

Clinical Characteristics of Children and Young People Looked after by a South-West England Local Authority in 2018

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Abstract

Background: The UK Department of Health has produced guidance on the statutory health assessment required for identifying and managing their health needs.

Methods and Design: We carried out a retrospective review of our looked-after children and young people (LACYP) caseloads in North Somerset Local Authority between Jan and Dec 2018 to ensure national standards are being met and provide a benchmark for future quality improvements.

Results: A total of 96 LACYP were identified, with equal Male/Female ratio, and average age of 82 months (ranging between 5 months and 18 years old). 58 (60%) of them were seen for only initial health assessments (IHA), while the others were seen for both IHA and Adoption Assessment (18%) or Adoption assessments only (22%). The average age of LACYP at IHA was 89 months, 20 months at Adoption health assessment (AHA) and 44months at review AHA. The average age of 38 LACYP who had either an adoption or review adoption health assessments (RAHA) was 3 years and 1 month compared to 9yrs 5 months for those who only had IHAs. 16 of the examined cohort (17%) ceased to be LAC within the year, with slight (56%) female predominance.

The largest proportion of LACYP planned for adoption were aged between 1 and 4 years (58%) with average age of 3 years and 1 month, while 24% were under 1 year, and 18% aged 5 to 9-year olds.

Twice as many LACYP were seen in Spring months (33%) compared to the those seen in Summer months (16%). 15 (11%) of the offered 136 clinics were not attended by 11 LACP. 45 of the LACYP (47%) were under section 20 accommodation (Children's Act 1989) while the others were subject to various court orders including interim and supervision orders.

Conclusion: Further research is needed to assess how to optimally address the high levels of physical and mental health needs of LACYP through the statutory health assessments.

Keywords: Adoption; Fostering; Integrated Services; Looked-After Children; Mental Health; Physical Health

Abbreviations: Adoption Health Assessment (AHA); British Association for Adoption and Fostering (BAAF); Ceasing to be Looked-After (CTBLA); Children and Young People (CYP), Initial Health Assessments (IHA); Looked-After Children and Young People (LACYP); North Somerset Local Authority (NSLA), Review Adoption Health Assessment (RAHA).

Introduction

Under the Children Act 1989, a child is looked after by a Local Authority (LA) if he or she falls into one of three categories: (i) provided with accommodation for a continuous period of more than 24 hours [Section 20 and 21], (ii) subject to a care order or (iii) subject to a placement order [1,2].

There is extensive evidence about the poor health and disabilities of looked after children, based on several socio-

economic and family circumstances they have experienced before entry to care or accommodation, including missed routine health surveillance and health promotion and failure to receive adequate compensatory care [3]. Children and Young People (CYP) looked after by the public (the Local Authority in the UK) are reported to have higher prevalence of mental and physical health morbidities than their peers living within their birth families [4].

Children and Young People's (CYP) experiences early in life may have long-term consequences for health and social development. Some LACYP are more likely to have experienced deprivation and poverty as a result of low family income or parental unemployment. The physical health, and social, educational and emotional wellbeing of looked-after CYP (LACYP) is influenced by the care they receive from their "public parent" while under the LA care [4].

The Department of Health's guidance document published since 2002 identifies the statutory health assessment as the basis for identifying health problems of this vulnerable group of children. It sets out requirements for an Initial Health Assessment (IHA) within four weeks of entering the care system, followed by a bi-annual health assessment for all LACYP under the age five years and annually for those over five [5]. NICE/SCIE PH28 report also highlighted the importance of access to comprehensive and accurate information about the LAC when conducting health assessments to prevent Professionals from making decisions that adversely affect the child or young person [5].

This study was conducted as a local service quality assurance audit, aimed at evaluation of current practice and implementation of best evidence improvements. Regular audit of Health needs among CYP under the public care is necessary to allow the commissioners plan effectively for the services that need to be in place for them [6].

Materials and Methods

We carried out a detailed clinical audit of the Looked-After Children and Young People (LACYP) cohort within the North Somerset Local Authority (NSLA) in South-West England, over a twelve-month period (Jan to Dec 2018), to identify their peculiar clinical characteristics, ensure that national standards are being met and to provide a benchmark for measuring the effectiveness of future quality improvements projects.

This was an audit of the LAC Health team workload

completed as part of the Clinical Governance strategies of the NSLA. No identifiable patient record was used and no research ethical approval was required.

analysis was performed with chi square (using Yates correction when relevant) for comparison of proportions among groups of patients (<http://www.socscistatistics.com/tests/chisquare2/Default2.aspx>) and T-test for comparison of two means (https://www.medcalc.org/calc/comparison_of_means.php). Analysis of variance (ANOVA) was used when testing for differences between three or more means (<http://www.danielsoper.com/statcalc/calculator.aspx?id=43>). Statistical significance is accepted at the p value of <0.05.

Results

Services Description

Initial health assessments (IHA), Adoption Health Assessments (AHA), as well as Review Adoption Health Assessments (RAHA) are usually undertaken within NSLA by a Consultant Community Paediatrician using the latest edition of Coram/BAAF Forms. Background Information was collated from various sources including Children's Social Care service records of chronology of events, minutes of Child Protection conferences and Review meetings, Maternity hospital record on M/B forms, parental health records summary provided by the GP or by the parents on the PH Coram/BAAF forms and from the Carer's CR-C Coram/BAAF forms. Additional information was provided during clinical interviews while completing IHA Coram BAAF forms.

Health care plans were formulated with specific recommendations for problems identified during the statutory health assessments, such as obtaining history and/or administering outstanding immunisations, request for information about birth or past medical history and referrals to therapy or other hospital services. The statutory review health assessments are completed mainly by the Nurses.

North Somerset Local Authority (NSLA) LACYP Population Compared with The National Database

The Department for Education, UK in 2017 [6] reported that NSLA had a total of 225 LACYP (51 per 10,000 children under age of 18 years) by March 2017 Table 1. This was less than the England's average of 62 children per 10,000 but similar to the South-West England average of 53.

	England	South West	NSLA
Children looked after at 31 March 2017	72,670	5,790	225
Rates per 10,000 children aged under 18 years	62	53	52
Children starting to be looked after during year ending 31 March 2017	32810	2,700	105
Children ceasing to be looked after during year ending 31 March 2017	31250	2,680	110
Percentage of looked after children adopted during the year	14	14	14
LACYP - Looked-after children and young people; NSLA - North Somerset Local Authority.			

Table 1: Showing Statistics of LACYP in England, South-West England and North Somerset.

The number of looked after children who ceased to be looked after in England (31,250) fell for the first time in 2017 by 2% on 2016 after rising steadily since 2008. Slightly more LACYP ceased to be looked after in NSLA than those who entered into care in the year ending in March 2017.

110 LACYP were recorded as leaving care in the year ending March 2017. Only a total of 77 notifications for Cease to Be Looked-After (CTBLA) were received for 75 CYP over the study period, consisting of 46 females (61%) and 29 males (39%). The mean age of 11 years for the females was not statistically different

from the mean age of 10 years 7 months for the males (DF: 73; t Test = 0.3483; P-Value = 0.7286).

There was no statistically significant difference between the distribution of reasons for Ceasing to Be Looked-After (CTBLA) when comparing NSLA and England data Table 2. The commonest reasons for CTBLA was NSLA as well as those older than 18 years were slightly higher than the national average (21% vs 14%) and (36% vs 28%) respectively while the proportion of those returned to their family was lower than the national average (24% vs 32%). independent living after 18 birthday (36%). The proportions of LACYP who CTBLA and were adopted.

Reasons	No of LACYP	NSLA population (%)	Avg Age (months)
Age Limit Graduates	27	36	216 (18yrs)
Return to Family	18	24	106 (8yrs 10mos)
Adopted	16	21	83 (6yrs 11mos)
SGO	5	7	19 (1yr 7mos)
CAOrd	3	4	115 (9yrs 7mos)

CAOrd - Child Arrangement Order; CPP-CIN – Child Protection /-Child in Need plan; LACYP - Looked-after children and young people; NSLA - North Somerset Local Authority; SGO - Special Guardianship Order; Sup-Ord – Supervision Order.
^s Chi-square = 5.08; degrees of freedom = 6; p = 0.53 (Not statistically significant).

Table 2: Comparing the Reasons for Cyp Ceasing to Be Looked-After in Nsla and England^s.

Clinical and Epidemiological Characteristics Of LACYP

A total of 96 LACYP aged between 5 months and 18 years (averaged 6 years 10 months) were assessed during the one-year period. There was an average of 8 CYP seen per month, with equal male and female distribution. Each of them had an average of four multidisciplinary professionals including Social Workers, Dentists, Opticians and Health Visitors and an average of three physical / mental health diagnoses.

Four (4%) of the LACYP were Unaccompanied Asylum-Seeking Children (UASC) aged 15yrs 8 months to 18yrs 11 months. 3 of the UASC were males living with foster carers and 1 female was in a residential placement. The average age of LACYP at IHA was 7 years and 5 months (89 months), 20 months at Adoption Health Assessment (AHA) and 44 months at Review AHA.

There was an average of 4 multi-disciplinary professionals involved in the care of each LACYP. The commonest professionals included Social Workers (100%), Dentist (77%), Optician/Orthoptist (52%); Health Visitor (44%), Audiology (16%), CAMHS (15%), SALT (13%), and Community Paediatricians (11%). There was a statistically significant association between number of professionals involved and the number of diagnosed

health problems ($p = 0.002$).

Nineteen socio-emotional risk factors identified among the LACYP included prenatal insults such as intra-uterine exposure to stress, tobacco, drugs and alcohol; postnatal insults like parental neglect, exposure to domestic violence; parental factors such as abuse in childhood, alcohol and substance abuse, mental health problems, and Learning Difficulties; adverse child factors such as physical, emotional or sex abuse, incomplete immunization and poor school attendance.

Each LACYP had an average of 5 identifiable risk factors, ranging from none to twelve. The commonest socio-emotional risk factors recorded were parent-related including poor mental health (65%), neglectful parenting (57%), drugs/alcohol abuse (41%) and exposure to domestic violence (47%).

Gender Differences

The females had a slightly higher rate of clinic non-attendance, which was statistically significant. 23 of the girls (48%) were on the pathway for adoption compared to 15 (31%) of the boys ($\text{Chi-square} = 2.87$; $p = 0.09$). There was no statistical difference between the genders in relation to other clinical characteristics Table 3.

Gender	No of LACYP	Avg No of Prof	Avg No of Diagnosis [#]	Avg DNA Clinics	Avg Age (mos)	Proportion planned adoption ^{&}
Female	48	4.3 ± 1.5	3.5 ± 2.4	1.5 ± 0.83	81 ± 63	23 (48%)
Male	48	3.8 ± 1.2	2.7 ± 1.6	1.2 ± 0.45	84 ± 76	15 (31%)
T-test	-	-1.803	-1.922	-2.201	0.211	2.87 ^s
P value	-	0.075	0.058	0.03 ^{**}	0.83	0.09

No of Prof – Number of multi-agency professionals, # Number of physical / mental health diagnosed problems, & LACYP who had Adoption Health Assessment (AHA) and or Review AHA, \$ Chi-square test, **Statistically significant.

Table 3: Showing the Male and Female Distribution of the LACYP.

Age Distribution

The preschool children 1 to 4 years constituted the largest group of LACYP (34%), while the school children 5-9 years were 24%. The infants less than one-year olds had the largest proportion of males and 5-9 year olds had the largest proportion of females Table 4. 31 (66%) of the preschool LACYP were on the adoption pathway, compared to 30% of the 5-9-year olds and none in those over 10 years old. The school children (5-9 years) had the largest burden of health diagnosis (average of 4 vs 3 for whole cohort).

The youngest LAC aged between 0 and 4 years had experienced higher than average number of socio-emotional risk factors compared to older CYP Table 4.

Age Range - Yr(s)	No of LACYP (%)	M/F ratio (No M/F)	Avg No of Prof [□]	Avg No of Diagnosis ^{#,□}	Avg of Clinics [□]	Avg No of Risk factors [□]	Planned Adoption ^{&}
<1	14 (15%)	2.5:1 (10M/4F)	3.5 ± 1.3	2.4 ± 1.9	1.8 ± 0.9	6.7 ± 2.9	9 (64%)
1 – 4	33 (34%)	0.9:1 (16M/17F)	4.1 ± 1.6	2.6 ± 1.7	1.5 ± 0.6	6.9 ± 2.5	22 (67%)
9-May	23 (24%)	0.4:1 (7M/16F)	4.2 ± 1.4	3.7 ± 2.6	1.2 ± 0.5	5.3 ± 3.1	7 (30%)
15-Oct	14 (15%)	1.3:1 (8M/6F)	4.2 ± 0.9	4.2 ± 1.4	1.2 ± 0.4	3.7 ± 2.6	0
16 - 19	12 (13%)	1.4:1 (7M/5F)	4.1 ± 1.1	2.8 ± 2	1.4 ± 0.7	1.8 ± 2.4	0
Total / Average	96	1:01 (48M/48F)	4.0 ± 1.4	3.1 ± 2	1.4 ± 0.6	5.4 ± 3.2	38 (40%)
F score	-	-0.1 ^{&}	0.69	2.634	2.616	9.956	-0.872 [§]
P value	-	0.873	0.601	0.039 ^{**}	0.040 ^{**}	< 0.001 ^{**}	0.054

No of Prof – Number of multi-agency professionals, # Number of physical / mental health diagnosed problems & LACYP who had AHA and or RAHA, § Chi-square test, £ Mean, ± Standard Deviation, **Statistically significant (ANOVA).

Table 4: Showing the Age Distribution of the LACYP.

Seasonal Distribution

Twice as many LACYP were seen in Spring (33%) compared to the those seen in Summer (16%). More patients were also seen in Winter (28%) compared to Autumn (21%). There was no statistically significant difference in the seasonal distribution of the LACYP's time of health assessments. Winter months were characterised by the highest number of clinics offered per LACYP as well as the highest rate of clinics not attended Table 5.

Season	No of LACYP	%	Avg No of Prof [□]	Avg No of Diagnosis ^{#,□}	Avg Age [□]	Avg-No Clinics [□]	Avg-DNA [□]
WINTER	28	29	3.8 ± 0.8	2.6 ± 1.7	77 ± 71	1.7 ± 0.9	1.6 ± 0.9
SPRING	32	33	4.6 ± 1.9	3.6 ± 2.4	104 ± 75	1.4 ± 0.6	1.2 ± 0.4
SUMMER	15	16	4.2 ± 1.1	3.4 ± 2.3	65 ± 62	1.3 ± 0.5	0.0 ± 0
AUTUMN	21	22	4.0 ± 1.0	3 ± 1.7	71 ± 59	1.1 ± 0.3	1.0 ± 0

F score/ Chi²&	-	6.8 ^{&}	1.91	1.29	1.63	3.64	29.33
P value	-	0.8	0.13	0.28	0.19	0.02**	<0.001**

No of Prof – Number of multi-agency professionals, [#]Number of physical / mental health diagnosed problems, [&] Chi square for goodness of fit, [□]Mean ± Standard Deviation, ^{**}Statistically significant.

Table 5: Showing the Seasonal Distribution at Presentation.

Clinic “Did not Attend” (DNA) Rates

The LACYP were offered a total of 136 clinics (11.3 per month), out of which 15 (11%) were not attended by 11 LACYP (Average of 1.4 DNAs). 5 additional clinics were offered to meet with the prospective Adoptive parents. The LACYP who failed to attend one or two clinics were significantly older (average age of 10 years and 10 months vs 6yrs and 4 months), with a p value < 0.001. The LACYP who missed their clinics had experienced less adverse socio-emotional risk factors (4 vs 6) compared to the others Table 6. Characteristics of LACYP Placed for Adoption.

Clinic Status	[§]No of LACYP (%)	Avg Prof[□]	Avg Clinics[□]	Avg Diagnosis^{#,□}	Avg Age[□]	Avg Risk factors[□]
DNAs	11 (11%)	3.5 ± 1	2.5 ± 0.7	3.1 ± 2.3	130 ± 80	4.4 ± 2.6
Non-DNA	85 (89%)	4.1 ± 1.4	1.3 ± 0.5	3.1 ± 2	76 ± 66	5.5 ± 3.3
T Test		1.37	-7.14	0	2.49	1.06
P value		0.17	< 0.001**	1	0.014**	0.29

Prof – Number of multi-agency professionals, # Number of physical / mental health diagnosed problems, § Gender ratio: DNA - M 5 / F 6; No DNA - M43/F42, £ Mean, ± Standard Deviation, **Statistically significant.

Table 6: Showing the Comparison of LACYP Who Attended Vs Dnas.

Thirty-eight LACYP (40%) were planned for adoption and had either an adoption or review adoption health assessments (RAHA) with an average age of 3 years and 1 month compared to 9yrs 5 months for those who only had Initial Health Assessments (IHA).

Five children who had only AHA were the youngest cohort with average age of 15 months, while 7 children who had AHA at average age of 17 months had subsequent RAHA after 6 months because their adoption placement was not yet completed. 15 children who had AHA on average of 3 months after an IHA had mean age of 19 months at the time of IHA. 9 older children who had their AHA in the previous year had only RAHA at an average age of 5 years.

The largest proportion of adopted LACYP (22/38) were aged between 1 and 4 years (58%) with average age of 3 years and 1 month, while 24% (9/38) were under 1 year, and 18% were aged 5 to 9-year Table 4. None of the LACYP older than 9 years were planned to be adopted.

There were statistically significant differences between the groups of LACYP who had only IHA and those planned for adoption with regards to their average ages, missed clinic attendance, number of clinics attended and the degree of their socio-psychological risk factors Table 7.

Categories	No of LACYP (%)	Avg Prof [□]	Avg Diagnosis ^{#,□}	Avg-Age [□]	Avg DNA [□]	Avg Clinics [□]	Avg Risk factors [□]
IHA	58 (60%)	3.9 ± 1.1	3.0 ± 2.0	113 ± 72	1.2 ± 0.4	1.2 ± 0.5	4.2 ± 3.1
IHA_AHA	17 (18%)	4.1 ± 1.1	3.3 ± 1.8	28 ± 25	2.0 ± 1.4	2.2 ± 0.7	8 ± 2.1
Adopt	21 (22%)	4.6 ± 2	3.3 ± 2.5	44 ± 30	0	1.3 ± 0.5	7 ± 2.5
F score	-	2.09	0.24	19.49	45.62	23.02	15.73
P value	-	0.13	0.79	<0.001**	<0.001**	<0.001**	<0.001**

IHA -Initial health assessment; AHA - Adoption health assessment including Review Adoption health assessment
 Prof – Number of multi-agency professionals, # Number of physical / mental health diagnosed problems, [□] Mean ± Standard Deviation, **Statistically significant.

Table 7: Showing Clinical Characteristics of Different Categories of LACYP in Regards to Adoption.

Legal Status of LACYP

LACYP in the care of the Local Authority (LA) in the UK are either voluntarily accommodated or subject to a Care Order (CO) made by court to grant shared parental responsibility with the LA [2]. 45 of the LACYP (47%) were under section 20 accommodation (Children’s Act 1989) while the others were subject to various court orders (CO) including interim CO, Emergency Protection Order (EPO), Police Protection Order (PPO) or Placement Order (PO). There were no statistically significant differences in the gender ratios and other clinical characteristics between the two categories, apart from their average age Table 8. The LACYP on court orders were significantly younger than those under s20 accommodation (4yrs 2mos vs 10yrs).

Legal Status	No of LACYP [§]	Avg Prof [□]	Avg No Clinic [□]	Avg Diagnosis ^{#,□}	Avg Age [□]	Avg-DNA [□]	Avg-Risks [□]
s20	45	3.8 ± 1.1	1.3 ± 0.6	2.7 ± 1.8	120 ± 77	1.4 ± 0.7	4.5 ± 3.3
COs	51	4.2 ± 1.6	1.5 ± 0.6	3.5 ± 2.2	50 ± 40	1.3 ± 0.6	6.2 ± 2.9
T test	-	1.41	1.63	1.93	5.68	-0.75	2.69
P value	-	0.162	0.11	0.06	<0.001**	0.45	0.008**

CO - various court orders, Prof – Number of multi-agency professionals, #Number of physical / mental health diagnosed problems, [§]Gender ratio: s20 - M 23 / F 22; CO – M 25 / F 26, [□]Mean, ±Standard Deviation, **Statistically significant.

Table 8: Showing Clinical Characteristics of Different Categories of LACYP in Regards to Their Legal Status.

Types of Placement

The LACYP were categorized into the three main types of placement: foster care in a substitute family receiving payment for the child’s living expenses; kinship care with a family member or approved custodian and supported residential care run by paid staff [7]. Kinship placements also included living with birth parents in a Family assessment centre. 78% of the LACYP were in foster placement, 17% in kinship care and only 5% were in residential care Table 9.

There was no statistically significant difference in the gender ratios of the three categories. All the 5 LACYP in residential homes were females, while there was a slight male predominance among the cohorts in other placement types (52% males in foster-care and 56% males in kinship-care).

The number of diagnosed problems in fostered and residential LACYP was significantly higher than those in kinship placements. Fostered LACYP were also significantly more likely to miss clinic appointments than other categories Table 9.

Placement Types	No of LACYP ^s	Avg Prof [□]	Avg Clinics [□]	Avg Diagnosis ^{#,□}	Avg Age [□]	Avg DNA [□]	Avg-Risks [□]
Foster	75	4.1 ± 1.4	1.5 ± 0.7	3.4 ± 2.1	82 ± 69	1.6 ± 0.8	5.4 ± 3.3
Family	16	3.6 ± 1	1.3 ± 0.6	1.6 ± 1	48 ± 40	1 ± 0	6.0 ± 2.6
Residence	5	4.6 ± 0.9	1.4 ± 0.5	3.6 ± 2.3	195 ± 17	1 ± 0	3.2 ± 2.8
F score	5.37 ^{&}	1.41	0.6	5.64	10.14	5.8	1.48
P value	0.068	0.25	0.55	0.005 ^{**}	<0.001 ^{**}	0.004 ^{**}	0.23

Prof – Number of multi-agency professionals, & Chi square test, # Number of physical / mental health diagnosed problems, ^s Gender ratio: Foster - M 39 / F 36; Family M 9 / F 7; Residence M 0 / F 5, [□] Mean, ± Standard Deviation, ^{**}Statistically significant.

Table 9: Showing Clinical Characteristics of Different Categories of LACYP in Regards to Their Types of Placement.

CYP who Ceased being Looked-After 16 of the examined cohort (17%) ceased to be LAC within the year, with slight (56%) female predominance. Statistical analysis showed no significant differences in age, adverse risk factors, number of diagnoses or number of professionals between those who ceased and others who remained in care Table 10.

LAC Status	^s No of LACYP (%)	Avg Prof [□]	Avg Clinics [□]	Avg Diagnosis ^{#,□}	Avg Age [□]	Avg DNA [□]	Avg-Risks [□]
Cease	16 (%)	3.8 ± 1.1	1.5 ± 0.7	2.4 ± 1.7	88 ± 70	1.2 ± 0.4	4.2 ± 2.9
Remaining	80 (%)	4.1 ± 1.4	1.4 ± 0.6	3.2 ± 2.1	81 ± 70	1.5 ± 0.8	5.6 ± 3.2
T test score	0.3 ^{&}	0.8	-0.59	1.431	-0.36	1.459	1.621
P value	0.58	0.42	0.56	0.16	0.72	0.15	0.11

Prof – Number of multi-agency professionals, #Number of physical / mental health diagnosed problems, & Chi square test, ^s Gender ratio: Cease - M 7 / F 9; Non-Cease – M 41 / F 39, [□]Mean, ±Standard Deviation, ^{**}Statistically significant.

Table 10: Showing Clinical Characteristics of Different Categories of LACYP in Regards to Their Types of Placement.

Discussion

Regular audit of Health needs among CYP under the public care is necessary to allow the commissioners plan effectively for the services that need to be in place for them [6]. It also helps the Local Authority and its multi-agency partners and care providers to constantly strive towards achievement of high-quality services that meet the diverse and complex physical and mental health needs of LACYP.

We compared the clinical and epidemiological characteristics of LACYP in a South West England LA with the national cohort. Our study sample comprised of 1:1 males and female ratio, which contrasts with the slightly male predominance in England (56% males at 31 March 2017) and 65% males in a London Borough [1,8].

Our LACYP population had disproportionately higher number of infants and younger children less than 10 years old, compared to the national average. The age profile of looked after

children in England includes 5% <1 year, 13% 1 to 4 years, 19% 5 to 9 years, 39% 10-15 and 24% for 16yrs and over [1]. In Wales 18% of all children looked after were under five years old [9]. This compares with our own population of infants <1 year being 15%, 13% 1 to 4 years constituted 34% while 5 to 9 years were 24%. The predominance of children and toddlers below 5 years of age in our LAC population was 48%, compared to the predominance of older adolescents in the London Boroughs population (44% > 15 years), and England average (24% > 15 years). This may reflect the higher prevalence of unaccompanied asylum-seeking children (UASC) in the London population. Our UASC population was only 4% compared to 6.3% of LACYP population in England [1].

31% of CYP starting to be looked-after in 2017 in England were under a care order, with 53% under a voluntary agreement under section 20 of the Children Act 1989 and 13% were detained for child protection and 2% under youth justice statuses. This compares with of our study population with 47% under section 20 voluntary accommodation and 53% under a care order. About 60

per cent of children looked after in Wales were in care as a result of a court order and 40 per cent were provided with accommodation on a voluntary basis. These proportions are broadly similar to those in England [10].

74% of children looked after at 31 March 2017 in England were in foster placements and 17% were fostered by a relative or friend [1]. This compares favourably with the current study (78% in foster placement and 17% in kinship care).

In 2017, the average age at adoption in England was 3 years and 4 months, 71% of them aged 1 to 4 years, 5 to 9-year olds represented 21%, 7% were aged under 1 year and the remaining 1% were aged 10 years and over. This is similar to our local population with the largest proportion of adopted LACYP aged between 1 and 4 years (58%) with average age of 3 years and 1 month, while 24% were under 1 year, and 18% aged 5 to 9-year olds. In England, the number of looked after children (4350) who were adopted in 2017 decreased by 8% from 2016, continuing to decline from a peak of 5,360 in 2015 [1].

Studies of Scottish adopted children under the age of five also showed that Children on an adoption pathway were significantly younger when they started to be looked after away from home than children on all other pathways. Over half (56%) of those on an adoption pathway had become looked after away from home before they were six weeks old [11].

The DNA rates for IHA among our LACYP population is 11%. This is similar findings of at the Heart of England NHS Foundation Trust, where a 20% 'decliner' rate was reported in 2012 (10% for IHA vs 70% for RHAs). 82% of the decliners could be successfully engaged either via telephone consultation (68%) or face-to-face (32%) through a more flexible arrangement chosen by the CYP [12].

There are recently many government-led initiatives in the UK to encourage closer integration of services provided to LACYP by statutory agencies and the voluntary sector through integrated care pathways to enhance their optimal physical and mental health wellbeing [13].

Limitations of The Study

Results of any retrospective audit like ours is fraught with some potential limitations and require some caution in their interpretation and wider applicability to wider populations outside the study area. Routinely collected information from patient encounters may potentially be incomplete and thereby introduce some bias. Our LA undertakes regular multi-agency discussions between the social and health teams, to encourage high-standards in the quality of routinely provided services. Furthermore, all the health assessments have been conducted by a single clinician and the same LAC health team to the same level of high standard

throughout the study period. The health team has access to the social care database and it's unlikely that any CYP who were in the care of the LA for even very brief periods are missed for their statutory health assessments.

The outcomes of the health assessment recommendations were not studied. Other authors have previously reported on the various problems encountered in the implementation specific health recommendations, which is usually around only 50% [14,15]. The report on the longer-term outcomes of CLA status of each individual CYP was also outside the scope of the study.

One of the great strengths of this study is the detailed description of the clinical and epidemiological characteristics of CYP under the care of a relatively small LA in the South West of England from a single-site.

Conclusion

LACYP are more vulnerable to mental and physical health morbidity than their peers living within birth families. Our LACYP population had disproportionately higher number of infants and younger children less than 10 years old, compared to the national average. Further research is needed to assess how to optimally address the high levels of physical and mental health needs of LACYP through the statutory health assessments, including necessary rearrangement of services to ensure closer integration of services provided by statutory agencies and the voluntary sector.

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Conflict of Interest

author declares no conflict of interest for this article and no financial or non-financial benefits have been or will be received from any party directly or indirectly related to the paper.

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