners and families felt that more help should be offered to families when they have ‘low level’ needs to prevent their needs escalating. Some parents said they were not sufficiently aware of the organisations that could help them. Others felt that they were not being listened to or that services (particularly education and children’s social care) were not acting quickly enough to help them.20

3.2 Children who have started and ceased to be looked after

Data on children entering care and leaving care is provided in a different format for Suffolk level data compared to national data and is based on information available at the time of writing this report. This is a complex area and further analysis is required.
3.2.1 Children starting to be looked after

Nationally, the number of children started to be looked after has continued to rise. From 2012/13 to 2016/17 the numbers increased by 13%, and from 2015/16 to 2016/17 there was an increase of 2%. By age group over this period, there was a slight fall in the proportions of children aged under 5 years and an increase in the proportions aged over 16 years entering care, which is likely to reflect the increase in the number of UASC.

In Suffolk, CYPS and Public Health have analysed local data of the number of children starting and ceasing to become looked after for the three-year period between 2015/16 to 2017/18 for children in care (both including and excluding UASC-See Appendix). Though not directly comparable to the national data, trends can be seen. The absolute number of children entering care (including UASC) has increased by 4.7% in Suffolk, when excluding UASC it has decreased by 2.9% over this time period. Similarly, there have been slight falls in the number of children aged under 5 years and a slight increase in the numbers aged over 15 and over entering care.

3.2.2 Children ceasing to be looked after

The number of children ceased to be looked after, fell by 2% from 2015/16 to 2016/17 nationally. The largest age group of children ceasing care are those aged 18 years and above, increasing 22% in the last five years, which is likely to reflect the increased number of children in care including UASC over the time. Children aged 1-4 years ceasing to be looked after has fallen by 28% since 2014, which is likely a reflection on falls in the number of children that have been adopted.

In Suffolk, from 2015/16 to 2017/18, there has been an 18% increase in the children in care (including UASC) ceasing to be looked after. With a 15% decrease of those aged 0-4 years over the last three years, and an 80% increase of those aged 18 and over ceasing to be looked after, reflecting higher numbers entering care as well as UASC.

3.3 Legal status

Most children are looked after under a care order, followed by voluntary agreement, and a small number of children are looked after under police protection or involvement with the Youth Justice System. National data shows that from 2013/14 to 2016/17, the number of children under a care order has increased by 26% to 50,470, whereas the numbers under voluntary agreement has fallen.

Over the past four years the numbers of placement orders have fallen. In 2013/14, placement orders represented 14% of children in care whereas as of 31 March 2017, only 7% were on placement orders. This is in line with decrease of the numbers for adoption and adoption placement orders granted nationally. Legal Status data in Suffolk as of 31st March 2018 shows that 56% of children in care were under full care orders, 25% were in accommodation under S20, 13% were under interim care orders and 7% with a placement order granted.

In Suffolk, the number of children in care who were adopted has seen vast decreases (almost 50%) over the last five years, decreasing from 81 in 2013/14 to 44 in 2017/18. In terms of the
number of children ceasing care due to a special guardianship order (SGO), this represented 15 children as of 31st March 2018.

3.4 Placement of children in care

Nationally as of March 2017, 75% of those looked after were in foster placements, 17% were fostered by a relative or friend and 1% were placed with a carer who is also an approved adopter or where they were subject to concurrent planning. There has been a 14% increase of children placed with parents in March 2016 compared to March 2017, similar to Suffolk. (increase of 16%).

Most recent data for Suffolk placements is available as of 31st March 2018. In Suffolk, the most prevalent placement type was foster placements at approximately 56%, followed by those fostered with friends of family at 14%. Therefore, indicating the bulk of placements (~80%) are in family settings. Following this, around 12% were placed in independent living placements and 4% were placed with parents. Adoptive placements (3.5%) and other placements (3%) were the least prevalent placement type (see Appendix).

Direct comparisons of England and Suffolk are available between March 2016 and March 2017. The numbers of children placed in secure units, children’s homes and hostels arrangements increased by 3.8% between March 2016 and March 2017 in England, compared to a decrease of 18.6% in Suffolk. In this same time period, the number of children placed in adoption reduced 14.3% nationally but increased 56.0% in Suffolk (from 25 to 39).

In 2016/17, 18% of Suffolk’s children in care were placed out of the county, reducing to 11% as of 31st March 2018. This is significantly better than national average (38%) and statistical neighbour average (17.6%) for the financial year 2016/17, highlighting Suffolk’s improved local provision successfully meeting the needs of children. More episodes of out of county placements were accounted for in the adolescent age groups.

As of 31st March 2018, one in five children (20.4%) placed in the county were more than 20 miles from home, which is significantly higher than the 2016/17 England average (4%) and statistical neighbours average (15%). Suffolk is a large county; however, it would be useful to review the local provision in areas where children in care live.

3.5 Placement Stability

Research shows that improving placement stability can lead to better outcomes for children in care. Strong case planning and additional placement choice are a number of ways suggested for improvement. Furthermore, the prominent role for foster carers and residential carers in promoting stability has been highlighted in research, as stability helps to facilitate positive relationships with peers, carers and social workers and enhances feelings of safety and security.

The proportion of children in care in Suffolk with long term stability of placements (those who have been looked after and in the same placement for 2 years) is relatively high with ~70.0% in 2017/18 similar to 67.7% in 2013/14. In terms of the proportion of children in care who had three or more placements in the previous year, this figure has also remained stable over the last 5 years, approximately 9.5% as of March 2018.

The Children’s Commissioner’s report on Stability Index of April 2017 noted that despite recent improvement, the instability of placements, a high turnover of social workers and a
requirement to move schools remain the experience for many children. Data from this report show that children in care were over three times more likely to move school mid-year than children who were not in care. For those in care, there was also a correlation between placement moves and mid-year school moves, with placement moves being the strongest predictor for mid-year school moves once other factors had been accounted for.

The stability index shows the East of England had the highest proportion of children in care (9.31%) with mid-year school moves. Statistics for social worker changes were not available, however, the report suggested that, unsurprisingly, there was also correlation between the number of placement moves and social worker changes.22

In terms of the total number of changes (including placement/school-moves or social workers changes) encountered during the year, the stability index report found that 19% of national children experienced two changes and 5% experienced three or more changes, with the report concluding that 35% of national children in care overall had significant levels of instability against the various measures.22 Suffolk level information regarding these areas have not been published, therefore it would be useful to review this when accessible.

3.6 Reasons for care ceasing

National data shows that in 2016/17, of the 31,250 children who ceased to be looked after, 32% returned home to live with their parents or relatives, 14% were adopted, 12% due to a special guardianship order, 15% left care for independent living and 14% were living independently in supportive accommodation.

In Suffolk, in 2016/17, of the 295 children who ceased to be looked after, 29% returned home to live with their parents or relatives (compared to 24% in 2015/16), 18% were adopted, 10% were given a special guardianship order (compared to 17% in 2015/16), 24% left care for independent living (compared to 17% in 2015/16) and 18% were living in ‘other’ placements. (Figure 3)

Figure 3: Reasons for care ceasing in Suffolk, East of England

3.7 Missing children

Nationally, in the year ending 31 March 2017 there were 10,700 children looked after who had a missing incident, which equates to 10% of all CiC during that year. 50% of the missing incidents were by children placed in secure units, children’s homes or semi-independent living
accommodation, 33% were by children in foster placement and 14% by children living independently.

In Suffolk, 2017/18 year to date data shows 1406 missing episodes compared to 1053 in 2016/17. It must be mentioned that a missing incident or episode in a child can be from the same child multiple times and is not reflective of how many children go missing in total. This data should be read with caution, as Suffolk is one of the LAs that have a different recording system, therefore may lead to an overestimate.

Data from missing episodes from a number of different care settings is available for three years from 2014/15 to 2016/17. The reported numbers of missing children over the three years have considerably increased by all agencies except two (Family/SO/SGO and Children’s Home Agency). This is a positive step for Suffolk, as all providers are improving their recording/reporting in view of improving and understanding the situation for missing children.

3.8 Length of time in care

The length of time children spend in care has remained relatively similar over the last two years, with males spending longer in care than females. Comparison of length of time in care (including UASC) over the two year period from 2016 to 2018 shows that the largest increase has been in durations of 0-1 months (increase of around 45 children) and 2-4 years (increase of around 60 children). The largest decrease has been for durations of 1-2 years (decrease of around 100 children). (Figure 4) Data further shows, that looked after children of older age groups from 10 years onwards, tend to spend longer durations in care.

Figure 4: Length of stay in care by duration 2016 and 2018

3.9 Education

NICE highlights the need to improve education for looked after children and young people. Across all stages of education children in care have lower attainment than non-looked after children. Children and young people in care are more likely to experience high educational needs compared to the general population; they are several times more likely to need an
Education, Health and Care (EHC) plan (previously Statement of Special Educational Need) and are much more likely to be excluded from school and to leave school with no qualifications. Some children in care have a positive schooling experience and achieve well in their education and research indicates that these children and young people are more likely to be female, and experience placement stability within a foster care setting where the carer is committed to helping and supporting the young person in their studies.21

Latest available data from the DfE shows in 2016/17, 57.1% of children in care had a special educational need or disability (SEND) of any level, compared to 58% in 2015/16.

29.3% of children in care had an EHC plan or statement in 2016/17, compared to 30.5% in 2015/16. Analysis has further shown that the numbers of children with SEND may increase up to 18% in the next three years, therefore this may be an area which may warrant prioritisation in the coming years.6

3.10 Educational progress

The latest available data from 2016/17 shows Suffolk’s educational attainment on a range of indicators compared with the England average as well as its statistical neighbour (SN) average, a snapshot is provided in (Table 1) below. The progress of Suffolk’s children in care has improved in all subjects and Key Stages over the last two years. It is now better than national average in all areas except for Key Stage 2 Maths. Table 1 below, further shows that whilst the percentage of children who reached the expected standard in Key Stage 2 reading and writing is significantly higher than the national and SN average, for mathematics this is lower (though not significant).

The percentage of children in care classified as persistent absentees has remained steady over recent years and they are now less likely to be classified as persistent absentees than all children and much less likely than children in need. However, exclusions from school of looked after children are consistently higher than for those who are not looked after. Absenteeism and exclusions are both issues that have been identified as an area of improvement, and actions to reduce this are explained below.

Table 1: Suffolk’s eligibility, performance and progress of children in care, 2016/17

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Suffolk</th>
<th>England</th>
<th>Statistical Neighbours Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of eligible children who reached the expected standard in key stage 2 reading</td>
<td>60.6</td>
<td>45.0</td>
<td>42.4</td>
</tr>
<tr>
<td>Percentage of eligible children who reached the expected standard in key stage 2 writing</td>
<td>66.7</td>
<td>47.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Percentage of eligible children who reached the expected standard in key stage 2 mathematics</td>
<td>42.4</td>
<td>46.0</td>
<td>43.7</td>
</tr>
<tr>
<td>Percentage of eligible children who reached the expected standard in key stage 2 reading, writing and mathematics</td>
<td>36.4</td>
<td>32.0</td>
<td>31.1</td>
</tr>
<tr>
<td>Percentage of children at the end of key stage 4 achieving a pass in English and mathematics at grade 4 and above</td>
<td>14.9</td>
<td>17.5</td>
<td>17.2</td>
</tr>
<tr>
<td>Average of Attainment 8 scores for children at the end of key stage 4</td>
<td>17.6</td>
<td>19.3</td>
<td>18.3</td>
</tr>
<tr>
<td>Percentage of sessions missed due to overall absence</td>
<td>4.7</td>
<td>4.3</td>
<td>4.6</td>
</tr>
<tr>
<td>Percentage of looked after children who were persistent absentees</td>
<td>10.1</td>
<td>10.0</td>
<td>10.6</td>
</tr>
<tr>
<td>Percentage of looked after children with at least one fixed period exclusion-2015/16</td>
<td>11.5</td>
<td>11.4</td>
<td>13.2</td>
</tr>
</tbody>
</table>

Source: CYPS Analysis, 2016/17

3.10.1 Virtual schools

What is being done

For many children in care, conventional school learning may not be effective, and as a result they require 'alternate provision', 3.8% of Suffolk’s children in care have received a reduced offer of provision. Looked after children who are permanently excluded are eligible for full-time provision. Furthermore, Pupil Referral Units (PRUs) have been established for many years to enable children who have been excluded get an education whilst their problems are addressed. In Suffolk the latest data shows the percentage of children in care attending a PRU was 6.8%.

A personal education plan (PEP) has been introduced with the aim to improve educational outcomes for children in care and is required when a child comes into care. It includes the views of all relevant persons involved in the children’s educational and wider life, and through SMART targets categorises how these needs will be met. Latest data shows an improvement in PEP’s were audited to be adequate, from 85.3% in March 2017, to 95.7% in March 2018. This can be accredited to new and more robust monitoring systems within this department.

The Pupil Premium Grant (PPG) for children in care aims to raise the attainment of disadvantaged pupils of all abilities to reach their potential. The grant currently £2,300 per child per year and is managed by the Virtual School Head (VSH).

Furthermore, the newly revised MyGo employment support offer alongside the revised Youth Support Offer aims to ensure all young people, including in care/care leavers receive a holistic, tailored and dedicated support offer to move them into education, employment or training.

In Suffolk as of January 2018 there are also now extended duties for Virtual schools, who are required to ensure that sufficient information is available to their setting, and their appropriate arrangements to meet training needs, schools can identify signs for potential mental health issues such as trauma and attachment difficulties.
4.0 Health and wellbeing of children in care

The health and wellbeing of children in care encompasses their physical health but also their social and emotional wellbeing and is influenced by multifactorial factors of the care they receive.9 The backgrounds and experiences of children in care are likely to make them particularly variable to poor health outcomes. Coming into care often means that frequent placements and school moves lead to common health issues and routine health checks and health promotion initiatives, are overlooked. Children and young people who have experienced disrupted childhoods and inconsistent or broken attachments with their parents and families are also more likely to have mental health problems than their peers.

The health and wellbeing need of the general children in care cohort, UASC and care leavers share common features but differ on a number of levels also. Therefore, in this following section the report presents the health needs of the three different cohorts of children separately, with information on services/service user data where available. Good quality long-term placements and accommodation are crucial for children in care and have a direct impact on health and wellbeing,12 therefore accommodation information is also provided for these groups.

5.0 Health behaviour

A balanced diet during childhood and adolescence is important for good health and development and can prevent both immediate and long-term health problems such as obesity and heart disease. As young people move from childhood through to adolescence they begin to have more control over their own food and drink choices and the eating habits young people adopt are often carried through to adulthood.24

In 2014, a Health Behaviours in School Children (HBSC) survey in England was undertaken as part of a cross-national study by the World Health Organisation.3 The England HBSC Survey involved 5,335 young people aged 11-15, including young people regardless of their background.

The survey found that 13% of children reported never eating breakfast and only 38% reported eating five portions of fruit and vegetables every day. 14% of young people reported drinking energy drinks at least 2-4 times a week with 5% drinking it daily. Girls (17%) were more likely than boys to report engaging in weight reducing behaviour (11%).

Additionally, physical activity levels amongst adolescents are in decline potentially causing long-term health implications. Only 15% girls and 22% boys are meeting the Chief Medical Officer’s recommended daily amount of at least 60 minutes of activity per day.4

Of course, there are caveats associated with the generalisability of the HBSC survey to the children in care population, however, it can be presumed that children in care will reflect a large proportion of the same health behaviours reported in the survey. Therefore, it is important that all professionals working with young people particularly with vulnerable groups, promote healthy eating habits and opportunities to support young people to be physically active.

5.1 Health complaints

The HBSC survey further found that overall, 65% of young people (59% of boys and 71% of girls) reported experiencing at least one health complaint on a weekly basis. This proportion
increased with age for both sexes. The highest proportion was reported to be irritability (35%), sleeping difficulty (34%), feeling nervous (31%) followed by headaches (29%), feeling low (26%) and dizzy (22%).³

Half of all young people reported experiencing two or more health complaints at least once a week. Children in care and those leaving care often report poor health also, therefore, when such complaints are reported to professionals, prompt investigation and action should be taken.

5.2 Long-term health conditions and disability

Within the HBSC survey, 22% of young people reported having a long-term condition (LTC), disability or medical condition. Out of which 24% reported that their condition or disability impacted negatively on their participation in education. If this prevalence estimate is applied to the Suffolk children in care population aged 11-15 years, this would give an estimated 115 children with a LTC or disability.³

As mentioned before, this is further highlighted by the high numbers of children with a special educational need or disability (SEND) in Suffolk and projected increases in children with SEND¹ therefore individuals within this group of children are likely to need to make considerable use of specialist CYP services.

Almost half of the children in the survey (49%) reported to be suffering from asthma, a surprisingly high proportion, followed by ‘other disability’ (36%), ADHD (6%) and epilepsy and diabetes (2% respectively). Of those who reported a long-term condition, 59% reported taking some kind of medication for their conditions. It must be mentioned are multiple caveats associated with these figures, as many young people’s perception of conditions such as asthma are different and non-uniform, which can lead to significant over estimates.

However, it can be assumed that the school aged children in care cohort would suffer from a number of these problems and those leaving care would report a higher prevalence of these conditions, if they were not picked up and addressed at early stages.

Therefore, good quality and timely initial health assessment and annual reviews are crucial to identify these children at early stages and support them to effectively manage their conditions to improve their outcomes.

5.3 Emotional and mental health wellbeing

Annual completion of the Strength and Difficulty Questionnaire (SDQ)¹ for children in care between the ages of 4 and 16 is mandated for all local authorities.² The SDQ examines potential symptoms relating to emotions, conduct, hyperactivity, peer problems and pro-social behaviour and calculates a total difficulties score. Higher scores are predictive of higher rates of mental disorder. Ranges of normal, borderline and abnormal scores have been calculated by the developers of the SDQ to enable assessment of results. The SDQ is completed by the

¹ What is the SDQ, Youth in Mind-http://www.sdqinfo.com/a0.html
² Audit Commission, NI 58 Emotional and Behavioural Health of Looked After Children, 2011
child’s parent/carer or teacher, with calculation of scores dependent on who has completed the form.

The local authority is responsible for the administration of all SDQ’S which includes: The collection of completed SDQ, Marking the SDQ, Storing the data, Sharing the SDQ with health and education.

NICE estimate that around 45% of all CiC in the United Kingdom have a diagnosable mental health disorder and that 70-80% have mental health problems that are recognisable to carers, teachers and social workers. There are caveats to the application of this prevalence to another area, however if this estimate is applied to the Suffolk children in care population, it can be estimated that 388 children and young people may have a mental health disorder. A 2003 report examined the prevalence of mental health disorders in CiC as categorised by the SDQ. Overall, it found that 42% of 5-10-year-olds and 49% of 11-17-year-old Suffolk children in care had a mental health disorder.

In 2012, Public Health Suffolk audited 408 SDQ forms and made the following two conclusions:

- The SDQ results audited suggest that there is a higher mental health care need for CiC in Suffolk than for the general national child population. The results also suggest that the need is greater in boys than in girls and in the 5-10 age group than 11-16. The impact of the abnormal scores for elements of the SDQ is high for all groups aged over 5, which highlights the importance of the predictor findings for the family or care network around the child, not just the child alone.
- Currently, the SDQ is not being used as effectively as it could be in Suffolk. It is being completed by parents/carers in isolation as there is no teacher or service user derived information provided. Additionally, changes in SDQ scores can be used to monitor potential mental health problems over time. Best practice is for the SDQ to be completed at onset of care and then at twelve monthly intervals. In Suffolk, the SDQ is not completed at onset of care.

In Suffolk SDQ’s have not always been completed in a timely manner to ensure they are available for a review health assessment. Of the 344 review assessments completed for Suffolk children in 2017/18, 288 SDQ’s were received by the health assessment team, however these came after the assessment was completed or the SDQ was not dated within the last 3 months to effectively inform the health assessment and outcome.

Additionally, between March 2017 and March 2018, nearly half of all Suffolk children (47%) screened using the SDQ were identified having ‘a concern for their mental health needs.

It must be noted there are plans to address some of these issues. A reviewing of the SDQ process is being undertaken by CYPS to improve timely support to address the young person’s emotional needs. There are also plans to change this business process, to utilise the software from the SDQ developers, with the intention to allow practitioners and professionals to access a child’s SDQ remotely and complete SDQ’s for the child to track their strengths and difficulties.

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3 Office of National Statistics (2003), The mental health of young people looked after by local authorities in England
at any time. However, until such software is developed and is in full use, it is important to consider how to manage the SDQ process effectively to identify mental health issues and provide a timely support.

There are also a number of factors which can negatively impact on a child’s emotional wellbeing such as the use of social media and increased internet usage. The Suffolk Cyber Survey undertaken in 2017, found that:

- Children are accessing social media before the minimum age limit; 80% of 13-year olds had a social media profile.
- 15-year olds are taking more risks and exposed to harmful content, more than any other age group.
- 44% of 15-year olds had seen pro-anorexia sites at least once or twice; 42% had seen sites promoting violence, hatred or racist views; 29% had seen sites encouraging self-harm.

In addition, chronic lack of sleep may also be an issue for many adolescents and could be associated with mental health problems. The HBSC Survey stated that 22% of young people reported not having enough sleep.

A lack of attention on the emotional wellbeing of children in care can lead to break down in placements and poor educational attainment. The importance of assessing self-harming/violent behaviour, substance misuse, self-esteem and feeling valued, community engagement, and family and peer relationships has been also highlighted in research.

5.4 Substance misuse
Vulnerability to and harm from substance misuse is increasing. The recently published Young People and Substance Misuse in Suffolk needs assessment reported that within social care assessments of CIN, CPP or CiC substance misuse was reported at 6-9% and thus considerably higher than in the general population of this age group in Suffolk. Although there are caveats associated with recording of this data, applying this percentage to children in care aged over 10 years, it can be assumed around 35-50 children may have a substance misuse problem in Suffolk.

In addition, lower numbers of children in Suffolk are also receiving intervention for substance misuse, latest data as of March 2018 shows that there has been a reduction in the number of CiC receiving an intervention (15%) compared to 75% in March 2017. It was reported that a large percentage of these young people do not want assistance, as they do not perceive drug taking as a serious issue.

A recent evaluation undertaken by Public Health of the screening tool (DUST) used for referrals to the local substance misuse service in Suffolk, Turning Point, looked at the profile of 376 young people aged 12-18 and found:

- Males account for 66% (247) of these young people.
- Almost two thirds (65%) of all young people were aged between 15-17 years.
- Of all young people 12% were children in care.
- Alcohol and cannabis use were the most common reasons that young people would like help and advice.
There is a high prevalence of young people with cannabis use on top of using other drugs/alcohol (secondary drug use).

5.5 Self-harm
Self-harm is on rise and is particularly an area of concern for teenage girls: around one third of 15-year-old girls reported having self-harmed. Recent analysis of emergency hospital admissions data shows that 13% of all emergency admissions in Suffolk for an accident or injury from 2009 to 2016 were due to a primary cause of 'intentional self-harm' in those aged 15-17 years old. Females represented 83% of these cases.

Additionally, the evaluation of DUST (mentioned above) in Suffolk reported that:
- Difficulty sleeping was the most commonly reported health problem by 44% of CYP.
- Low self-esteem, mild anxiety and frequent bouts of unhappiness/depression accounted for 35% of all young people.
- Self-harm was the fourth most commonly reported category under psychological health accounting for one third of all young people.

5.6 Sexual health
Consequences of poor sexual health can be serious. Unintended pregnancies and sexually transmitted diseases (STIs) can have long-lasting impacts on people’s lives. National research shows, the number of visits to genito-urinary medicine (GUM) clinics have doubled over the last decade, and that there is a clear association between sexual ill health, poverty and social exclusion.

Furthermore, the HBSC survey found that the proportion of 15-year olds reporting very early sexual activity has decreased significantly since 2002 which coincides with substantive reduction of teenage pregnancy at both national and local levels. In 2016/17, the proportion of care leavers aged 19-21 years in Suffolk who were not in education, employment or training (NEET) due to pregnancy or parenting was 5.8%, compared to the national average of 7%. However, teenage pregnancy is linked with deprivation, and as mentioned earlier in the report, there is more work to be done around children in care and care leavers living in areas with high deprivation in Suffolk.

5.7 Sexual exploitation
Sexual exploitation can happen to any young person – whatever their background, age, gender, race or sexuality or wherever they live. The risk factors include a history of abuse, (particularly sexual abuse), recent bereavement or loss, homelessness, low self-esteem being in or leaving care, living in gang affected neighbourhoods and lacking friends from the same age group.

The Child Exploitation and Online Protection Centre, undertook a thematic assessment of 2,083 victims of child exploitation and found that most victims were females. It is likely that male victims are under-represented due to difficulties in identifying sexual exploitation. Some victims were as young as 9-10 years old, however young people commonly came to the attention of statutory and non-statutory authorities at aged 14-15.

This study noted that children who go missing are at risk of sexual exploitation. The Suffolk system has a good reporting system for missing episodes, but it is important to explore why children go missing and raise awareness of the risks for sexual exploitation.
6.0 Existing services and service use

6.1 Initial health assessments

Evidence shows that accurate and up-to-date personal health information has significant implications for the immediate and future wellbeing of children and young people during their time in care and afterwards. Understanding their own ‘health history’ is an essential part of growing up securely. Inconsistent record keeping can lead to wrong decisions by professionals and adversely affect the child or young person.9

Statutory guidance states that children require an Initial Health Assessment (IHA) within 28 days of coming into care and a Review Health Assessment (RHA) every 6 months for children under 5 years and annually thereafter. In Suffolk, the completion of IHAs undergo a rigorous process, including a comprehensive assessment of a child’s physical and mental health and wellbeing, education, and parental information in order to provide a complete understanding of a child’s health and wider profile. IHA forms are additionally shared with professionals in health, social care, foster care as well as the young person and parents.

2017/18 referral information following an initial assessment for 436 CiC (which exclude Waveney and out of county IHAs) shows that those entering care have various health needs with high numbers of children presenting with emotional and mental health difficulties, incomplete immunisations, poor dental health and special educational needs and some requiring screening for blood borne viruses and vision tests. The following information is used for only illustrative purposes (see appendix for detailed information).

Of the 436 CiC, 16.3% required a referral to a dentist/orthodontist, 12% to emotional and mental health services, 11.2% for immunisations, 10.3% to an optician, 8.9% to a GP, 4.1% to a paediatrician, 3.6% to a health visiting/school nursing and 2.5% to a speech and language therapy services. Smaller number of referrals were made to audiology (12), sexual health (7), weight management (9), smoking cessation (6) and others.

The national performance data is collected for children who have been in care for 12 months or more and is reported yearly to the DfE. This data for Suffolk shows that as of 31st March 2018, 85.4% of children in care who have been in care for 12 months had received an annual health assessment. The average for 2016/17 was 87.6% in Suffolk, compared to the national average of 90%. As of March 2018, 87.5% of children in Suffolk had an immunisation status recorded. The proportion of children in Suffolk who had an immunisation status recorded in 2016/17 was 88%, on par with both the national average and with its statistical neighbours.28 Suffolk performed similarly in relation to dental hygiene with 86.7% of children having an annual dental check in 2016/17 compared to nationally 84.1%. Latest data shows as of March 2018, 83.5% of children in care had a dental check.14

Within Suffolk, IHAs are provided for children in care (excluding UASC) by the following health providers on behalf the Ipswich and East Suffolk CCG and West Suffolk CCG:

- **Integrated Community Paediatrics Service (ICPS)** – assessments are undertaken by a community paediatrician or a GP with special interest up to the age of 18 years. Assessments for all female UASC are also undertaken by the service.

- **East Coast Community Health (ECCH)** – assessments are undertaken by a community paediatrician up to 0-18yrs for those children from East or West Suffolk who reside in Waveney.
The SCC CiC Health Team works closely with partner agencies, considering the child or young person’s: feelings; fears; disability; race; culture and gender. All appointments are now offered at a convenient place chosen by carers and children/young people.

Of the 359 CYP who became children in care in 2017/18 and required an initial assessment, 74% (264) were the responsibility of the CCGs. Of the 264 assessments, 65% (172) of assessments were completed.

Within Suffolk, IHA completion within the 28-day timeframe was 15.9% at the end of March 2018, which is an increase from 2.3% reported at the end of March 2018. This evidences that timescales are improving, and the Suffolk is moving in the right direction.

Nevertheless, demand for services is increasing, there have been an increase in numbers of appointments made to clinics for IHAs, and also an increase in large sibling groups coming into care in the last few months.

Furthermore, a recent report on Initial Health Assessments in Suffolk,29 reported a number of challenges that affect the completion of IHAs with the expected timeframe, which include delays in receiving consent to undertake an assessment, limited capacity of paediatric health professionals causing delays in scheduling appointments, and delays in returning completed assessments to the local authority.

A recent review of IHA provision in Suffolk30 also highlighted increasing demand putting pressure on current capacity, importance of timely information to speed up initial screening, a difficulty of recruiting of GPs with specialist interest to undertake health assessments and higher numbers of children presenting with emotional vulnerability with immediate support for this being variable. The review also identified challenges around the role of nursing in the pathway, the interface of the assessments with the SCC Administration Hub, and clarity over assessment pathways for UASC.

However, it must be noted that Suffolk is working well as a system to address these issues:

- During 2017/18, improvement was made by the local authority to notify health services that a child has entered care by increasing administrative capacity.
- CYP now have a health action plan based on the information made available by the social worker through the pathway plan including any other information available to clinicians at the point of the assessment.
- Models of service delivery by medical professionals are being explored to increase capacity and improve timeliness of scheduling appointments.

6.2 Connect – The dedicated service for mental health and emotional wellbeing

The Connect service specialises in working with trauma and attachment difficulties, and complex care or parenting issues, and offers specialist assessments, consultation, a wide range of therapeutic interventions and support for CYP, their foster carers and adoptive parents. The service is provided through the ‘Child and Family’ pathway of Norfolk and Suffolk Foundation Trust (NSFT) and was fully implemented in September 2017.

The Connect team deals with all children in care below the age of 18, with the exception of those located in Great Yarmouth and Waveney, Thetford, and those out of area, and now offers services for children in care placed in Suffolk by outside authorities. Emergency mental health issues are dealt with out of hours by a shared emergency team. The A&A service is unified across mental health services.
There have been a number of new developments in the last year in Suffolk, to target the mental health and emotional wellbeing needs of vulnerable children.

As part of Suffolk’s Children and Young People’s Emotional Wellbeing Transformation Plan, the Emotional Wellbeing Hub is the new service for 0-25-year olds. This includes a new online referral form for professionals, a consultation helpline for expert advice and a new multi-agency team of emotional wellbeing practitioners. Also, in general, every school has a named Primary Mental Health Workers (PMHWs) that can provide bespoke support to all children including those in care and care leavers.

A principal challenge for Child and Adolescent Mental Health Services (CAMHS) regarding children in care is the management and treatment of children who are not quite meeting the criteria for diagnosis of a ‘mental health condition’. Emotional and conduct issues may defy a psychiatric diagnosis yet are perceived by other stakeholders to be an issue where mental health services could be productively involved. Emotional and behavioural difficulties are reported as an area of need across stakeholders, and a common reason for children and young people to enter crisis.

This was flagged up in a 2012 and 2016 needs assessment for CAMHS, yet service provision for these children remains unclear. However as mentioned ahead, CAMHS has a new and developing service called the ‘youth pathway’ for those aged 16+, recognising that turning 18 and becoming an adult can be a difficult transition for young people.

Recognition of these greyer areas can be seen in recent (2016) revisions of the service specification, with involvement of Connect in corporate parenting in cases where the placement is at risk of breakdown ‘acknowledging that this might not be a clinical intervention but giving the benefit of a psychologically informed approach’.

Those who fall into this gap in expectations are children with emotional and behavioural difficulties. It is clear they and their families are frustrated by these challenges, yet there is not a clear approach to how they should be managed. There seems an expressed need for these difficulties to be included in the specification for an existing or new service. Progress has been made, which is mentioned ahead in section 8.6, however due to multifactorial challenges this still remains an issue. The ongoing redevelopment of Connect may partly alleviate this as the intention is to redesign the service to support those “experiencing emotional distress and mental health problems as a result of neurodevelopmental trauma and attachment difficulties”.

An important point was noted in a recent report from the ‘Named Nurses for Safeguarding Children and Children in Care Team’; children who are ‘out of county’ but who reside in Suffolk currently have no mental health provision. The report states that this is being addressed by the CCGs and NSFT.

6.3 Connect activity

Activity data is available for the financial year 2017/18 of the Suffolk connect service.

In 2017/18 a total of 117 new referrals were made to the Connect service, out of which 7 were urgent. Referrals came predominantly from social services, GPs and ‘other’ services. Adolescents aged 10-15 years were the most prevalent age group accounting for 60% of male referrals and 64% of female referrals, followed by the 5-9 years age group. There were very few referrals from young people aged 16-17 years. A total of 100 CYP were discharged, out
of which 11 (11%) resulted in a Tier 3 service referral and two were discharged to other providers. A total of 813 contacts were attended to (face to face and telephone), equating to a monthly average of 67. (Table 2)

Regarding referral waiting times, data is available only for 2016/17, which shows that 75% referrals had their first contact within 18 weeks, although not directly comparable, a similar figure for 2017/18 would be expected.

Table 2: Snapshot service activity data between April 2017 and March 2018

<table>
<thead>
<tr>
<th>April 2017 to March 2018</th>
<th>Suffolk Connect Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total New Referrals</td>
<td>117</td>
</tr>
<tr>
<td>(no. of new urgent referrals)</td>
<td>7 urgent</td>
</tr>
<tr>
<td>Source of referral</td>
<td>Predominantly from (in descending order)</td>
</tr>
<tr>
<td></td>
<td>• Social services, GP, Other services</td>
</tr>
<tr>
<td>Age and sex breakdown</td>
<td>Age group</td>
</tr>
<tr>
<td></td>
<td>0-4</td>
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<td></td>
<td>5-9</td>
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<td></td>
<td>10-15</td>
</tr>
<tr>
<td></td>
<td>16-17</td>
</tr>
<tr>
<td></td>
<td>Not recorded</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
</tr>
<tr>
<td>Total discharged referrals out of which:</td>
<td>100</td>
</tr>
<tr>
<td>Discharged to Tier 3 services</td>
<td>11(out of 100)</td>
</tr>
<tr>
<td>Discharged to other providers</td>
<td>2 (out of 100)</td>
</tr>
<tr>
<td>Total number of attended contacts</td>
<td>813 consisting of</td>
</tr>
<tr>
<td></td>
<td>671 Face to Face (82 first time, 589 follow up)</td>
</tr>
<tr>
<td></td>
<td>Telephone 142</td>
</tr>
</tbody>
</table>

6.4 Accommodation providers for children in care

SCC have made a number of changes and progress in the last few years to support and improve the accommodation for looked after children. As seen below, this progress is a promising way forward.

- In 2016, SCC through a new contract, provided supported and supervised accommodation to 60 young people across Suffolk. They were also awarded a supported lodgings contract with the aim to place 20 young people.
- In 2018, SCC set up a residential disabled CYP home, which included 3 short-term emergency beds to improve placements for 16-17-year olds but further an emergency bed for chronically excluded young persons.
- SCC now quality assures providers whom they spot purchase with, and as a result there are several recommended spot purchase specialist providers who operate in the
county and discussions are in place with some whom are considering crossing the border into Suffolk.

6.4.1 Children’s homes for children in care

As of 31st March 2017, 70 children (rounded to the nearest 5) in Suffolk were in residential accommodation (secure units, children’s homes representing 11% of all looked after children in the county).33

Five children’s homes are maintained by SCC for housing children in care (see Appendix). Four homes are for those aged 11-17 years, and one home is for those aged 8-13 years. Suffolk’s children’s homes operate a unified referral service.

Challenges that children’s homes face for looking after young people, can range from substance misuse, missing episodes, child exploitation, disengagement with education, poor social skills, self-harming, gang behaviour and attachment disorders. There are however measures that are already in place to target these challenges, which should be highlighted. Good progress has been reported with placement sufficiency for those aged 16+ due to relationships with partners and providers. In addition, close working links have been established with main partners to address common issues that children are experiencing and prevent further exposure or deterioration. For example;

- Access to education support- there are good networks and relationships with mainstream schools and the virtual school and the ‘School Ready’ programme which offers children who are not accessing education, some basic education and structured learning.
- Links with the substance misuse service - each home has an assigned Turning Point worker to address drug taking behaviour and support for those required.
- Links regarding child exploitation- there is a ‘Make a Change’ worker assigned to the homes and active involvement with Child Exploitation groups.
- Multi-agency working- SCC works closely with the police. Each home is linked in with local officers who attend the homes team meetings & regularly meet with homes managers. There is an ongoing project with police with the aim to not criminalising children in care and giving consistent approaches to children who go missing.
- Access to health support- there are links into CAMHS, which include clinical supervision for staff, pre-planned and ‘drop in’ Connect consultations regarding children and children in care nurses.

6.4.2 Semi-independent accommodation

Semi-independent living is used for children in care as a supportive environment such as Housing Related Support bed spaces, Staying Close and Staying Put. As of January 2018, 120 children in care were accommodated in semi-independent accommodation and 25% (30) of them were aged 16-17 years. Furthermore, three of the above-mentioned children’s homes have semi independence flats attached to them.

6.4.3 Bed and Breakfast placements

Statutory guidance to the Children (Leaving Care) Act 2000 states that it would be inappropriate for 16 and 17-year-old care leavers to live completely independently, and also that bed and breakfast (B&B) accommodation should only be used very occasionally and only
in the short-term. The use of bed and breakfasts was low and only in an emergency when safe alternatives were unavailable/when a placement broke down. Due to newly commissioned alternative emergency beds in 2017, the use of B&B accommodation as of March 2018 is nil in Suffolk.

6.4.4 Foster caring service
Between March 2016 and September 2017 there has been a steady number of filled local authority foster placements in Suffolk, at a constant 400 placements. (See Appendix) When foster carers have supported adolescents, the results have shown to be largely successful. However, there is a challenge in recruiting new adolescent foster carers.

Data from CYPS show that numbers on the Permanence Tracker (which tracks permanence of a child), indicate Suffolk has a higher proportion of children with permanent placements. It must be noted that, for younger children it is easier to be placed in any placements, due to being more adaptable to changing environments. However, for older age groups coming into care, adapting to these placements can be difficult (due to challenges such as behaviour problems and vulnerabilities) which can therefore occasionally lead to placement changes into supported accommodation.

7.0 Health and wellbeing of UASC
Unaccompanied asylum-seeking children have significant physical, psychological and mental health needs, which can be influenced by a range of factors, such as experience of hardship, basic health care in their home countries, witnessing traumatic events in their home county and distress during their journey to the UK.

Nationally in 2016/17, 89% of UASC were assessed as having a primary need of absent parenting, 5% abuse or neglect, 3% family in acute stress and 2% of family dysfunction, with similar numbers reflected in the last five years. Suffolk level data is unavailable; however, we can assume Suffolk UASC needs would be similar to this.

The main differences that UASC population face in Suffolk relate to low levels of English speaking, reading and writing skills. UASC start their education in the UK at a much lower academic level (lower than the national average) and as a result, predominantly are enrolled in to the mainstream service ‘English for speakers of other languages’ (ESOL). Within Suffolk, colleges have efficient ESOL provision.

7.1 UASC health needs
A report from Kent Public Health Observatory reviewed the health needs UASC arriving in that county. It found that the most important health issues relate to:

- Communicable diseases (e.g. Tuberculosis (TB) screening and Hepatitis B, sexual health issues) and a need for catch-up preventive immunisations and increased screening.
- Physical health issues (dermatological and musculoskeletal problems were the most common, along with anaemia).
- Psychological problems (most commonly post-traumatic stress disorder(PTSD), anxiety and depression).
Furthermore, the Kent report provided an overview of issues that need to be considered when meeting the health needs of UASC. This ranged from increased responses to health assessments, more detailed mental health assessments, physical health interventions (such as for scabies) and the development of health passports (as per statutory guidance). Additionally they mention that UASC are at a higher risk of safeguarding issues such as going missing, female genital mutilation (FGM), trafficking, and these issues should be considered at the time of initial health assessments and other health contacts.²

Within Suffolk, the main health issues observed for the current UASC cohort are similar to that of Kent:

- Emotional and mental health issues are common due to trauma endured in their home country and as well as adversities experienced during their journey to the UK. Many suffer symptoms of Post-Traumatic Stress Disorder (PTSD) such as flashbacks/nightmares/insomnia, stomach pains, self-harm, anxiety and depression.
- Cases of TB and scabies, FGM and sexual exploitation are prevalent.

Criminal behaviour is prevalent among vulnerable groups and recently some of local UASC have been involved in criminal incidents. There is no concrete evidence to suggest any of the local UASC have been involved in gangs, but the service reports they are aware that some UASC may have connections with gang members and recreational drugs and alcohol.

As mentioned earlier characteristics of children in care are changing. Nationally, female UASC are increasing, as is reflected in Suffolk, with two female UASC recently arriving (via the National Transfer Scheme). Furthermore, sexual exploitation and FGM may be common in this cohort, therefore there are plans for this to be explored jointly with police.

### 7.2 UASC health services

Within Suffolk, the Health Outreach Service (HOS) undertake IHAs for UASC who become looked after by the local authority, aged between 16-18 years, often leading to an annual health review. A very small number of UASCs under the age of 16 are seen by West Suffolk Foundation Trust Community Services. Both of these services are commissioned by East and West CCGs. It was noted that the lack of background information about these children can be challenging, even in terms of validating age and name in some cases.

UASC have access to the same statuette services as the indigenous looked after population such as wellbeing services (through GP referrals). However as of June 2018, a new mental health service 'My View' has been piloted for one year for this group, offering drama therapy to help with issues of trauma and loss. Drama therapy has proven to be effective in addressing issues relating to trauma/PTSD/attachment for children who do not speak the native language of that country. Other services available to UASC include:

- Suffolk Refuge Support offers general advice and support to UASC, as well as additional homework club and activity/sports groups.
- The Refugee Council offers support to help UASC better understand the legal process to remain in the UK.
- The Grandmentors Scheme, (whereby a Grandmentor aged 50+ mentors a care leaver) is in the process of being tailored to the needs of UASC also, due to their lack of adult/parenting figures in the UK.
SCC is also in the process of setting up a UASC children in care council, to meet their specific needs.

7.3 Accommodation for UASC

The vast majority of UASC are placed in Ipswich therefore putting further pressure on the current resources available in this area. In 2017, two housing providers have provided placements for UASC, hence workers are from these providers are experienced in understanding the specific needs of this cohort.

UASC under the age of 16 years are usually placed in foster care, however there are low numbers of in-house foster carers which look after UASC, therefore agency foster placements are often used. Female UASC are placed within foster care due to issues with sexual exploitation.

As of March 2018, 52 UASC were placed in independent living, 15 in foster placement and 3 were fostered with friends or family.

Suffolk place a higher number of UASC compared to its statistical neighbours and have responded to this high demand efficiently providing a range of services for their challenging needs and are continuing to expand on provision for this cohort. However, based on evidence, the inclusiveness of mental health assessments and provision for specific health interventions need to be clarified with local providers. With the developing initiatives such as Grandmentors scheme, it is anticipated that these gaps may be addressed.

8.0 Health and wellbeing of care leavers

There are significant challenges care leavers face, most notably mental ill health, limited accommodation and poor educational outcomes. However, a breadth of positive work has been undertaken in Suffolk to improve outcomes for this group and are mentioned throughout the following section.

8.1 Mental health of care leavers

A recently published report from the Children's Charity Barnardo's found that:

- 46% of care leaver cases reviewed as part of this research were perceived by their personal adviser had mental health needs as having mental health needs.
  - 25% of the case files involved a young person who had faced a mental health crisis since leaving care.
  - 65% of young people identified as having mental health needs were not currently receiving any statutory service.
  - Focus groups discussions with care leavers revealed that those professionals supporting care leavers, often do not have sufficient understanding of mental health and how to support young people.

The Leaving Care Service in Suffolk noted that care leavers are more likely to suffer with mental ill health; notably anxiety, depression and self-harm are more prevalent. Although CAMHS offers a 'youth pathway' for those aged 16+ (recognising that turning 18 and becoming an adult is a difficult cut off point for young people), there are ongoing challenges with the admission into the CAMHS pathway due to their differing needs. However, the recent development of the ‘emotional wellbeing hub’ mentioned before, is hoped to plug this gap.
In addition, the SCC offer an enhanced care leaver health assessment to all care leavers within the age range of 17 years before they leave care. All children entering care are now issued a health passport when they complete an IHA, those care leavers who are over 18 and may have not received or have access to their health passport, are offered a health summary record to access their health histories.

Given the mental health needs of this group of young people, it is important to embed mental health workers within the leaving care team or upskill the service to understand mental health better. Furthermore, development of youth specific services aimed at those in their teenage years and early 20’s would prove beneficial.

8.2 Accommodation for care leavers

Another major challenge that care leavers face is difficulties securing and holding on to accommodation post 18 and therefore leading to homelessness in some cases. Research suggests that care leavers are sixty times more likely to be homeless than children who have not been ‘looked after’.

In Suffolk as of May 2018, out of 360 care leavers, 40 were ‘staying put’ with former foster carers, equating to 11.1%. Of these 360, 69 were UASC, who are currently transferred to independent accommodation at the age of 18 and two are ‘staying put’.

There are however strategies embedded within the Leaving Care Service to support this group of young people to secure and hold on to their accommodation post 16 years. For example, a Transition Panel for those aged 16+, looks at how a young person should be supported when they reach 18 years. It has been reported that it is imperative Adult Community Services (ACS) are part of the transitional planning to ensure that any young people with additional needs do not fall through gaps in service.

Due to the challenges care leavers face there is a need for the implementation of tighter checks so that care leavers can access good quality house sharing, and further implementation of pre-eviction panels, to ensure that the Leaving Care Service can support care leavers who are at risk of losing their homes and prevent homelessness, in order to implement the Homelessness Reduction Act 2017.

8.2.1 Educational Outcomes

In general, care leavers do less well in educational outcomes compared to the general non-looked after population. Only six percent of care leavers in the UK go on to attend university compared to 43% of the non-looked after population.

Suffolk, however is performing well in a number of educational indicators for care leavers compared to national averages. In 2016/17, 46% of care leavers (aged 19-21 years) were reported to be in education, employment or training, performing similarly with the England average and statistical neighbour averages (~49%). This figure has now increased to 67.1% in Suffolk as of March 31st 2018.

One of the indicators which can determine educational outcomes of care leavers, is of children in care aged 16-17 years not in education, employment and training (NEET). In 2016/17, the Suffolk average of this cohort was 28.7%, reducing to 24.8% as of 31st March 2018.
8.3 Leaving care service

The leaving care service in Suffolk works with young people in local authority care (16-18 years) and care leavers (18-25 years) to help them to prepare for independent living. The service runs county wide, working closely with other partner agencies. The leaving care service initially becomes involved at around the age of 15.5 years, where a leaving care social worker is allocated to support the current social worker with a Pathway needs assessment and plan. As the young person transitions through the leaving care service, at around the age of 18, they are allocated a personal adviser (PA) who will continue to support into adulthood.

New legislation in The Children and Social Work Act 2017, has extended the age eligibility to provide a service to those aged 25 years (previously from 21 years) even if the young person is not in education or training. The leaving care cohort is approximately 360 young people (aged 18-21 years) and it is estimated that almost the same number of relevant former care leavers could request a service for more advice or support as a result of the change. However even with additional funding from the DfE, it is unlikely to meet the extra demand for this cohort. Thus, this area will require additional resources.

It is important to keep in touch with care leavers to track their progress and outcomes, and local data shows that the leaving care service is in touch with over 90% of care leavers.

Developing young people’s independence skills is key to supporting their transition to adulthood. The service has a passport to independence programme which helps provide care leavers with more opportunities to be able to make a purposeful contribution to society. However more needs to be done to embed this across the service, to ensure foster carers, supported housing providers and other important partners are supporting the young person to develop these skills.

A recent project, which highlights good progress is ‘The Grandmentors Scheme’, whereby a Grandmentor (someone aged 50+) mentors a care leaver. This is a positive and unique service to the leaving care service and the service is aiming to progress this county wide.

One of the wider suggestions to improve the challenges that care leavers face is for Pathway Planning be continued by an Individual Reviewing Officer (IRO) post 18 years as well, to ensure that, there is more continuity in a young person’s pathway from 18+.

9.0 Edge of care service- family solutions

The report has discussed earlier about the overlapping needs and risk factors for children in need and children in care and importance of preventative provision to help children stay home. Therefore, the work of the designated edge of care service in Suffolk, Family Solutions is important to mention.

There is no clear definition for children at the edge of care, however there are common features of this cohort such as parental behavioural issues, families who have had previous (unresolved) referrals, long term neglect, emotional abuse, children who have had several moves in family life and who have educational issues. The main needs of children at the edge of care therefore are based around emotional, behavioural and physical health problems with each need requiring tailored support.

Family Solutions, works with young people and their families age 12+, however, also works with younger siblings in these families when needed. The Family Solutions Team (FST) uses
the crisis intervention model, where staff are deployed in each locality to ensure swift response and delivery of service, and additionally supports the re-unification of families. However, one of the challenges the service face are situations where referrals are not made prior to entry to care and to address this, a collaboration with EDS is being addressed to develop the crisis intervention model in a more systematic way.

Data shows that Family Solutions have a high success rate in children avoiding the need for care, and furthermore, that there is no clear evidence of recidivism. It must be noted that this data comes with the caveat that only those who were 11+ at entry and only cases referred from July 2016 are included (which is the point at which Family Solutions was better established with more rigorous recording).

In terms of CIN at the edge of care, of the 55 children receiving their intervention after 12 months of their intervention ending, 9 became CiC, the remaining 46 children had either remained CIN, become CPP or had their cases closed, Therefore, demonstrating a success rate of 84%. The highest successful closures were in those aged 16+. Success rates for CIN, 18 months after the intervention had ended were 86%.

For CPP at the edge of care, of the 8 children receiving their intervention, 7 had their cases closed therefore demonstrating an 87% success rate of cases closed 12 months after receiving intervention, and 75% success rate after 18 months.

Furthermore, to extend their service delivery to the meet the needs of Suffolk, the FST are in the process of tendering for a Family Functional Therapy (FFT) type intervention service (see section 12.0) which intends to increase the capacity to respond to different needs and support further reductions in the need for children remaining at home with family in a safe and protected environment.

10.0 Stakeholder engagement

10.1 Children's views

The CYP Engagement Hub conducted a series of interviews with young people in care and leaving care, focusing on their experience of services and identifying areas for improvement (n=6). Whilst this is a small cohort size, valuable insight is provided, therefore results have been included to provide context and supporting information.

Children were asked ‘what is working well?’ ‘what is not working well?’ and ‘how could this be improved?’ regarding a number of areas of their care.

When asked what was helpful and unhelpful to them before and after coming into care, many of the responses stated that social care was better perceived after the young people came into care and accredited this to the situation being calmer. Young people felt that things worked better when they had one social worker with whom they were able to form a good relationship. Parents’ unwillingness to work with social care were often cited as a reason for things not working well.

“A dedicated professional spending time with the young person 1-1 to get to know them and their situation & that the social worker was able to get things done”.
“the social worker should discuss this with the YP how they best feel they would understand”

“School counsellor, Pastoral support, Youth offending (having something to do, keeping busy)”

“We shouldn’t have so many social workers, we need help with emotional issues”

“We need help with emotional issues”

Young people were asked ‘what would have helped you not come into care/did you understand the plan?’ All the young people felt they knew the plan and the practical support was positive. One person replied they wanted to come into care earlier than it actually happened and felt that they were involved in the initial plan. The majority of young people highlighted the importance of quality relationships with social care staff.

When asked about the quality of ‘meetings and paperwork’, a few children felt that their experience of ‘meetings and paperwork post being in care was positive especially when they had members of family/support in attendance. One young person had a member of pastoral support attend with them and they felt supported. However, suggestions to improve this process were around young person friendly meetings (people, place, time) with a dedicated person for the young person to relay information/read documents. There was a notion that in all the chaos before coming into care, meetings/paperwork aren’t necessarily important to the young person at the time, rather it’s the relationships that matter.

“I never went but that was my choice as they were boring”

“My dad and my aunt being there was helpful”.

The comments highlighted that the support networks of these young people were often poor, due to the family issues experienced, and as a result there was great value in having a consistent support worker who was felt to be on the young person’s side.

“My family had fallen out so didn’t come although they were invited”

“there wasn’t a network”

When young people were asked what children feel are the most important things for children in care, these ranged around the following areas:

“Listening to our views, feeling safe and feel like part of the family and have a good placement”

“Opportunities and activities, education and work”

“Support with socialising and interacting with others”

Young people noted more work needed to be done with families to understand the young person’s needs and more consistent planning and better contact with their family. They also
mentioned better planning and communication (where possible) with the young person around when they are going into care.

“Someone is needed to work with my family, around how to understand me”

“Overall it has been a good experience. Communication could be better. I don’t feel informed about the things that are going on. I should have had less social workers and better hand overs.”

10.2 Professionals views

Public Health Suffolk conducted an online survey in September and October 2017, seeking comments from professionals working in different roles around children in care. The survey questionnaire was based on recommendations in NICE guidance. 31 individuals responded to the survey: 14 of these (45%) worked in care provision in face to face roles and a further 8 (26%) were in management roles. Other respondents worked in primary care or were involved in commissioning the service.

When asking professionals, about the current information sharing practices with different services involved in children care, 16 rated the information sharing practice as ok, although 10 rated it as very poor to poor. The corresponding questions asked what needs to be improved in this area, the three top themes that emerged were: more frequent information sharing, joint working with authorities and more staff capacity

“Communication between professionals needs to get much better - one database system would be ideal because we don't have access to everything and then can miss vital information.”

The survey also asked what Suffolk is doing well as a system to address the needs of children in care. Four people mentioned that the system worked well to act on concerns and five people mentioned health care and assessments in a positive way. Respondents also felt that the system in Suffolk was good at supporting carers and children and had good working relationships across organisations. Other answers focused on placement choice and social work.

“Good social care service - fostering, adoption, placements in family like settings Improvements with 16+ housing Positive key partner relationships - Police, Health”

“Priority is given to supporting and tracking the progress of children in care - We care about being a corporate parent.”

“staying put arrangements - good foster placements and in-house children's homes - overall good support from children's social workers”

Regarding gaps in the current provision of children in care, the majority of the survey respondents indicated that biggest gap in current provision of children in care was mental health support/provision followed by the speed and capacity of health assessments.

“Health services need to provide a more robust service to children in care and care leavers by introducing a service that does not only do health assessments
Two responses mentioned the need to improve placements for children with complex needs, two responses touched on provision for care leavers, and two commented on the importance of health intervention (rather than health assessments). Other topics raised were the importance of contraception, respite care, early intervention, and improving health assessment speed and quality.

When asked how many children get to know their carers before they move to a new placement, 81% of the survey respondents felt that less than half of children were able to get to know the adults who would be caring for them before they moved placement.

11.0 Assessment of unmet needs

To appropriately assess the needs of children in care in Suffolk, it is important to triangulate and evaluate the available data and views of stakeholders to understand whether existing Suffolk services are efficiently meeting the complex needs of these children.

As mentioned earlier, we have estimated the following health and wellbeing needs of children in care in Suffolk using the findings from the HBSC survey, the accompanying literature review and local service information.

Mental Health and emotional wellbeing

The assessment of the health needs and related services show that mental ill health is the most common condition among children in care, UASC and care leavers. Professionals working with children have raised their concern about timely health assessments and access to services affecting outcomes for this group of children. Additionally, children in care and care leavers have expressed their concern about difficulties accessing appropriate mental health provision. Therefore, indicating a potential unmet need regarding mental health and emotional wellbeing of this group.

As NICE suggests, around 45% of children in care may have a diagnosable mental health disorder. When applying this prevalence estimate to the Suffolk children in care population, it is estimated that 388 children may have a mental health disorder. When comparing this estimate to the 117 new referrals that were made to the Connect Service in 2017/18, it falls short. However, an average of 67 children per month received support from Connect and another 100 were discharged during this period. 11% of children assessed in 2017/18 were referred to further specialist mental health services.

Additionally, 813 contacts attended their service out of which over 92% were offered through face to face provision. This indicates an adequate number of children being referred, assessed and receiving intervention by the Connect Service in 2017/18. Until more detailed information on children receiving support from specialist mental health services is available, it is difficult to make an informed judgement if the expressed unmet need is a real one.

However, the evidence clearly shows that currently, the SDQ is not being used as effectively as it could be in Suffolk. There is considerable research evidence that the SDQ is a valid initial
screening tool for identifying children whose mental health needs should be investigated further. It is not designed to be used as a clinical diagnostic tool. Screening tools are measured by their sensitivity\(^4\) and specificity.\(^5\) When used optimally (jointly by teachers and parents/carers), its sensitivity for identifying any mental health disorder is 63%.\(^6\) Its specificity is 98%, if the SDQ prediction of “disorder unlikely” is used as a proxy for a negative test result.

Additionally, changes in SDQ scores can be used to monitor potential mental health problems over time. Best practice is for the SDQ to be completed at onset of care (by teachers and parents/carers) and then at twelve monthly intervals, however this is not being done in Suffolk, where it is being completed by parents/carers in isolation as teacher or service user derived information is not provided.

A main area of concern is that it is not known how results of the SDQ are shared and acted upon by professionals. Therefore, it would be useful to the both the referrers and the Connect service if SDQs are shared with Connect Teams when a child is referred to the service.

Currently, a review of the SDQ process is being undertaken by CYPS to improve timely support and strengthen analysis of young people’s mental and emotional health and wellbeing. There are plans to change the SDQ process in view to utilise the software from the SDQ developers, this will allow practitioners and professionals to access a child’s SDQ remotely and complete SDQ’s for the child to track their strengths and difficulties at any time. As a result, all children in care will have a SDQ completed where possible and progress of decline in the likelihood of developing or having strengths and difficulties as defined in the results can be monitored whilst interventions are changed / implemented or completed. Until such software is developed and is in full use, it is important to consider how to further support the review of the SDQ process to effectively identify mental health issues and provide timely support.

**Substance misuse and long-term conditions**

As mentioned in section 5.4 the Young People and Substance Misuse in Suffolk needs assessment reported that within social care assessments of CIN, CPP or CiC substance misuse was reported at 6-9% and equating to 35-50 children in care aged 10+ who may have substance misuse problem. Additionally, there have been reductions in the number of CiC receiving interventions for substance misuse.

Many young people may not perceive themselves to have a substance misuse problem, and therefore do not access treatment. Therefore, this may be an area of potential unmet need, and further work is required to address the challenge of improving the number of children with substance misuse problems receiving treatment, especially as prevalence could be higher amongst older age groups including UASC.

\(^4\) Ability to correctly identify positive results.

\(^5\) Ability to correctly identify negative results.

**Edge of care**

Suffolk has large numbers of CIN and CPP who are identified as requiring support from CYPS. The edge of care service works with this group of children and are delivering good outcomes with a success rate of averting CiC cases of over 80%. However, when comparing the numbers of CiC, with numbers of children Family Solution are working with, there is a difference, indicating potential unmet need. We acknowledge that not all CiC need intervention from this service and many receive support from other teams offering early preventative help.

In addition, higher proportions of children are entering the care in Suffolk for parental issues and family problems. Young people and professionals have expressed the importance of early prevention in identifying families in distress and providing support not only to the child but the whole family. This indicates, there may be potentially unmet needs supporting struggling parents known to services such as social care, drugs and alcohol and the police. It would be useful to review family facing preventative services in Suffolk to understand who these parents/families are and what support they require. Additionally, due to increased deprivation, low social mobility and expected increases in adolescent populations, it would be beneficial to target the boroughs/districts of Ipswich, Waveney, Forest Heath in Suffolk.

12.0 Evidence of effectiveness

A literature review was undertaken to support this work using the following questions as the base for the evidence search: This report presents the summary findings from each area; full detailed analysis is available in the accompanying full evidence review.

- Who are children at the ‘Edge of Care’?
- What are the risk and protective factors for children coming into care?
- What are the needs of children in care?
- What are the expected outcomes for children in care?
- What are the optimal service models for children in care?
- When is it safe for children in care to return to their family?

**Who are children at the ‘edge of care’?**

The Green Paper ‘Care Matters’ published in 2006 highlight that children services should on avoiding the need for care, except for those who truly need its support. The following areas have been indicated as essential for success of any early intervention with children and young people at the ‘edge of care’ and their families:

- Quality of the relationship between the social worker and the child or young person, and between the social worker and families
- Strong multi-agency working – this need to be at operational and strategical level, including strategic analysis and understanding of the needs of children in care accompanied by investment in services to address these needs.
- Preventative interventions that take place alongside assessment.
- Clear and consistent referral pathways to services.

Evidence based programmes and early interventions for children in care and children on the edge of care and their families are listed below in order of their effectiveness and include:
• **Multi Systemic Therapy**\(^{36}\) (MST) – an intensive intervention for children and young people aged 11-17 years and their families where young people are at risk of out-of-home placement.

• **Multi Systemic Therapy for Child Abuse and Neglect**\(^{37}\) (MST-CAN) – a type of MST for families where there is evidence of child abuse and neglect.

• **Functional Family Therapy**\(^{36}\) (FFT) – a ‘whole family’ intervention for young people aged 10–18 years with a history of offending or with violent, behavioural, school and conduct problems.

• **The Intensive Family Preservation Service**\(^{36}\) (IFPS) – services aimed at primarily providing short-term and intensive services.

• **Parenting programmes and interventions**\(^{36}\) – relies on the development of self-efficacy through learning the skills of sensitive and responsive parenting.

**What are the risk and protective factors for children coming into care?**

The risk and protective factors for children in care are complex and their interaction is multi-levelled, the current Assessment Framework triangle developed by the Department of Health in 2002 covers the wide-ranging factors:\(^{23}\)

![Assessment Framework Diagram]

It is important to highlight that the presence of one or more risk factors will not necessarily result in child abuse and neglect, just as the presence of protective factors does not guarantee that children will be kept safe. Risk and protective factors for physical abuse, emotional abuse, neglect and sexual abuse may vary. Risk and protective factors also operate differently as children grow.

**What are the needs of children in care?**

The needs of children in care are complex and they can include:

• **Health needs** – Coming into care often means that frequent placements and school moves lead to common health issues, including routine health checks and health promotion initiatives, are overlooked. \(^{38}\)
• **Attachment problems** - Studies show that children and young people who experience stable placements are more likely to overcome attachment problems and to succeed educationally, be in work, settle in and manage their accommodation after leaving care.\(^{39}\)

• **Educational needs** – Comparing to their peers, children and young people in care are several times more likely to have statement of special educational needs, to be excluded from school and to leave school with no qualification.\(^{10}\)

• **Physical or sexual abuse** – children and young people in care are more likely to be more vulnerable to abuse not only from foster or residential carers, but also from their family during access visits and from other children in care settings. They may also be involved in prostitution.\(^{31}\)

• **Social exclusion** – children and young people in care are more likely to lose contact with their families and communities of origin and become socially excluded through unemployment and poverty.

### What are the expected outcomes for children in care?

Reflecting the needs of children and young people in care as presented in the Assessment Framework, crucial factors that are likely to impact their outcomes significantly are summarised as follows:\(^{32}\)

- **Improving Placement Stability through**
  - Strong case tracking, and case planning to avoid drift and achieve permanence.
  - Increased placement choice, leading to improved matching.

- **Improving Educational Outcomes through**
  - An ability to remain in the same school after placement move(s).
  - The presence of ‘educational supports’ (for example: someone to attend school events, peer support)
  - Contact with an educational psychologist – which may also help to reduce the likelihood of placement breakdown.

- **Improving Health Outcomes through**
  - Fewer changes in placement and more stable placements.
  - Improved recording and assessment of a child’s health history, current health and wellbeing, including improved mental health screening.
  - Tailored health-related interventions.

### What are the optimal service models for children in care?

The literature review undertaken, had explicit inclusion criteria of only rigorously evaluated optimal models, therefore could not identify best practice available elsewhere, apart from NICE guidelines for children in care. It would therefore be useful for a further evidence review to be undertaken, specific to best practice models regarding children in care to inform shared learning.

NICE guideline [PH28]\(^{9}\) outlines that the key elements of the service for children in care should include and covers how organisations, professionals and carers can work together to deliver
high quality care, stable placements and nurturing relationships for children and young people in care.

Although the NICE guidance and other guidance produced by the government clearly outline the elements of service provision for children and young people in care, some researchers argue that there is mixed evidence about the features that characterise good children’s social care services, and a significant proportion of it is based on expert opinion and has not been tested quantitatively. The five key features that were highlight as important include to achieve successful service for children in care include:

- Workforce stability and engagement
- Leadership
- Inter-agency working
- Organisational culture
- Effective (IT) systems.40

When is it safe for children in care to return to their family?

National level research states returning home is an outcome for nearly 40% of children in care, up to half of the children who return home re-enter care because their home moves break downs and a third of them continue to receive poor care.41

Evidence from research highlight the following key areas in relation to reunification:

- The importance of considering reunification as early as possible
- The importance of high quality assessment and planning processes
- An emphasis on involving families throughout the reunification process
- The role of foster or residential carers in promoting stability

The timing of reunification is key but also ongoing support is required to achieve long-term success. Children can be successfully and safely reunited with parents who have been abusive or neglectful in the past. 41

12.0 Information gaps

The report has identified a number of information gaps which are as follows:

- Whilst local level data was available for some indicators as of 31st March 2018, DfE data for the financial year 2017/18 has not yet been published, therefore direct national and statistical neighbour comparisons were not available for 2017/18.
- The Literature review had inclusion criteria to explicitly include only rigorously evaluated optimal models, which did not identify any optimal models. A further evidence review would be useful to focus on best practice of any level elsewhere, for shared learning.
- Local data sources are dependent on recording in the data system, and thus may affect true values.
- No information was available to understand the profile and characteristics of parents and families.
13.0 Conclusions
The number of children in care in Suffolk are increasing both nationally and locally, thus putting pressure on current resources and service provision. Furthermore, the characteristics of the profile of the children in care cohort are changing, most likely due to the inclusion of UASC in the last few years.

The needs of children in care are complex and the main reasons for entering care are reported to be due to neglect and abuse, parental issues and family dysfunction. SCC is committed to improve outcomes for children in care whilst managing the increasing demand through its Sufficiency Strategy. As a result of strategic and operational work, children in care outcomes are improving in many areas. For example, the comprehensive and prompt provision of services and support for UASC despite their challenging needs, Suffolk’s children in care educational progress and improvements in levels of initial health assessment completion. Additionally, there have been vast improvements in accommodation provision and support (including children’s homes) and a substantial amount of work has been undertaken to improve outcomes for care leavers.

Despite this positive work, health behaviour and health issues of this group of children require further improvement. A large proportion of children in care are likely to have a long-term condition or disability which can affect their outcomes and future potential. Professionals working with children in care and service providers have a role to play to promote and support healthy eating, physical activity and reduce risk taking behaviour such as substance misuse, sexual activity and crime.

Mental health prevalence is high among children in care and care leavers with difficulty of accessing relevant services raised as the main concern from accommodation providers and health and care professionals. The current assessment tool (SDQ) for mental health conditions is not being effectively used and shared with the relevant professionals at Connect or other specialist services.

14.0 Areas for improvement
1. In Suffolk, the completion of IHAs undergo a rigorous process, including a comprehensive assessment of a child’s physical and mental health and wellbeing, education, and parental information in order to provide a complete understanding of a child’s health and wider profile. IHA forms are additionally shared with professionals in health, social care, foster care as well as the young person and parents. There are some reported challenges in timely completion of IHAs, such as delays in social worker completion of paperwork due to limited capacity (delays in getting parent/carer consent and variable quality of completion of the forms). These areas require immediate actions from social workers.

2. Emotional and mental health issues (specifically access to services) were raised as a concern by children and professionals involved in stakeholder engagement, as well as accommodation and other service providers. As part of Suffolk’s Children and Young People’s Emotional Wellbeing Transformation Plan, the Emotional Wellbeing Hub, a newly developed provision, will improve access to this area. At the same time, a review of the current provisions and pathways to Connect, CAMHS and other wellbeing
services would improve access to mental health support for children in care and care leavers.

3. The SDQ is an evidence-based tool for identifying children whose mental health needs should be investigated further, however it is not currently being used as effectively as it could be in Suffolk. Best practice is for completion of the SDQ at onset of care and then at twelve monthly intervals. Currently, a review of the SDQ process is being undertaken by CYPS to improve timely support and strengthen analysis of young people’s mental and emotional health and wellbeing. It is therefore recommended that the ongoing work to improve this process focuses on:
   3.1. A review of the current process of sharing completed SDQs i.e. outcomes with other professionals, especially with mental health and wellbeing services.
   3.2. Inclusion of SDQ outcomes when a child is referred to Connect and other wellbeing services.

4. Given the large number of adolescents displaying emotional and behavioural difficulties and mental health issues, developing a therapeutic service provision for adolescents to provide ongoing support for vulnerable groups of children is recommended.

5. Continued support for care leavers in the following key areas is recommended:
   5.1. Access to services for emotional and behavioural difficulties still presents challenges- a review of the current provision for those requiring immediate support is recommended.
   5.2. Further work is required to ensure adults services, foster carers, supported housing providers and other partners are supporting care leavers to develop independent skills to successfully transition to adulthood.

6. Suffolk should aim to collaborate with partners across the children in care system to collectively assess the extent to which the Suffolk system is adhering to the NICE ‘Looked-after children and young people [PH28]’ guidelines, to identify gaps in service provision and thus action to address this.

7. Suffolk should continue to provide high quality data to monitor outcomes and measure improvements through ongoing work to join data across different providers and services.
Glossary

<table>
<thead>
<tr>
<th>GLOSSARY Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
</tr>
<tr>
<td>CIC</td>
<td>Child in care</td>
</tr>
<tr>
<td>CIN</td>
<td>Child in need</td>
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<tr>
<td>CPP</td>
<td>Child protection plan</td>
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<tr>
<td>CYP</td>
<td>Children and young people</td>
</tr>
<tr>
<td>CYPS</td>
<td>Children and young people’s service</td>
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<tr>
<td>HNA</td>
<td>Health Needs Assessment</td>
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<tr>
<td>IHA</td>
<td>Initial Health Assessment</td>
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<tr>
<td>LAC</td>
<td>Looked After Children</td>
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<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>MASH</td>
<td>Multi-Agency Safeguarding Hub</td>
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<tr>
<td>NEET</td>
<td>Not in education, employment or training</td>
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<td>ONS</td>
<td>Office of National Statistics</td>
</tr>
<tr>
<td>UASC</td>
<td>Unaccompanied Asylum-Seeking Children</td>
</tr>
</tbody>
</table>

References

7. Centre for Child and Family Research Loughborough University. Mental health of Looked After Children in the UK - Summary.
Appendix

1. Children’s Homes in Suffolk

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Beds</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandra House</td>
<td>Bury St Edmunds</td>
<td>7</td>
<td>11 – 17 years (mixed gender)</td>
</tr>
<tr>
<td>Ashby House</td>
<td>Lowestoft</td>
<td>7</td>
<td>11 – 17 years (mixed gender)</td>
</tr>
<tr>
<td>Elizabeth House</td>
<td>Beccles</td>
<td>7</td>
<td>8 – 13 years (mixed gender)</td>
</tr>
<tr>
<td>Heather House</td>
<td>Martlesham</td>
<td>5</td>
<td>11 – 17 years (All female)</td>
</tr>
<tr>
<td>Redwood Lodge</td>
<td>Stowmarket</td>
<td>6</td>
<td>8 – 13 years (mixed gender)</td>
</tr>
</tbody>
</table>

2. Foster Care Placements

![Number of Filled Local Authority Foster Placements](chart1.png)

![Age 11+ Children in In-House Foster Care](chart2.png)

3. Number of placements by type (excluding UASC)

![Placement Type Breakdown](chart3.png)
4. Projections (excluding UASC), from 2017 to 2039 by gender.

5. Correlation of CIC numbers with deprivation
6. Entering and leaving care numbers by UASC and non UASC

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2015/2016</th>
<th>2016/2017</th>
<th>2017/2018</th>
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<tbody>
<tr>
<td>0 - 5</td>
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<td>18</td>
<td>28</td>
<td>28</td>
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</tr>
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</table>

No of children starting and ceasing to be looked after (excluding USAC) by age group.

<table>
<thead>
<tr>
<th>Year</th>
<th>2015/2016</th>
<th>2016/2017</th>
<th>2017/2018</th>
</tr>
</thead>
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<tr>
<td>No. children becoming looked after</td>
<td>146</td>
<td>136</td>
<td>139</td>
</tr>
<tr>
<td>No. children ceasing to be looked after</td>
<td>58</td>
<td>62</td>
<td>66</td>
</tr>
</tbody>
</table>

Legend:
- Blue: 0 - 5
- Red: 6 - 10
- Green: 11 - 15
- Purple: 16 - 17
- Orange: 18